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Transcript of Hearing on Professional Liability

Joint Committee on Tort Liability

JOINT COMMITTEE ON TORT LIABILITY

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PROFESSIONAL LIABILITY

Los Angeles, California

July 11, 1977

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California Legislature

Joint Committee on Tort Liability

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CHAIRMAN

A G E N D A

Professional Liability
State Building Auditorium, Room 1138
107 South Broadway, Los Angeles, CA
July 11, 1977

1.	James Ludlum	Counsel to California Hospital Assn.
2.	Samuel Shore	California Trial Lawyers
3.	Nicholas P. Krikes, M.D.	President elect, CMA
4.	Howard Hassard	Hassard, Bonnington, Rogers & Huber, counsel for CMA
5.	Paul Slawson, M.D.	California Psychiatric Assn.
6.	Jack Long	California Legislative Council of Professional Engineers
7.	Ralph Gampell	President, California State Bar
8.	Gilbert Jones	Bonnie & Jones
9.	Don Zuk Sanford Rothenberg, M.D.	Johnson and Higgins Representing Southern California Physicians Insurance Exchange
10.	Jerry Sullivan	Walker, Sullivan & Co.
11.	David Rubsamen, M.D.,J.D.	
12.	Ted Ellsworth	The Doctors Company
13.	J. David Gaynor, D.D.S.	California Dental Assn.
14.	Victor McCarty	Certified Public Accountants Assn.
15.	Laura Peluso	Architects & Engineers Professional Liability Insurance

78-1-199

Joint Committee on Tort Liability
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CHAIRMAN JOHN KNOX: Could we come to order, please, so that we will start the meeting on time. We have a fairly long agenda today and we would like to be sure and give everybody an ample opportunity to make an appropriate comment. This is a regularly called hearing of the California Legislature's Joint Committee on Tort Liability. We are here today to discuss with some particularity the question of professional liability and we have a number of witnesses representing various points of view.

I have a very brief opening statement, and copies are available at the front. (See Appendix I) We all remember that two years ago Californians were briefly denied essential medical services because many doctors felt they were unable to pay the high premium cost of over $10,000 per physician on an average basis. Now there are other professionals, attorneys, dentists and accountants, and I am very fond of saying, now that it affects attorneys the time has come to do something about it. We are all faced with similar skyrocketing insurance charges. California attorneys, for example, were recently billed and told that their malpractice insurance premiums would be increased over 300% from about $600 to about $2,000 on the average and some, of course, were higher. In response to these escalating costs, the affected professions have ceased practice, raised their fees, gone without insurance, and we have learned that about 20% of the physicians in this State are going bare or have moved to other states. These responses, however logical and understandable for the professions,

are certainly not in the public interest. The only acceptable solution in California for this crisis is to somehow assure that liability insurance is both available and affordable.

The purpose of today's hearing is to learn the reasons and possible solutions of the problems. Our witnesses are mainly representatives of law and medicine because these professions are facing the most severe problems and the Legislature has already enacted some laws intended to redress their problems. I understand we will be reviewing what effect those changes have had. However, we will also hear from accountants and engineers.

This is the first of a series of hearings to be held by the Committee this month. On July 18 we will hear testimony in San Diego on product liability problems and on July 22 we will meet in San Francisco to hear testimony on insurance company practices. These and other hearings will form the basis for interim recommendations we intend to make for legislation before the next session of the Legislature. We are aware that the problems are complex and politically difficult to resolve. Accordingly we ask witnesses to give their primary concern in formulating their proposed legislative solutions to the public interest, recognizing that this may not always coincide with the given profession's best interest, and I would like to emphasize that last point. I think that I can speak safely for all the members of the Committee and the staff that we are satisfied a serious problem exists so we don't need a lot of horror stories, except insofar as they may be illustrative. We are primarily interested in what can be done or what has been done and what effect it may have on the particular processings. I would like to introduce

the members of the Committee and the staff who are here and others as they appear later on. To my left is Assemblyman Alister McAlister of Santa Clara County, who also is Chairman of the Finance, Insurance, and Commerce Committee of the State Assembly, and to his right is Darlene Fridley, Secretary to the Committee. On my far right one of the Staff Counsel, Fred Hiestand, and to my immediate right another Staff Counsel, Martha Gorman. In the front row we have our two staff interns, Harriet Bearman and Brian Regan. Herschel Rosenthal from Los Angeles is also with us. Glad to have you here, Herschel; and coming up is Senator Newton Russell of Los Angeles County. Glad to have you here, too.

Our first witness this morning is Mr. James Ludlum, Counsel for the California Hospital Association and with him will be witness number ten, Jerry Sullivan of the Walker, Sullivan Company. Mr. Ludlum and Mr. Sullivan.

(See Appendix II for written testimony.)

MR. JAMES E. LUDLUM: Thank you, Mr. Chairman. For the record, I am James E. Ludlum of the law firm of Musick, Peeler, and Garrett in Los Angeles and I am presently Senior Counsel for the California Hospital Association and with me is Jerry Sullivan. I will testify first and then Jerry Sullivan who is the President of the Walker, Sullivan Company will follow and we will both be available for questioning. I thought that the reason we might testify together is because we will cover the whole gamut of what is happening to the hospital situation in California and recommendations that we might make to you as to where we go from there. In the first place I would like to introduce the fact that I have served on Secretary Richardson's famous Commission on Medical Malpractice

in 1971-72, and more recently have been a member of the American Bar Association Commission on Medical Professional Liability which will be making its report to the American Bar Association in August in Chicago this year.

I would like to direct myself first to the national picture and what the ABA Commission will come out with and what its findings will be. The report will be somewhat as I see it here in California. We are a little bit like the volcano watchers on Mount Kileauea. We have had an eruption. We are not having an eruption right now, but there is plenty of bubbling going on down there in that volcano, and we don't know whether it will break loose and what will occur. What the ABA Commission is finding is that there is presently no panic, but we have stabilized the insurance market for medical professional liability at a very high, and perhaps excessively high rate. However there is no assurance that the problems which we had in 1974, 75 and 76 will not break loose again. The insurance companies are, to a degree, coming back into the market. There has been some fulfilling of the market through reinsurance and in some states through what we call bedpan mutuals, or doctor-owned or hospital-owned companies. Elsewhere there is, as I say, not a critial problem in the insurance field, except for the cost. Now it's important for this Committee to know that the subject of tort liability problems as it relates to the total picture is now of concern to the American Bar Association. The Chairman has alluded to the lawyer's problems and they are now looking at it on a big scale. There will be a recommendation to the ABA House of Delegates in August that they form a Commission somewhat similar to yours, except at the voluntary

level, to look at the total liability situation.

Now as a contribution to your work, I have prepared a written statement, which I will not read, but which will be a further contribution to your work. I call your attention to certain parts of it (I think copies have been distributed to all the members). In particular, I point out that on Page 3 of the statement there has been set forth for your consideration the recommendations of the ABA Commission on what should constitute a liability system, and I think that any committee such as yours has to start out with a set of goals. I think you will find this of assistance to criticize, modify as you may see fit, and then judge any proposals which you receive against these goals. I won't go through them at this point except to point out the fact that at least the present system certainly doesn't meet these goals. Whether a better system can be evolved in time is itself a problem. Another part of our interim report, and again I am referring to Page 4, lists certain modifications in the current tort system which are recommended by that Commission. By and large most of these recommendations, and certainly the substantive ones, have been adopted in California. As a matter of fact, California was a lead state in tort reform in this area, some of it done by court action and some by legislation, but mostly in AB 1XX of the 1975 Session. I call your attention to the fact, however, that certain of the recommendations have not been followed in California to date. The Figure 1 that I referred to has to do with guarantee of results on Page 6 where it is recommended by the ABA Commission that there only be liability in the event there is a written promise to guarantee a result.

On the issues of nontaxable status of awards on Page 7,

again, there has been no action here in California as yet. This is something which should be of interest to juries and we believe this information should be brought to their attention.

Item No. 16 relates to punitive damages, and this is a critical unresolved problem in California not only for the malpractice liability problem but for all types of liability coverage. The issue is an open legal issue as to whether or not you can insure punitive damages. It has not been resolved by the courts of California. The courts nationwide are split on this issue. On behalf of the Association we have taken the viewpoint that it is insured under our policy but our insurance company has not agreed with this and sometime we will be in litigation to determine the degree of that coverage. Fortunately, it has been a harassing point to date more than it has been an issue of dollars, but more than 60% of the cases that are filed against hospitals at the present time include an allegation of punitive damages, and yet we hardly have a dollar one on this issue. But this does mean that the insurance company must notify the hospital, and on the doctor's side, the doctor, that he may be uninsured for this allegation. The allegations are always in millions of dollars and it creates a very sticky point between the plaintiff and the defendent and makes it extraordinarily difficult to settle because, really, from the hospital's point of view, if the case is settled, we have no issue of punitive damages. If it goes to trial, then we are exposed to additional risk. It distorts the relationship in the negotiating process at this point. We are finding that plaintiff's attorneys are becoming concerned about this issue when they settle cases because they now want us to waive punitive damages against them in the event we choose to coun-

tersue. Now I think there is something to be said on both sides for a need for relief from the matter of punitive damages. We believe, and the ABA Commission believes, that the issue of punitive damages should be in the professional areas, be under the jurisdiction of the ruling commission, whether it be a licensing board for both the Bar and for medicine, and that they should have the power to assess punitive damages or, in lieu thereof, their other penalties...

CHAIRMAN KNOX: I see, okay.

MR. LUDLUM: ...and that it should be treated as a professional disciplinary matter and not left to judges and juries, or primarily juries in this case, because they cannot relate to what the professional problem is, which is supposedly the justification for punitive damages. So we would strongly urge you in looking at the issue of total liability to both lawyers, doctors, dentists and other professional groups to see if a modification of the punitive damage matter cannot be taken.

Another matter which has been a critical issue to all parties is whether or not the crisis of 1974, 75 and 76 was insurance-caused prices. In other words, were the insurance companies the culprits in this matter? I think it is important for you to know that the ABA Commission will find that this was not true, that they were the victims of the crisis just as were the professions and others. And in that regard, one of the studies which has been prepared on this, and I don't know whether it has been made available to the Committee, is the study on the cost and profitability -- I don't know where they got that word -- of hospital malpractice insurance.

CHAIRMAN KNOX: Cost and what?

MR. LUDLUM: Cost -- studies on the cost and profitability of hospital...

CHAIRMAN KNOX: Profitability?

MR. LUDLUM: Yes. And the negative possiblity has shown starting in 1969 is when the cost exceeded the returns including investment incomes. I don't know whether Mr. Hiestand has a copy of this study yet. There are only a few copies produced and I'll have it xeroxed and furnished to you. California is one of the four states that was studied and it parallels the study which was made in California by the Auditor General's Office and tends to confirm this, but it does indicate that the insurance companies did not see the changes which were occurring and did not rate their premiums fast enough. Then they were caught in the wage price freeze of 1972, '73 and '74; they were also caught with long-term contracts under which they could only increase premiums by roughly 15% a year at the time that their costs were going up 100% a year. So when these contracts ran out, when the wage price rates came out, they had to raise their premiums as they did in California 300%-400%.

CHAIRMAN KNOX: I wasn't satisfied with the Auditor General's report as far as giving us a true picture of what happened inside insurance companies. I hoped that...

MR. LUDLUM: It didn't. I agree with you.

CHAIRMAN KNOX: ...it would do a better job. I thought the Auditor General's report was totally inadequate to give us any guidance at all.

MR. LUDLUM: It used external figures and this study will give you internal figures, cost figures. I think it will be much

more useful to you in this regard. And I don't know why it hasn't been given more publicity. I think it is an important working document for you to use in this regard. What it does prove is that there was a time lag on the malpractice insurance picture such that the insurance companies themselves could not anticipate it with their method of accounting and they got frightened. As a matter of fact, if you will look at the last sheet of my statement we have the frequency chart for California in the hospital field and it shows starting in 1966 you've got a relatively level frequency pattern and then starting in 1971, 72, 73 and 74, you've doubled the frequency. Now at the same time that occurred, our severity, or the cost per claim, was doubling. There is 400% right there as you multiply these things out. But more important as you look at that chart is that in 1975 and 76, there was a leveling out of infrequency which we believe was the result of both the publicity about AB 1XX and the result of AB 1XX. So even though we have not received the full benefit of AB 1XX and won't until the Supreme Court opines on this subject, one way or the other, hopefully favorably, we have received a substantial benefit from the implementation of AB 1XX and obviously would get a great deal more after that is decided, hopefully favorably. Now the other study which...

CHAIRMAN KNOX: Senator Song from Los Angeles County is with us.

SENATOR SONG: Mr. Ludlum, perhaps I am not following you. I was somewhat late. How are you trying to use the term "frequency" -- frequency of what?

MR. LUDLUM: Frequency of claims.

SENATOR SONG: Of claims. For 100 beds?

MR. LUDLUM: For 100 beds. That's correct.

SENATOR SONG: So in 1974 it was 6.86 per 100 beds?

MR. LUDLUM: Correct.

SENATOR SONG: And as far as the average disposition per claim, not necessarily in dollar amounts, can you tell us what proportion of them were in favor of the claimants and...

MR LUDLUM: About 50% of them were closed without payment.

SENATOR SONG: Without payment.

MR. LUDLUM: Isn't that correct, Jerry?

SENATOR SONG: Then out of the 50% that were paid, do you have any idea on the average how many proceeded to judgment or how many were settled?

MR. LUDLUM: Well, obviously all the ones for which payment was made, there was either a judgment or a settlement, but as far as going to actual litigation and to trial, I think the record would show around 6 or 7%.

SENATOR SONG: And of that number, if the statistics that I have been exposed to in Los Angeles County in reference to our Superior Court here are correct, about 60% of them were defense verdicts, were they not?

MR. LUDLUM: It might even be a little higher than that.

SENATOR SONG: A little higher.

MR. LUDLUM: I think you have to know why that occurs is because those are the big ones that are highly speculative. The ones where it is clear liability are the ones that are settled.

SENATOR SONG: Well, that may or may not be true. I am certainly not disputing you in this particular sense, Mr. Ludlum, but you say that these are speculative and they are going after the

big amounts. This would necessarily involve a substantial investment, so to speak, on the part of the plaintiff's counsel.

MR. LUDLUM: Correct.

SENATOR SONG: Expert fees, depositions, discovery. I understand that sometimes in these cases, where they hope for a recovery in six or seven figures, that they may invest $50,000, maybe $100,000, or in excess thereof as far as the plaintiff is concerned. It is not totally speculative. I would assume no attorney would take a flyer like that unless he felt he had a fairly good chance of making a recovery. Isn't that a fair assumption?

MR. LUDLUM: That's a fair assumption. It is speculative on both sides. The costs are run up on both sides.

SENATOR SONG: You indicated, however, that in your opinion more than 60% of the claims that proceed to trial will result in defense verdicts.

MR. LUDLUM: Correct.

SENATOR SONG: Well, it seemed to me, going back to your prior statement (and here again I am not disputing it because I have no particular store of knowledge nor the expertise with which I might argue with you about these figures), you indicated that the ABA study has concluded that the insurance companies were not after -- and I use the term advisedly -- at fault with reference to this malpractice situation.

MR. LUDLUM: They are not comparable. I think it might be...

SENATOR SONG: Frankly, I've looked into it at length serving in one committee or the other in Sacramento, and I have yet to see any kind of figures or statistics or conclusions that I

would consider to be reliable at all. Now, do you know who conducted the AB study and what they actually studied?

MR. LUDLUM: Well, this study was done by ABT. It is an Associate Inc. of Cambridge, Massachusetts. Woodford and Fondiller were the actuaries on the study that did that review. They are one of the six or eight big national actuarial firms.

CHAIRMAN KNOX: Senator, we are going to get a copy of it and have the staff analyze it.

SENATOR SONG: All right, fine.

CHAIRMAN KNOX: I have not seen it, and I guess nobody has seen it as yet, so they will provide us with a copy of it.

MR. LUDLUM: I agree with you, Senator, one of our big problems has been that we haven't had this type of information yet. The problem to us as providers is the same as it has been to you as legislators.

SENATOR SONG: You have indicated, Mr. Chairman, you didn't find the report of the Auditor General particularly stimulating. Neither did I.

CHAIRMAN KNOX: I didn't think it got inside the insurance company.

SENATOR SONG: Mr. Ludlum's statement here was in the form of a conclusion, or at least an opinion. The only thing that concerns me, and I will close with this, Mr. Chairman, is that I have never seen anything that really satisfies me and I don't think it satisfies anyone who has looked at this problem with any degree of objectivity. I have also heard on more than one occasion statements to the effect that, for example, the major malpractice carrier in California had lost $400 million in the stock market and

that may have been a contributing factor as far as that company deciding to withdraw from the malpractice field. Is there accuracy to that? I guess it is nothing but a rumor at this point.

MR. LUDLUM: Well, we have been interested in that. Argonaut at that time was the insurance carrier for the Group Workmen's Comp Program of the California Hospital Association, so we have followed the travails of Argonaut with a great deal of interest since we paid them very substantial premiums in another field. Our impression of the Argonaut situation is that it is very complex but it is true they suffered very severe underwriting losses by going into the New York picture at the wrong time. Their timing was terrible. They did have capital stock market losses. Under the insurance laws, they cannot recover capital losses against premiums. It cannot be reflected in future premiums. What it does is affect the ability of the carrier to write additional risks or to write those risks in writing because it must maintain capital and surplus related on a ratio to the premium. This is when the insurance commissioners come in and you know what has happened to the Signal Imperial situation where their ratio became too low. They were actually almost put out of business; not quite, but almost, here in California.

CHAIRMAN KNOX: Mr. Ludlum, we spent about three hours, some of us, in the Insurance Commissioner's office the other day and I am afraid we are all getting brainwashed by insurance accounting systems. I'm not sure that's true that they don't recover stock market capital losses by raising premiums. I don't think the information the insurance company has shows that -- pardon me, Senator. I just think we've got to get inside the situation. I am not satisfied with the information we have at all at this point, but that's

another subject perhaps, Senator, and I apologize for interrupting.

MR. LUDLUM: I think it is well worth getting into and we have followed it very carefully because, as a matter of fact, as our program has grown so rapidly in premiums, we have had to relate to this issue with our own carrier. The Truck Insurance Exchange, which has been carrying the hospital risk, ran out of capital to cover the additional premium which we were paying for them and had to lay half of its risk off with the Farmers Insurance Group.

CHAIRMAN KNOX: We have a situation where the Insurance Commissioner will require a certain amount of capital which is co-mingled. It is not segregated nor is it to cover reserved and un-reported risks. Where there is a stock market loss and you have a publicly held company with non-accessible stock and we haven't seen any effort to raise that lost capital by these companies, so I don't know..... There is only one place their losses can come from in the premium failure, and I don't -- and if somebody can disabuse me of that, I would sure like to know about it.

MR. LUDLUM: We will take that up at another point and give you our information because we are equally concerned about it since we are a major purchaser of insurance. Our premium runs roughly $150 million a year, so we are interested in these issues the same as you are because we are being placed under cost caps by both state and federal government as to increasing hospital costs. Obviously anything which goes up the way malpractice premiums do is a concern to us.

To continue, our experience, as I have indicated from the chart under AB 1XX, has been that if we had not had AB 1XX, we would have been under water. Now, we are waiting to see what

happens on the Supreme Court. We will be joining with the legislative leadership on the suit against the Commissioner which hopefully will test it. We will be an amicus, but we will obviously wait perhaps a year before we reach that result. Another issue which is important to us is the American Motorcycle case on the apportionment of losses. This is something, again, your committee may want to look at, depending upon what finally comes out of the Supreme Court...

CHAIRMAN KNOX: We have looked at it, yes.

MR. LUDLUM: ...and it is a very important one to us. With our apportionment of losses, there has been a reduction in the proportion that the hospitals have had to pay vis-a-vis the doctor. It doesn't solve the doctor's problem obviously, but it has been a relief to us because it has countered to a degree the movement by the courts and juries to test liability against hospitals for doctors' acts. There is an increasing trend of liability for hospitals for the doctors' acts. We don't think that will turn around. That will continue. It is not necessarily bad, but it affects our ability to be insured.

CHAIRMAN KNOX: Have you looked at our legislation on the "Mary Carter" agreements?

MR. LUDLUM: Yes, I want to conclude in saying we obviously support that legislation. It is a very critical problem to us and it will be more serious as we are dealing with the uninsured doctor problem. We have had the problem with the insured doctor, but we are going to have the issue with the uninsured doctor and we have cases involving, I think, roughly 200 cases where there are uninsured doctors involved and we are sure there would be pressure on

them to engage in "Mary Carter" agreements and testify under the biases which will occur. We think that is a sound bill that you presented and will certainly support it.

There are two other bills which we would support too. The two bills by Senator Behr on emergency care, because we have problems in staffing our emergency departments. The problem is, briefly, a doctor does not like to come in without a physician-patient relationship, yet he is called in on automobile accident cases, he has no knowledge who his patient is and yet he comes in on a very serious case where the party is already going to sue somebody because of either the automobile accident or because of certain other things that may have happened to him. So they are reluctant to come in. We think we need some protection for those outside doctors. We are prepared to assume the risk for the regular doctor who is at the emergency room. That's part of our business. But in order to get the back-up coverage from physicians, we need that and it is very important to a well-qualified emergency room. You would want a good neurosurgeon, a good orthopod to come and take care of you if you or your family was involved in that situation. We think we need relief on that.

Those are temporary things. Looking to the big picture as to where you go from here, it is our feeling that probably AB lXX, in the long run, is not the ultimate solution, that this situation will break loose again two or three years from now and we will see an increase of the severity and frequency factors. So we believe that the work of your committee is of tremendous importance, that we no longer can look at malpractice separately from total tort liability. We have to look at liability or a compensation system

for all types of injuries. We then must correlate the compensation system so we do not have one system for medical malpractice, one system for legal malpractice, one for Workmen's Comp, one for long-term disability so that we are duplicating our costs with very high overhead that doesn't go back to the parties for which it is to benefit. We would urge you then not to look at any one system, but look at the total system. Your experience under AB 1XX will be helpful to you. The periodic payments, Mr. Sullivan will speak to that. Experience on the effectiveness of modifying the collateral source rule is very important to this total picture. That means what you are really doing is moving toward correlating the insurance system and the liability system. Until those two can be brought together as a whole we are going to be dealing with this on a piecemeal and very unsatisfactory basis forever.

CHAIRMAN KNOX: I want to just clarify one thing. When you say that there are 6.86, or whatever it is, claims for 100 beds, those beds turn over a number of times per year so it is not 6% of the people of the hospital who are sueing. How many times does a bed turn over on the average?

MR LUDLUM: Well, our occupancy runs about 285 patient days per bed per year.

CHAIRMAN KNOX: So if it is 6.86 or whatever it is claims per 100 beds...

MR. LUDLUM: And you have about a 7-day occupancy -- I should have my computer here but it is just a relatively low factor. But when you have millions of patient days, it mounts up in California.

CHAIRMAN KNOX: Before I ask any other questions, I would like to introduce another colleague, Assemblyman Floyd Mori on my

far left, from Alameda County. Are there any questions from members of the committee?

MR. LUDLUM: One closing thing, in connection with the compensation system, we are working on a -- what we call a Medical Injury Compensation system which would be a modified workmen's compensation proposal. We would hope to have that available in the next three or four months and we would like to furnish it to your committee for your study as well.

CHAIRMAN KNOX: We are very interested in that. I know your alternative system is right in handling it. Any questions from members of the committee? Questions from the staff? Ms. Gorman.

MS. GORMAN: Back to your proposal you mentioned on punitive damages. Would that proposal be that when they are assessed by a licensing board, or whatever, that they would be paid to the claimant for...

MR. LUDLUM: No. They would be paid into a general fund to support the activities of the License Board or into your General Fund in the state. We don't think that the plaintiff is entitled to it.

CHAIRMAN KNOX: All right. Mr. Sullivan.

(See Appendix III for written testimony.)

MR. GERALD SULLIVAN: Thank you, Mr. Chairman. I'm Gerald Sullivan, President of Walker, Sullivan Company. We are the brokers that handle the program for professional liability for the California hospitals.....When you work in the upper layers you have less data available. However, through a lot of effort here in California, we have been able to maintain excess markets and no little job of this has been because of the existence of AB 1XX.

Let me just relate very quickly a little bit of history because I think it will show you what has been happening and the impact of this type of legislation which has been significant even though it hasn't been talked about a great deal. Two years ago when I was in the process of starting renewals of the master contracts with the upper layers of the CHA, AB 1XX was winding its somewhat torturous way through the Legislature. Normally the renewal process starts just about this time of year. Lloyds of London, by the way, is one of the major carriers involved in these excesses. We do have now significant support of domestic carriers as well. But usually the negotiations start with the underwriters with Lloyds who are, as we term them, the leaders in these particular coverages. In any event, in June, two years ago, when we started negotiations, AB 1XX had gotten through the Assembly in the form it was in at that time, and went with me to London when we started negotiations. The underwriters had at that point in time covered some very significant losses. They frankly were thinking very seriously of not renewing the coverages at all. And this would have been a major problem. We had to make major increases in price at that point for the excess layers, which are excesses of $100,000 per occurance. In fact, at that point in time the increases were something in excess of 100%. But the underwriters did agree to renew and this was entirely on the basis that AB 1XX would get through and become law in essentially the fashion that it got through the Assembly. Subsequent to the negotiations and before the actual contract anniversary date, which is the end of September, we watched the movement of AB 1XX very closely and the underwriters watched it very closely. In fact we knew almost on a daily basis anytime there was any favorable or unfavorable

change and I can assure you we were all very delighted when the Governor signed it into law. It became effective, of course, then in December 1975. A year later we found ourselves in a position of again renewing coverage for the next year. At this point there wasn't a great deal to be said about AB 1XX because it really had been in effect only a couple of months and had had virtually no impact at that point in time. However, the fact that it had passed, the fact that we could say that through the concerted effort of an awful lot of people both in and out of the Legislature, we were able to take some positive action, an action which the underwriters frankly felt was some of the best legislation they had seen throughout the United States. We had watched a lot of it throughout the United States very closely. In any event, at that point, because of the trends we were beginning to see, because of the positive impact of having taken some action, AB 1XX being the evidence, we were able to renew last year with an increase of only about 12%. A far cry from the problems we had been facing in the years previous. We are now in the process of renewing again for the upcoming 12 month period of time. Negotiations are in progress now and while they're far from complete and we've got a long way to go as yet, early indications are that we will probably be able to complete renewal and be able to provide to the hospitals their first million dollars of commitment -- that's where about 93% of their premium goes -- at substantially the same price as they were paying last year. Again, a significant improvement over what we had in the past and an improvement over what we're seeing in a lot of other parts of the country. We do happen, as a brokerage office, to get involved in a lot of other areas of the country and we were not able to be

nearly as successful in many other areas. A good deal of it, I am convinced, was because of AB 1XX. In the prepared material, I present some statistics showing both the frequency of losses and the average cost of losses with two working layers; the layer of $400,000 excess of $100,000, $500,000 excess of $500,000. Rather than get into detail here, they are there and they are available to study. But basically they do indicate that while we are beginning to see some solution to the problem (i.e. it is not deteriorating nearly as rapidly as it has been in the past) the battle is far from over. Inflation is still there, it's still providing a very heavy push on cost, you're still seeing some increases in the number of reported claims, so we're not out of the woods by a long shot. In this regard, we are also worried about the constitutionality test coming up on AB 1XX. If that does get thrown out, we do have some major problems in providing coverage. Because of time, I'll step...

CHAIRMAN KNOX: May I ask a quick question?

MR. SULLIVAN: Yes.

CHAIRMAN KNOX: Just as a matter of information, you're saying that Lloyd's, for example, was more receptive to California underwriting for excess because of the passage of AB 1XX even though it had not been tested in the courts yet?

MR. SULLIVAN: That is correct. They haven't made any major impact on ratings at this stage. The domestic companies haven't because they're still waiting the constitutionality test to see what's going to happen. In that regard, one of the elements of AB 1XX which doesn't really need constitutional test in the way it is being used at the moment, is monthly income settlement. Periodic payment approach of settling claims. And, as Mr. Ludlum

indicated, many of the claims, in fact a majority of the claims, are settled rather than going through the court procedure. Actually, I guess I could move very quickly on that because I think it goes directly to your question, Mr. Chairman, and that is because we had started about three years ago in developing procedures for monthly income settlement, we were able to demonstrate positively that it does work. Then when it was incorporated as usable to afford judgement in court in AB 1XX, it simply confirmed to the underwriters that we were here trying to do something. Perhaps it wasn't 100% settled, but it was more than they were seeing in almost any other area of the country. Their alternatives were, we'll continue to write, but we wanted to assure them that the losses that they are seeing will be paid for when AB 1XX is proved constitutional. Then they'll react to that right at that time. Actually the monthly income settlement procedure, while it really got started about three years ago, with some emphasis, I might add, at the Kelly Niles decision in 1975, I think that's the way I can assure them; although it was probably a year before the mechanics of the procedures and markets needed to make this work for all were developed. However, at this time our office has probably handled some 300 cases throughout the United States, in all areas of liabilities, not just malpractice, using the monthly income settlement approach. Why do we use it? Why is it effective? Well, basically what it does is get the claimants their money more rapidly. The monies that are made available to them are structured specifically to meet their individual needs. They're paid out, or at least a portion of them. Usually the largest portion is paid out over a period of time, which we have found is a useful tool in avoiding what we see as a problem

where the unwise would get hold of the money. This is especially important when you're dealing with minors who are in college. Unfortunately, in a number of major bodily injury cases, incompetency is a problem. And payments are guaranteed for life, whatever that life may be, which is a great question when you're all standing about trying to deliberate how long an individual is going to live, and how much money is going to be made available to provide the treatment and care which of course this type of procedure is used. You get a more intelligent use out of their money. In the long run, everybody is in an improved posture, this is not a panacea, not usable in all cases by any stretch of the imagination, but it is there, it is usable, in fact it's working.

Another area of the bill which hasn't been used successfully yet, but I think it can have a similar impact, maybe even a greater impact, is the collateral source rule. But again, being done in such a manner to be sure that those who are injured are getting properly and adequately compensated but still use the funds as wisely as we can, basically is what the compensation is trying to do. Well, I go into some detail in the prepared report as to how the procedure works. You can go into it there. I would like to emphasize strongly that we concur fully with the remarks that Mr. Ludlum made in his conclusion as to where we should go in the particular problem areas. I am sure you are well aware what we're seeing, and what we have seen of malpractice is only the tip of the iceberg. I personally think that products liability is probably a bigger problem area, although it really hasn't reared into as heavily. Attorneys errors and omissions, architect errors and omissions, safety officers liability, all of these areas are suf-

fering the same sort of problems. Inflation is pushing the average cost up and the number of claims is increasing. It's most frustrating, I guess is the only way to put it. All these systems seem to operate in a highly inefficient compensation system. That's really the point. That will conclude my remarks here.

CHAIRMAN KNOX: Thank you very much. Any questions from members of the Committee. Any questions from the staff? Mr. Hiestand.

MR. HIESTAND: Yes. Mr. Sullivan, if the California Supreme Court were to rule, say hypothetically, that AB lXX was constitutional in its entirety, would this enable you to calculate with any great accuracy right away the cost of premiums for medical professional liability insurance?

MR. SULLIVAN: Of course that means we would have to sit down and measure the impact of various aspects such as the $250,000 limitation for pain and suffering, the impact of monthly income settlement, the impact of a number of items. To be perfectly honest, with one area that I have the most data available is monthly income settlement. I think there I could probably give some reasonable estimate. But what the future impact of that particular step would be overall with regard to the other items, frankly I would have to turn to other sources a lot stronger than mine, getting to the area back of actuarial study to predict what really could occur. I think some reasonably decent estimates could be made depending on what may come out of the constitutionality decision. Assuming everything stands as it is, we'd have to take each specific item of the bill, determine as best one can what its impact seems to be and I think we can convince underwriters to accept that. Then time will tell us whether we're right or wrong and we'll have to adapt to

that. As experience shows, we're either right or wrong in our initial estimates.

CHAIRMAN KNOX: Mr. Hiestand, I think that the HEW study which will be out in the next two or three months on the closed claims subsequent to '76 which will give us some indications as to the cost factors which are related to these issues, will make it possible to calculate premiums much more accurately than we have in the past. You take that with the AIA's Study on Closed Claims. They have a lot more information now than we had when you and I first got into this game. Of course a writ of certiorari can always be granted by the Supreme Court on the 14th Amendment too.

VOICE: Not on independent state grounds.

CHAIRMAN KNOX: Thank you very much gentlemen, we appreciate your coming.

MR. SULLIVAN: Thank you for the privilege of appearing.

CHAIRMAN KNOX: Our next witness is Mr. Samuel Shore of the California Trial Lawyers Association. Mr. Shore, do you have copies of the statement you want us to pass out? The Sergeant will take care of it for you, Mr. Shore.

(See Appendix IV for written testimony.)

MR. SAMUEL SHORE: I appreciate the opportunity of appearing here this morning as the President of the Los Angeles Trial Lawyers Association. As you may know, we represent injured plaintiffs in civil litigation. We have almost 2,000 members and I think that my feelings about the so-called tort reform issues are representative of most of our members. We represent people in the general public, consumers, if you will, of legal, medical and other services. Any of them, whether they be injured by a lawyer or by a

doctor, we feel are entitled to recovery and to compensation that is fair and adequate. I know that it is not necessary for me to state to this committee that the Constitution of the United States and of the State of California are things to which we as attorneys, members of the Legislature, the executive and even the boards of supervisors, have been sworn to uphold and to support. The principles of the Consitution are the things that we fear for, as trial lawyers, representing individuals, individuals who have no other way to be heard, except through us. And reform is not destruction of a system that has taken over 200 years of development. Reform is a principle toward which we would be hopeful to be helpful. And I think that it stands to reason that the reform of the tort system, anything that's 200 years old, must have had a few cobwebs that have developed and which require reformation. Reform is something which is designed as an improvement of, a drive toward, excellence, not a destruction. The destruction of the tort system, it would seem to me by recent statements and legislative bills, is more in the order of what some of the forces that are in power might be attempting to do. One of the basic concepts of our system of tort is to protect and to preserve the rights of the plaintiffs as well as the defendants, supporting all of the rights guaranteed by the Constitution. Equal protection, due process, all of those wonderful words that I'm sure we're all aware of, must be considered in all legislation when dealing with the public. The individual has heard those words but relies upon the Legislature, upon his lawyer, and upon the courts, and hopes the executive branch of government will continue to preserve his rights to those concepts. Recently a series of bills have been introduced which I would

consider to be a guaranteed right to kill by doctors. I'm a doctor. I practiced medicine for some 15 years before I became a member of the Bar. I don't think it makes any difference to a plaintiff who is killed, or loses an arm, whether he loses it in the emergency room, or he's passed through the desk, called the admitting office, where he has signed to guarantee the payment of the hospital bill, as to whether he is injured before or after he signs the consent form for hospital admission. It's equivalent to saying that an attorney who is retained in the outer office by a potential client is no longer responsible for letting the statute of limitations blow. But if he comes into his inner office, then he becomes responsible and is liable for failing to protect his client's rights. The injury is the same, and that's the measure, really, of whether or not a defendant is liable. Whether a doctor is responsible for an injury that is only worth $2,900, or whether it's worth $300,000, the doctor's degree of culpability isn't being measured, it is the degree of injury that is being measured and just as we are so concerned with the constitutional rights of privileges and immunities of citizenship for the public at large, the injured person, including perhaps even attorneys, we're concerned with the rights of doctors. It is just as wrong to threaten a doctor with losing his proprietary right to practice medicine just because in a moment of negligence someone suffered an injury that was worth more than $3,000 or $30,000.

SENATOR SONG: Mr. Chairman.

CHAIRMAN KNOX: Senator Song.

SENATOR SONG: This is to Mr. Shore. I'm quite interested in the fact that you're also a medical doctor as well as President

of the LA Trial Lawyers Association. You are obviously opposed, in your capacity here today, to any bill or proposed law that limits liability and thereby reduces the opportunity of the plaintiff to recover, and you'd likewise be opposed to any ceiling of the amount that might be recovered.

MR. SHORE: I certainly would.

SENATOR SONG: And do you somehow equate this with certain consitutional rights? Let me ask you this, Mr. Shore, and I'm not necessarily in contravention with your position, but is there a constitutional right on the part of medical doctors to continue with this practice? I'm quite acquainted with what the study of medicine entails. My son has just commenced a six year residency so he can become a thoracic surgeon. That means many, many years of training. But will he then have a constitutional right to practice medicine? What if the situation then would render it impossible for him to continue because malpractice insurance will cost him $100,000. Wouldn't that be unconstitutional?

MR. SHORE: Well, sir, it would be grossly unfair and some measures should be taken to prevent that.

SENATOR SONG: Like what, for example, Mr. Shore? Aside from limiting liability and putting ceilings on recoverable damage?

MR. SHORE: I would suggest, sir, perhaps a suggestion, an old one to the Legislature, because something like three or four years ago I testified in support of the bill that would create a state fund to protect the public from the negligent doctor. At that time it was a bill that was authored by Assemblyman Torres. At the present time, the State Bar has a bill pending which I would support strenuously, creating a similar fund which would protect the

public from negligence on the part of an attorney.

SENATOR SONG: Up to a certain amount, of course.

MR. SHORE: Beyond that point, then the individual lawyer would certainly be able to afford the excess coverage.

SENATOR SONG: When you talk about the state fund, then you're talking about the state entering the field of protection of the consumer, are you not?

MR. SHORE: I was hoping that the state was already in that field.

SENATOR SONG: Then why shouldn't the state enter every liability field? I understand the local entities requested products liability and other forms of liability insurance but are having a deuce of a time finding an underwriter to underwrite them.

MR. SHORE: I would like to point out, Senator, in May of 1977, the Journal of Insurance -- I was permitted to see it but I am not a general subscriber to it and I don't get a chance to have much time with it -- presented all of the aggregate premiums collected by all of the companies in the State of California and the aggregate pay-outs, as well as the difference, which was their profit. And 50%, I don't know of too many businesses that can muster a 50% profit in a field where they claim they are going out of business. I agree that there may be things that we don't see on the surface and it may be that it's not as profitable as they're accustomed to perhaps, in say, automobile insurance. I don't know, but I would say that if they don't want to be in the field, and they say they don't want to be in the field, then the state has the responsibility to look after the public, the consuming public who are depending upon this state to take care of them.

SENATOR SONG: Even if it means driving the private carriers out of business?

MR. SHORE: Well, I wouldn't suggest that we deprive them of the business unless they want to be deprived of it and I've heard that they do. It would be interesting to see if they do...

CHAIRMAN KNOX: Could I ask a question? Are you through Senator?

SENATOR SONG: Yes.

CHAIRMAN KNOX: As I understand your position, the primary place we ought to look is to insurance company standards or possibly a state fund rather than restricting the statute of limitations or all of the other things that are suggested, as a way of limiting the amount of payments for torts. Can we also look to the processing of claims, both on the plaintiff's and the defense side to see if there isn't a substantial waste of funds there in the litigation process?

MR. SHORE: I think that that...

CHAIRMAN KNOX: What would you think if we, and believe me, I'm not proposing this, we're just trying to get everything we can before the committee, what if we said that all claims that don't show a gross recovery of $15,000 were subject to compulsory arbitration?

MR. SHORE: I think in Los Angeles County we have taken steps in that direction.

CHAIRMAN KNOX: What if the law said that you simply cannot go to court, the jury is not available to you, for a smaller case, of whatever amount might...

MR. SHORE: I think it might be an expedient way to

handle small claims.

CHAIRMAN KNOX: Would the Trial Lawyers Association support such a move?

MR. SHORE: I believe we would.

CHAIRMAN KNOX: Any other suggestions you have for constructive solution of what we all have to agree is a problem?

MR. SHORE: One of the things that I think would help, certainly, the entire tort system is to decongest the Superior Courts.

CHAIRMAN KNOX: How would we do that?

MR. SHORE: I would suggest that the Superior Courts of this county, at least, and I am hopeful that you would expect that it would be throughout the state, would be taken out of the political arena by not requiring that they go hat in hand to their sister branches of government every time they need the manpower to efficiently operate a system of justice.

CHAIRMAN KNOX: You mean you would turn it over to the judges of Los Angeles County to decide how many judges they need?

MR. SHORE: I mean that the appropriations for that sort of thing would be something which, of course, the Legislature would obviously have a hand on, but on the other hand the need should be to a large extent dependent upon a showing by the judges, yes sir. I don't know, it -- the computers and the judges know what their needs are. The backlog of cases is a demonstration of whether they are correct or not. I would suggest that greater efficiencies perhaps might assist. I would suggest that perhaps efforts along those lines should be endorsed and strenuously pushed.

CHAIRMAN KNOX: Well, now, we are being asked this year

to approve 34 new Superior Court Departments for Los Angeles County, which is your bailiwick, as I understand it. Does your Association have a position on the need for those 34 judges?

MR. SHORE: We certainly do; we strongly support that.

CHAIRMAN KNOX: And have you made an analysis of the workload of the Superior Court to determine whether or not it is operating in the most efficient fashion?

MR. SHORE: There are inefficiencies which are intrinsic in almost every system. We have been -- I am on a committee that works towards overcoming them.

CHAIRMAN KNOX: But before endorsing that, the Association made an analysis of the Superior Court in Los Angeles?

MR. SHORE: Yes, sir.

CHAIRMAN KNOX: And you decided that it was as efficient as could be expected and 34 judges were needed?

MR. SHORE: Yes, sir.

CHAIRMAN KNOX: All right. Any questions from any members of the Committee? Yes, Senator.

SENATOR RUSSELL: Have you told that to the Governor?

MR. SHORE: Yes, sir. Also the Board of Supervisors.

CHAIRMAN KNOX: Anything further, Mr. Shore?

MR. SHORE: No, thank you.

CHAIRMAN KNOX: Any further questions? Questions from the staff? Thank you very much. We appreciate your...

SENATOR RUSSELL: I have...

CHAIRMAN KNOX: Oh, excuse me, Senator. Senator Russell.

SENATOR RUSSELL: Mr. Shore, will you be remaining here or will you be departing after your testimony?

MR. SHORE: Oh, I have a courtroom down in Long Beach that is waiting for me, but I will be happy to wait until...

SENATOR RUSSELL: Well, I don't want to hold you up. My question was, relating to your testimony on page three, I don't know if you testified. You talked about a Journal of Insurance in the May issue. It is a summary. I have talked to some of the insurance people here and they are not familiar with it. Could you tell me a little bit about those figures which you quoted here purporting to show a 50 percent profit, and what were the figures, from what did they come, and how were they derived?

MR. SHORE: I must admit as I have indicated, I only had the -- almost half of the Journal was made up of these statistical calculations, and I was able to see them only briefly, but they list each of the carriers that do business in California, and some of the carriers are quite well known to me as being essentially involved in professional liability litigation, and these were the figures that I reviewed and that is how I came to the point where I was able to make that statement.

SENATOR RUSSELL: Was the 50 percent profit a compilation or interpretation of those figures that you made, or was there a figure that showed a 50 percent profit?

MR. SHORE: Oh, no, they didn't do it as clearly as that. They just gave the aggregate amount of premiums collected, the aggregate payouts, and the aggregate of costs for the administration.

SENATOR RUSSELL: So you made the compilation yourself?

MR. SHORE Yes, sir.

CHAIRMAN KNOX: Thank you very much, Mr. Shore. We appreciate your attendance. Next we have Dr. Nicholas P. Krikes,

President-elect of the California Medical Association. Mr. Hassard, do you want to come up with your client? You are next. Doctor, if you have statements to deliver, the Sergeant will take care of it.

(See Appendix V for written testimony.)

DR. NICHOLAS P. KRIKES: Mr. Chairman, the California Medical Association is pleased to comment before the Joint Legislative Committee on Tort Liability. My name is Nicholas P. Krikes. I am a Family Practitioner from San Bernardino and President-elect of the California Medical Association, a professional organization representing the vast majority of privately practicing physicians in the state. I am sure you are well aware that CMA has been deeply involved for the past few years in what has become known as a professional liability crisis. Actually, physicians in California have been actively seeking solutions to the problem for more than a decade. Experience has taught us one thing. There are no easy answers to the problem of tort liability, either with regard to medicine or any other segment of our society.

We commend the Legislature for establishing this joint committee to investigate the full range of tort liability, for the problems of medical liability are only a part of the larger afflictions whose roots are deep and widespread through our entire society. There are some fundamental problems underlying this crisis. The increase in litigation during the past 10 years is phenomenal. Costs and claim frequencies are escalating. In part, this is due to a greater emphasis on litigation as a method of resolving social problems. The present system of resolving claims is expensive and inefficient. Of the billions of dollars paid in liability insurance premiums, as low as 20% actually gets to the injured parties. The

present system is capricious with regard to compensation. One individual may be more than amply compensated while another with a similar situation may not receive a penny. The system is inordinately slow. Personal injury cases often take months and sometimes even years before an injured party receives compensation. The expansion of certain legal doctrines, mainly through case law, has broadened the scope of tort liability, immeasurably adding a factor of uncertainty and company stability to insure against risk. Many commercial insurance companies' reserves were disastrously affected by stock market plunges in 1973 and '74. This has resulted in even greater increases in premiums which did not necessarily reflect increased losses that they are insuring against. Further, insurance companies' records have not clearly reflected actual experience in any casualty liability lines. In addition, with reference to medical liability, we believe there are a number of special factors contributing to increased costs. The growing complexity of modern medicine coupled with the increased availability of care creates a greater risk of untoward results. Media coverage of medical advances describing care and technology not even known ten or fifteen years ago, in conjunction with medical entertainment television programming, has fostered unrealistic expectations of success for all treatments. Often patients appear to be conditioned to underestimate the complexities and difficulties of the procedures physicians undertake and to overestimate the availability of compensation for results which are less than hoped for, regardless of the reason for such results. The doctor-patient relationship has changed dramatically in recent years because of increased medical specialization, the effects of urbanization, patient transiency, third-party

financed medical care and the public's attitude that any untoward results should be compensated. In the past five years in California, the rise in the number and size of claims has produced tremendous increases in physicians' liability insurance premiums, an average of over 600% since 1972. These premiums are felt by the patients in their doctor's fees, health insurance costs and the cost of medical care generally.

A tort liability crisis has a negative impact on both cost and availability of medical care. Defensive medicine is a term applied to the alternative of medical practice to avert the threat of a possible lawsuit. Positive defensive medicine is a conducting of tests or other procedures which may be only marginally medically indicated, but which are carried out because of the ever present threat of suit for professional liability. Such defensive medicine obviously adds substantially to the cost of medical care.

However, there is also a negative aspect to defensive medicine and that is the choice by physicians not to undertake certain procedures or types of practices. This negative defensive medicine has an increasingly greater effect on the availability of care often most strongly felt in rural or other already underserved areas.

For the past ten years the CMA has aggressively sought to reform the liability system. Unfortunately, it took a major crisis to bring the Association close to achieving any of its long-standing goals. Assembly Bill lXX was hailed by many as one of the most progressive pieces of tort reform legislation passed in America, for it fulfills some of the objectives sought by the CMA.

However, even with these reforms doctors still pay the highest professional liability premiums in the country and the number of claims and the amount of awards continues to be far above the national average. Despite the passage of this legislation, concerned companies have continued to raise the premiums. Only when the reforms embodied in the 1975 Medical Injury Compensation Reform Act are constitutionally confirmed will they lower cost for doctors and their patients.

The California Medical Association is pleased that the question of the constitutionality of AB 1XX is now before the courts. Because of the tremendous stake physicians have in this case, the CMA is appearing as an amicus curiae. We strongly believe that the outcome of this case will be a key factor in determining the future of tort reform efforts, although we remain uncertain as to the real dollar impact the suit will have upon the medical profession liability premiums.

As you are aware, the CMA by means of a sizable grant, initiated the independent California Citizens' Commission on Tort Reform. We hope that the Commission will recommend conceptual changes, both in the broad spectrum of tort law and in specific areas of liability as well. In addition to this Commission, we are supporting another major study which is nearing completion. This is the California Medical Insurance Feasibility Study. It will determine, without regard to negligence, type, frequency and severity of events occurring in the course of medical management, which might be compensable under an alternative system. Until now we have had only limited data with regard to medical adversities with or without negligence. Most of this data is in the form of closed

tort claim studies which do not provide adequate measurements for the cost of possible alternative compensation systems such as no-fault. Results of this study will be publicly announced in the near future and your committee will be among the first to receive this information.

With regard to the medical professional liability insurance, it is important to note that there has been a significant change in type and source of coverage available to California physicians in the past few years. Nearly all the major commercial carriers have withdrawn from this market or indicated an intention of leaving. American Mutual, Pacific Indemnity, Casualty Indemnity Exchange, Star Insurance, Hartford, Signal-Imperial and Aetna are no longer writing in California. Travelers has indicated their intention to leave at the termination of their present contract. With the commercial carriers withdrawing from the market, California physicians have been forced to set up their own insuring mechanisms offering claims-made or claims-paid cooperative trust forms in coverage.

Until recently medical malpractice insurance was written on an occurrence basis covering incidents arising out of the practice in the policy year without regard to the reporting or settlement of the claim. The claims-made form of insurance covers only those incidents reported during the policy year and resulting from accidents during the previous year during which the insured was covered by the same company. To cover claims in years after the termination of coverage for that carrier, the physician must purchase a reporting endorsement which is commonly referred to as a tail. Another recently proposed type is the claims-paid cooperative trust. Since these cooperative trusts are fully accessible, the

physicians' ultimate liability is unknown. The effect of both of these forms of coverage is to shift a portion of the risk from the insurer to the insured physician because the cost of coverage of future claims is not set at the time of purchase of the original policy. Because of these considerations, the California Medical Association has worked hard to provide its members with the alternative of occurrence coverage but has been unsuccessful to date partially due to the stringent reserve requirements of the California Department of Insurance.

CHAIRMAN KNOX: Doctor, have you come to the conclusion that the reserve requirements are excessive? Can you say that?

DR. KRIKES: Yes, yes. The medical liability crisis involves legal doctrines in insurance but it also involves a complex equation of medicine, doctors, nurses, hospitals and patients. Any discussion of this problem must involve an acknowledgment of the fact that modern high-quality medicine carries with it an inherent risk of untoward results regardless of the degree of skill and judgment applied. CMA and its member physicians are constantly working to reduce any avoidable risk through a wide variety of means. CMA supported the passage of AB 1XX which created the new Board of Medical Quality Assurance. CMA is working with the Board and its three divisions. The Division of Licensing has recognized CMA's continuing medical education program as a proper mechanism at no cost to the state for accrediting educational programs and verifying some plans by individual physicians with the educational requirements for re-licensure. Physicians are paying markedly higher license fees to pay for the increased disciplinary activities. However, in this regard it should be noted that the Governor has yet to

complete his appointments with the Regional Medical Quality Review Committees although they were required to become effective more than 18 months ago in December 1975. We have a liaison committee that works directly with the executive committee of the Board. Also, physicians representing our key committees relating to quality of care, continuing education and health manpower attend and take part in meetings of the Board and its divisions. The medical profession in California has a long history of peer review activity -- the physicians' own systems to monitor and enhance the quality of care. A wide variety of volunteer programs exist to promote high-quality health care and the efficient use of medical resources. We have hospital admissions committees which may require specialty board certification for physicians to perform certain procedures. We have hospital committees which retrospectively review the need for surgical procedures. There is also peer review through utilization review committees, health facility planning groups and county society medical foundations. These local peer review activities are based on the principle that only practicing physicians can judge what constitutes good medical practice and moreover have the responsibility to do so. In addition, the CMA's Peer Review Commission coordinates statewide peer review activities. It provides a comprehensive information exchange for physicians. It also functions as an information resource for local peer review committees and helps resolve disputed peer review decisions. Since 1961 physicians from CMA's Medical Staff Survey Teams have been invited by hospital staffs to help evaluate themselves and the care they render. Today California hospitals undergo Consolidated Accreditation and Licensure Surveys that are jointly conducted by CMA,

the Joint Committee on Accreditation of Hospitals and the California Department of Health. Together with the California Hospital Association, the CMA cosponsors patient care audit workshops. These are intensive training sessions for hospital teams of physician trustees, administrators, nurses and medical records personnel. This is not, strictly speaking, peer review since it deals with trends in patient care, not with individual cases. Team members learn to develop criteria for evaluating patient care in their own institutions. Since 1972, these workshops have trained teams for more than 350 hospitals. They have provided a valuable resource and impetus for enhancing patient care. We believe that in spite of all of the efforts to date, the medical liability crisis has not diminished and problems in other areas of liability are looming ever larger on the horizon.

However, we look to this committee with confidence. It stands as a tangible recognition by the Legislature that the tort reform problem is indeed a deep one, adversely affecting society as a whole. We hope that you will affirm the direction set by the Legislature in the passage of AB lXX. Reforms, if allowed to stand, may begin to contain costs and provide some degree of equitability and predictability in adjudication. We urge this in recognition of the crisis nature of this problem. We further urge this committee to give full consideration to the recommendations developed by the California Citizens' Commission on Tort Reform to increase the likelihood that the various segments of society and the legislative leadership can go forward together to resolve this pervasive problem. We subscribe to resolving all the tort law ills if humanly possible. Your timely involvement in the receipt,

review, exposure and response to their recommendations is, therefore, crucially important. We believe that the work of your committee will greatly benefit from the fullest possible exposure of the forthcoming Citizens' Commission report. Thank you for the opportunity of addressing you today. I will be happy to answer any questions.

CHAIRMAN KNOX: Doctor, I want to indicate to you that we are in constant touch with the Citizens' Commission, and are working with them. They have been very generous about giving us the benefit of their research so we don't go through this material twice at the taxpayers' expense. So that's been very helpful. I just want to ask a peripheral question and I am curious about it. Has the CMA ever taken a position on whether or not it is appropriate for a doctor to have proprietary interest in a hospital where he is on the staff?

DR. KRIKES: We do not have an official position regarding this.

CHAIRMAN KNOX: It is peripherally important to the tort study to find out whether or not medical costs are being contained to the extent that they can be in these cases and I was concerned about that factor.

DR. KRIKES: This is one of those things that is kind of frowned on although there is no official...

CHAIRMAN KNOX: It is frowned on?

DR. KRIKES: Yes.

CHAIRMAN KNOX: Any questions from members of the committee? Senator Song.

SENATOR SONG: Doctor, at one of the special sessions

called during the so-called crisis, you will recall the bill introduced by Assemblyman Howard Berman, do you not?

DR. KRIKES: Yes.

SENATOR SONG: Following the introduction thereof, there was a plebiscite conducted by your organization among the doctors as to whether or not they would like that particular bill enacted. Isn't it true that the overwhelming majority of the members of your association voted against that?

DR. KRIKES: Yes, that's correct.

SENATOR SONG: I thought it was quite disappointing. Wasn't that caused by -- and may I ask you for your opinion -- wasn't that caused by the fact that the majority of doctors don't want to participate to the extent of, in effect, paying for those members of your association that pay a higher premium than they do? Wasn't that the primary reason for their negative vote?

DR. KRIKES: No, I would disagree with you, Senator, with respect to that.

SENATOR SONG: What in your opinion was the reason for the result of that plebiscite?

DR. KRIKES: I really don't believe there was any one overwhelming reason with respect to the outcome of this plebiscite. There were several factors that those of us who had considered it seriously had some grave reservations about. One of them is that the predictability of the cost of this program to the state was certainly highly in question and Fred will confirm that. The other was that we had some reservations about turning this entire problem to the state because we were fearful that if the state controlled this, that this could be utilized perhaps in a manner which we did not approve with

respect to controlling the practice of medicine. I think this is a deep philosophical conviction that most of us have.

SENATOR SONG: Are you implying that if the state were to enter the field as suggested by, I think it was Mr. Shore, that the state then would regulate the practice of medicine?

CHAIRMAN KNOX: Now in fairness to the Doctor, Senator, I think he was giving us the reasons that he thought some doctors voted the way they did. I don't suppose it necessarily reflected his own view.

DR. KRIKES: That's true, Mr. Chairman.

SENATOR SONG: Doctor, I don't mean this personally.

DR. KRIKES: I understand.

SENATOR SONG: But your opinion is that that particular reason is one of the reasons?

DR. KRIKE: Yes.

SENATOR SONG: But isn't it true, coming right down to bare fundamentals, if a doctor whose premiums amount to, say, $2,000 per annum, agreed to the terms of that particular bill, the mandatory inclusion of all practitioners, and you have a doctor whose premium is $50,000, the man whose premium is for $2,000 would probably be increased, wouldn't it?

DR. KRIKES: Yes, I would suspect it would be, although in proportion it would not be great, and also, I believe that the number of doctors paying the increased premium would be far in excess of those paying $50,000. It would just be a broader base.

SENATOR SONG: Just speaking for myself only, which, of course, I am the only one I am authorized to speak for, and I am groping for an answer. The attorneys cannot hear -- they say we've

got to protect the constitutional rights of anyone to maintain a lawsuit without any limitation on damages and limitation on liability and so forth and so on. Then if doctors come out and say, we commend the Legislature for their effort and we wish you would continue to proceed to see that coverage is made available to the doctors without unreasonable pain so we can continue to serve them but you don't want the state to enter the field. Generally speaking, isn't that in defense of the doctors? So your solution, then, would be completely contrary to that proposed by the attorneys. You would like to see a limitation placed on liability and a ceiling placed on the amount that could be recovered?

DR. KRIKES: Yes, I think these are possible solutions. There are other possible solutions also, as I am sure you are well aware. The only thing I can say is that with respect to what the distinguished attorney said, I think that the doctor is usually right.

CHAIRMAN KNOX: Thank you. Mr. Mori.

ASSEMBLYMAN MORI: Just looking at the past, could you indicate to what degree the profession or the CMA's organization had recommended against the particular doctor. Has a doctor been -- I don't know whether you call it disbarred -- what do you call it? Delicensed or whatever? Defrocked...

DR. KRIKES: Defrocked.

ASSEMBLYMAN MORI: Defrocked as a result of any action of the CMA or these so-called peer evaluating mechanisms that are there?

DR. KRIKES: Yes. Of course, you understand that the CMA itself cannot take away the license of a physician.

ASSEMBLYMAN MORI: That's true, but possibly a peer review mechanism within the CMA could recommend certain things.

DR. KRIKES: Yes, this has been done on a number of occasions. I have served on CMA's Committee on Appeals, for example, which reviews cases in which questionable practices are charged. One of the big problems is because of our legal fraternity. I can speak about one specific case that comes from my county in which our local county medical society has been attempting to perform just such a function and which because of a legal entanglement proposed and thrown up by this specifically charged physician has resulted in costs to our local county society approaching $20,000, which for a grassroots county like mine represents approximately 15% of our total budget, which is a catastrophe. The reason we can't pursue this more decisively is because of the legal processes involved.

ASSEMBLYMAN MORI: Yes, it has been alleged that rather than peer review, it is possibly peer protection that the CMA doctors participate in. What's your response to that?

DR. KRIKES: I hear this frequently from many sources and I would respectfully disagree with you. A lot of the peer review that is performed also is something that you really can't document; for example, say defensive medicine. That's very hard to document and I think there is a tremendous amount of good pressure put on physicians by the peer review activities; for example, say the County Society Foundation reviews claims and if we see a pattern of practice evolving, what we do is we call the specific doctor in and have a discussion about this particular problem and more times than not, this particular physician involved will rectify his type

of practice. This type of thing never sees the light of day, but it is a very important part of our procedure.

CHAIRMAN KNOX: Thank you. Mr. Hassard. Howard Hassard, Counsel for the CMA.

(See Appendix VI for written testimony.)

MR. HOWARD HASSARD: As your Chairman stated, I am Howard Hassard, a lawyer representing the California Medical Association. Before I get into the content of my testimony, I would like to state to the committee my purpose this morning is to try to avoid duplication of written statements that have been presented to you by Jim Ludlum, Jerry Sullivan and Dr. Krikes.

To concentrate on a few specifics, it occurs to me that the committee might consider something in the way of rather immediate improvements in the tort system without in any way meaning to belittle or downgrade the absolute necessity for an overhaul of the whole thing. I suspect that social reforms are accomplished in decades, not years and months, and in the meantime, there are a number of, I think, specific things. In preparing for this morning, I looked back at my files and I noted with some astonishment that between the Senate and the Assembly in the past ten years, there has been a continuous interim of special or select committees of one body or the other delving into professional liability both within the health field and within the other professions. It is obvious and I was amazed at the number of times I have testified before committees on the subject matter that is before you today. In the course of it, I took a look at the most -- I guess the most recent published report which was known as the Waxman Committee's report of late 1974, and in going through the recommendations, I

was somewhat astonished to observe that practically all of those recommendations have been implemented by the Legislature, mostly in AB 1XX but some in other separate pieces of legislation. Still the problem is with us and I am afraid that I have to agree with the statement that I think Mr. Ludlum made that it is just on a plateau as of now, and two or three years from now there will be another crisis. It seems to be inherent in the nature of things.

Now, the letter that I asked to be distributed to you identifies three areas in which our experience up to now indicates that AB 1XX needs refinement, let me say, not necessarily change to any great degree, but the experience to date indicates that there are three portions of AB 1XX that could benefit by immediate legislative action. One relates to the collateral source section -- I won't read the letter and it is strictly a specific sort of hole in the collateral source section of the bill. Another one relates to the limitations for non-economic loss with ceiling on damages which was referred to earlier, and there again there seems to be a little hole in the way of what's the limitation when you have both husband and wife as co-plaintiffs. And the third, and I think probably the most important, has to do with that portion of AB 1XX that established the concept in the law of periodic payments. I might supplement some of Mr. Sullivan's testimony. He calls them structured settlements. Well, that's basically a periodic approach either done by way of settlement or done by way of judge action after a jury trial. In the long run, it seems to me this may be far and away the single most important reform contained in AB 1XX. In Mr. Sullivan's written

statement, he gives a couple of horror stories. On my practice over a long period of time, I could give you some more horror stories, people who got large sums of money awarded and weren't able to handle the money, lost it and were worse off than they were before with their remedy exhausted. I don't think that is fair. I don't think it is fair to the individual and I don't think it is fair to the public because those people go right on to the public rolls. There is no other place to go. In addition to that so-called structured settlement, give the injured party more with less cost to the public as a whole for the reason that Mr. Sullivan explained in his statement, I've been really terrifically impressed the past year with several structured settlements that I know about in peripheral matters where with an outlay of usually four, five or six hundred thousand dollars a person has been assured of care for life, assured of ability to be housed and fed and clothed for life with money left over that would have ended up as the jury award probably in the area of from two to four to five million dollars. Because by the time it would get to a jury, instead of the fund being put out at interest, the fund being there, a blackboard would have been used and the plaintiff's attorney would have put the figures on the blackboard and those of you who try cases are familiar with the expert who comes in and tells the jury how many dollars it is going to take to buy what one dollar will buy today ten years from now and twenty years from now. You get up into the stratosphere. Unless the injured party is actually assured of having whatever is awarded for the balance of that person's life, these astronomical figures are an economic waste and it seems to me that AB 1XX and the periodic payment has done a great thing.

CHAIRMAN KNOX: Let me ask you this, why does that cut insurance premiums, because the obligation isn't so large in the given fiscal period or what?

MR. HASSARD: Again, in the course of time it's bound to cut insurance premiums because it cuts that huge outlay you now have. Incidentally, on insurance, I didn't intend to get into this subject but I listened to several questions, several answers this morning and I listened to Dr. Krikes and Mr. Shore. One thing that struck me was the statement that you could compare premium income in a given year with pay-out in a given year. Well, if you think about it for a second, the pay-out covers policies written in prior years. It's the wrong thumb. Now I had one example here. Exhibit D, the end of Mr. Sullivan's testimony is a chart showing 1976 California Medical Malpractice business. Way down on the right hand side is American Mutual Liability Insurance Company and it shows premiums written: nothing. Pay-out: $3,740,000. Well they went out of business in California on May 1, 1973. Our office happens to represent them. They've been paying out money ever since, and in 1976, they paid out $3 million, with zero coming in.

CHAIRMAN KNOX: I think the members of the Committee are well aware that that's not an appropriate question. I think there might be some other criticism of insurance companies but that isn't...

MR. HASSARD: It is also true, it is also true...

ASSEMBLYMAN McALISTER: Mr. Chairman, we...

CHAIRMAN KNOX: Mr. McAlister.

ASSEMBLYMAN McALISTER: Mr. Chairman, we, this is a point in fact we went over in great length a couple of years ago when the medical malpractice crisis was so hot and I figured that people had

learned their lesson then and we still have people coming back and comparing apples and oranges.

MR. HASSARD: That's right. I couldn't resist that an apple and an orange was compared to the two.

ASSEMBLYMAN McALISTER: It's not even that close a comparison actually.

MR. HASSARD: No, it really isn't.

CHAIRMAN KNOX: Well, the members of the California Legislature don't all claim to be experts on this, but we've been exposed to so much of it, as you indicated, over the last five or six years or more that we're becoming that way shortly. We've heard an awful lot about it. Between that and the death penalty and a few other things we're getting.

MR. HASSARD: All I can say, as I said, I know that insurance rating is confusing and complicated. Then there is the matter of stock losses. I know of one thing that happened here in this state several years ago was that the actuaries in calculating rates used variable figures for their estimate of future inflation and if you estimated at 10% you came out with one premium level, if you estimated at 20% you came out with a great deal higher premium level. Who is to say who is right or wrong, and who is to say whether that was to recoup losses or not to recoup losses. I don't.....to go back to the question you asked, Mr. Chairman, I don't think you're ever going to get the answer.

CHAIRMAN KNOX: Well, it may be, but we have to, you know. On the other hand, if they estimate double digit inflation and we turn out to have single digit inflation, have they got a mechanism to give the premium payors some money back? I haven't seen any

signs of that either. Before you leave periodic payments, I just want to ask one question about it which I should know the answer to, but I'm not sure. This thing is set up in a nature of a spendthrift trust so that the recipient can't obligate to a creditor his lifetime payments, or how do they do that?

MR. HASSARD: Well, if they're by settlement, they're structured in the way the parties agreed upon the code section, they are in the nature of a spendthrift trust.

CHAIRMAN KNOX: They are? In other words, if it goes to judgement and that's the judgement of the court, it's set up like a spendthrift trust so that the individual can't obligate to a creditor more than, let's say a month's payment.

MR. HASSARD: There's an elaborate section in AB 1XX, but I can't give you a quote.

CHAIRMAN KNOX: That's alright, I'll look at it.

MR. HASSARD: But I will say one thing, periodic payments are new, they are complicated. It is quite possible that some court is going to hold some portion of the AB 1XX part that deals with periodic payments unconstitutional, or interpret it in such a fashion that it doesn't -- isn't workable. I would hope that if that happens that the Legislature doesn't become discouraged, and whatever needs to be done to promote the concept, and be done...

CHAIRMAN KNOX: I notice...

MR. HASSARD: I think that concept is applicable whether you have a new system or the present system.

CHAIRMAN KNOX: I notice in my own office that, not only in the medical field but in a lot of other fields, settlements are on a periodic payments basis.

MR. HASSARD: Yes.

CHAIRMAN KNOX: Offers are made on that basis, so it's a trend in casualty settlements which I think is probably therapeutic.

MR. HASSARD: That's my impression also. The next subject that I wish to bring up I've just labeled "Unclutter the Courts." Now I know that the Legislature has done a number of things over a period of time with that intent in mind. Some of the things that the Legislature has done are very, very good. But the courts are still cluttered and there still is inefficiency and waste in the way litigation is handled. If you don't mind, since the Legislature has decided lawyers can be jurors, I've been summoned on a jury panel. I didn't try to get out of it because I was curious. I've been on a jury panel now since the first part of the year. I've been in court a number of times. I've never been allowed to sit on a jury, but I've spent a number of days sitting on the back benches and a couple of weeks ago, sixty of us had an experience that I think shouldn't happen. We sat for two full days while four separate personal injury cases were settled in the judge's chambers, one after the other. One morning, one; the afternoon, two; the next morning, three; in the afternoon, the fourth. The judge was fine. He tried to explain to the jury why it was required to sit there for two days with nothing happening. He did an excellent job. But, there were sixty people. Didn't matter to me, but there were some wage earners there that I know were off work. They were not getting compensated.

CHAIRMAN KNOX: Was that in San Francisco?

MR. HASSARD: It was in San Francisco, because I live in

San Francisco. It was just, I thought, terribly unfair to the suffering public. I was also very much interested that while the judge was courteous and tried to explain, the lawyers that caused all that zipped their briefcases up and ran out of the room without even looking at the people they caused to sit around for a half day in.....I was not very proud of.....

CHAIRMAN KNOX: How strong is the pre-trial settlement conference system in San Francisco?

MR. HASSARD: It's mandatory. In each...

CHAIRMAN KNOX: Yes, but is it a good conference? It's mandatory, I know, but there are some pre-trials that are better than others.

MR. HASSARD: Well, of course that varies from the individual judge. I would say in the cases of judges I observed, I am sure the pre-trial conferences were competently handled. Well handled. One of the judges said, "well, lawyers just won't settle till they see the jurors sitting there," and I think there is something to that. In any event, I'm just using an example that happened to me. I think we really need to explore something more meaningful than token arbitration which is all that has been suggested so far. I'm well aware that the Legislature cannot deprive a person of a jury trial. But there have been a number of other states that have adopted one or another form of mandatory screening, either call it arbitration or call it screening panels, either by a judge or by a special panel. New York State has one approach, it's by a panel. Other states have a slightly different approach. I really think that this committee ought seriously to consider something meaningful in the way of pre-trial procedures that are, as I

said, more than just a token. I wouldn't have any dollar limit. Fifteen thousand dollars, or $10,000; $7,500, I guess is the present law. I know in the professional field, generally you never see a case in which the demand is less that $50,000 or $100,000. They're just non-existent. If the concept is good, and it seems to me the concept is good, of having a screening of all personal injury cases, and I would add property damage or product liability to it, all personal injury or property cases by a screening mechanism, and then if the parties cannot agree, okay, summon in a jury. But when the members of the public are summoned in as jurors, let them be jurors, not sit around as settlement aids.

CHAIRMAN KNOX: I'm intrigued. You know, in England they've abolished the jury trial in civil cases. Of course, they don't have a constitution there, a written constitution, so that Lord Netting just -- in a case one day, just said that we aren't going to have that anymore. And perhaps we can't do it; but you know, we don't really have an unfettered right of trial by jury in civil cases. We don't allow juries in cases which sound in equity. I'm thinking of commissioning, I don't know how my colleagues feel about this, but I'm thinking of commissioning a study by a few professors to just see whether or not we have an absolutely unfettered right to jury trial in all civil cases that sound in law. I don't know.

MR. HASSARD: There have been...

CHAIRMAN KNOX: Or perhaps we can change the way they sound.

MR. HASSARD: There have been previous studies along that line, Mr. Chairman.

CHAIRMAN KNOX: Yes. Well let's take a look, we'll take a look at them.

MR. HASSARD: I think you may need to take a new look.

CHAIRMAN KNOX: Yes.

MR. HASSARD: And I am not proposing to abolish the jury, because I realize that would take a constitutional amendment.

CHAIRMAN KNOX: I'm not either.

MR. HASSARD: And I think they serve a purpose, but I certainly don't see any reason to allow the jury system to be used as a settlement device.

CHAIRMAN KNOX: Right.

MR. HASSARD: And I think the courts are being used along that same line. I also think that there needs to be some type of statutory duty of care established for the use of the courts. Now, we have a tort called abuse of process. It's seldom used, very little, not well known at all even by lawyers, but I believe there are decisions of our Appellate Courts saying there is a tort of abuse of process. As such, it is presently defined by the courts in a fashion that makes it very difficult to ever come into play, but it seems to me that before a lawyer filed a complaint, he ought to at least certify that he has looked up the -- checked on the facts and has looked up the law applicable to the facts as he sees them. In other words, that he has done some preparation. Now maybe that's going to happen anyhow. But for the past couple of years the California Medical Association has had a program under which it has been available to its members for countersuit purposes under certain circumstances. It's not a financing and it's not a going out and seeking. People have to come to the CMA. We have a file

yea thick as of now, of correspondence, just answering inquiries and it's utterly amazing the unnecessary, ill-advised litigation that goes on throughout the state that just shouldn't be. All it does is add frustration and anger to people that are the victims of it and more cost to the taxpayer and court system. A great deal of it would be eliminated if there was some feeling of responsibility on the part of the lawyer, even though I'm not thinking of the big club; just a little club.

CHAIRMAN KNOX: Let me ask you this. Sometimes a lawyer has to file a suit, Joe, almost immediately, before he can really .....you might have a...

MR. HASSARD: That's why if a person first came to them...

CHAIRMAN KNOX: But how about a concommitant situation where the defendant raises spurious defenses?

MR. HASSARD: I would...

CHAIRMAN KNOX: Or the defendant sends out boilerplated interrogatories which run up the cost of litigation unnecessarily. Could there be some concommitant situations there...

MR. HASSARD: I think yes.

CHAIRMAN KNOX: Because our investigation indicates that there are abuses on both sides.

MR. HASSARD: My experience indicates the same thing.

CHAIRMAN KNOX: Yes.

MR. HASSARD: I'm not making this proposal as something that would be limited to one segment of the Bar. Quite the contrary. I think it's a general concept. As I said, the courts are free and open to everyone. They're not quite free, but they're open to everyone and there should be some responsibility in using

them. Punitive damages have been mentioned earlier today in Mr. Ludlum's proposal. I noticed, in testifying before the Waxman committee three years ago, I made the same proposal. Basically, the purpose of punitive damage is not to have a windfall for an injured person but to have a penalty on the wrong-doer, and it seems to me that like all other penalties, if it is to be imposed, the penalty itself should go to the public. Either in the form as Mr. Ludlum proposed, as a special fund, or into the.....you know if you're caught speeding in an automobile, the cop supposedly does not get the fine. It's supposed to go into the general treasury. But it really.....punitive damages have been misused, particularly in the professional liability health field in the last few years, as a club, and its purposes, I think, distorted. It seems to me that the concept of punitive damages doesn't have any business in the practice of medicine and in the whole civil field. It seems to me that it needs considerable reform.

CHAIRMAN KNOX: Is it possible that a lot of these requests for punitive damages are lawyers practicing defensive law as doctors sometimes in fact practice defensive medicine by doing some things that they wouldn't be strictly required, but if they don't do it they might get sued for it?

MR. HASSARD: It's partially that, and that is happening more and more in the practice of law, naming those codefendants by the bushel. There's another thing that has come along in the past several years. Punitive damages, though, in the health field have been used by plaintiff's lawyers full well knowing that the insurance policy of the doctor or hospital being sued excludes punitive damages. Full well knowing that therefore the insurance company is

going to write a form letter to the policyholder saying that we'll defend you and that we'll pay whatever the compensatory damages may be awarded but punitive damages we will not pay. That is calculated to scare, and it's a scare technique that I guess has been found to be effective at times. And I think that's not what punitive damages were originally developed for. I'm sure they were originally developed as a means of penalizing a very bad wrongdoer, one who is almost licentious is the word used in the statute. I won't dwell on that because it's very well covered in Mr. Ludlum's written statement, it's been covered in past testimony, and it's mentioned in the Waxman report.

Another item, and this is in the insurance arena generally but I'm going to approach it a little differently. In the last two or three years, particularly since 1974, throughout the United States but also in California, there has been a tendency for physicians and hospitals to develop what is called an off-shore captive insurance company. And off-shore means basically the Bermudas, the Bahamas and the Virgin Islands. These off-shore companies are organized without any requirement on the part of the governments in the areas in which they're organized, for any capital reserve. Now admittedly, and it's been testified here earlier today, there's question about the size of capital and surplus that California requires. And I'm not mentioning off-shore companies. My purpose is not to point the finger at them to punish them, but is to point out that they are really playing Russian roulette, because whenever what is contributed by the groups of institutions or individuals who form the off-shore company runs out, that's it. The ball game is over. And if there are any injured people who

haven't yet been compensated, they're going to be basically out of luck unless the circumstances are such that the individual defendant involved is personally rich. And that isn't likely to be the case very often. So that what the off-shore company concept really does, I think, is place an unknown risk on the public as a whole. Now I don't propose that they be punished or that there be stiff penalties or that we have a long-arm statute or anything. I would propose that our own California Insurance Code be reevaluated as to whether or not the capital and surplus requirements are unrealistic in today's world. Now I'm using the word unrealistic because I don't know if you can say high or low because I don't know if anybody knows if they are high or low. I know, and I'm not being critical of the Insurance Department or the Commissioner, if I were the Insurance Commissioner I would do just what he has done because if I had the public responsibility of administering insurance laws, I'd be conservative. I certainly wouldn't want to give a certificate of authority to a company that in a year or two goes bankrupt. But I think the Legislature, particularly this committee, and Mr. McAlister and apparently his Insurance Committee should take a good hard look at what can be done legislative-wise that will move the burden from the Insurance Commissioner to exercise judgement of his risk almost and to make a more realistic appraisal of what capital is needed to do what.

CHAIRMAN KNOX: You mean you wouldn't want the Commissioner to have that responsibility but to broaden it some way to some other...

MR. HASSARD: To broaden it, yes, that's it. If I were the Commissioner, I would be very, very conservative.

CHAIRMAN KNOX: What group would you suggest would have that responsibility?

MR. HASSARD: I would suggest maybe a brand new group.

CHAIRMAN KNOX: Oh.

MR. HASSARD: An advisory group. I would not suggest that the Legislature try to set rates. Obviously the Legislature can't set rates. And I wouldn't suggest the Legislature do anything more than it has in the past, and that is set minimum capital and surplus requirements. I don't suppose it should set maximum, but there ought to be more flexibility and another body that can evaluate and assume resonsibility so that in the.....maybe this is only an interim thing that I'm thinking about, but it is awfully real. At the present time the little bedpan companies have to use claims-made to form policies. They have no choice. A claims-made form of policy, as I'm sure members of the Legislature know, you've heard a lot about it, has lots of drawbacks. In the long run they have the same cost factors as an occurence form so it really doesn't save any money in the long run. It does make rates a little bit easier to establish, but that's about it. A claims-made is about all these little companies can do. The major companies, in spite of testimony of about 50% profit and what-not, major companies are leaving the state. I would guess that by 1979, we'll have one, at the most, left and that will be CMA operating in San Diego and Imperial Counties and they...

CHAIRMAN KNOX: You say that they're leaving the state. They're leaving for the purpose of medical malpractice. Are they leaving for any other line?

MR. HASSARD: I really can't answer you, Mr. Chairman.

CHAIRMAN KNOX: I'm just wondering if we're using our market advantage in California to force some of these companies to participate in our own problems here.

MR. HASSARD: There have been bills along that line. I think Nevada actually did an act, a statute to that effect, that if you were going to do business with -- in Nevada in the casualty field, you had to include professional liability. I know there have been bills in the California Legislature along that line, and I don't know of any that have gotten anywhere. And I don't know how practical that is, or how constitutional, but it's an approach. In point of fact, in medicine, physicians are getting closer and closer to having nothing but their own self-insurance mechanism, their own company. There is a distinct limitation on the amount of capital that can be acquired, so many thousand doctors, or so many hundred hospitals can only raise so much. If you apply a standard that means that so much is inadequate, there if nothing else is available, you mandated inadequacy, which is my point. The off-shore answer bothers me. I just don't think the off-shore answer is a good answer. It...

ASSEMBLYMAN McALISTER: We have a bill pending before the Legislature now which would make it easier for off-shore activities, much to my dismay.

MR. HASSARD: Well, the off-shore concept, assuming it could save income taxes if there was anything to tax, can't change the laws of nature. You can't change the laws of economics because if you have a limited fund with no resource on that limited fund, when that limited fund is gone, it's gone.

CHAIRMAN KNOX: Hap, if I had more time, we'd go down to

the Bahamas and investigate the situation.

MR. HASSARD: Yes.

CHAIRMAN KNOX: Any further questions from the members of the committee? Members of the staff? Thanks very much. Oh, pardon me. Go ahead.

MS. GORMAN: This may be a little complicated, but you were talking about procedural changes and multiple defendants in lawsuits. Do you have any suggestions on procedural changes we could make that would decide who should defend and what defendants should stay in? I know in the federal court, in pre-trial procedure they generally decide much earlier than we do what defendants are still in the case. Now speaking of...

MR. HASSARD: You're right. The Federal District Judges have much greater control over the management of litigation before them than Superior Court Judges do. I think that if I understand your question correctly, the answer would lie in adopting the federal statutory approach toward the District Judges control over the litigation but that too has problems because of the difference in the amount of litigation. But there is no doubt when you are in federal court, from the time the complaint is filed, the judge has almost total control over the case, tells you when you have to do what, and you have to do it.

ASSEMBLYMAN McALISTER: You don't think that would work in the state?

MR. HASSARD: Well, I'm sure it would work. Whether it's practical or not, there is no basic reason why there couldn't be a preliminary hearing on necessary parties and the requirement of disclosure by identification. I think that we have a spotty degree

of pre-trial leadership in the California Superior Courts. I think some are outstanding. I have observed some excellent judges and I've seen some bad ones too. You just need additional leadership and that's what a Federal District Judge -- in many cases they call it leadership, some guys -- sometimes it depends on which side. Sometimes it's called fascism, depending on how it comes out; but it's a stronger situation, there's no question about it.

MS. GORMAN: That's the reason I was sort of hedging a little bit.

CHAIRMAN KNOX: Anything further? Thank you very much. I appreciate your attendance. I think we'll pause now for lunch.

....

CHAIRMAN KNOX: We'll have to proceed with a little more alacrity this afternoon, although we certainly don't want to cut anybody off. Any comments that people want to make are certainly welcome. In addition to that, if there are long statements and they could be summarized we'd appreciate it because all of the material will be in the record of the committee, and then, we'll have a transcript of the actual hearing at some point. I may just take off my coat here. Our first witness this afternoon is Dr. Paul Slawson of the California Psychiatric Association. I assume that is you, sir. Alright, if you'll proceed.

DR. PAUL SLAWSON: Mr. Chairman, members of the committee, ladies and gentlemen. For the record, my name is Paul Slawson. I am a physician, full-time faculty member at UCLA School of Medicine. I teach psychiatry. I'm here because of my position with the California Psychiatric Association, which is our statewide professional association, in which capacity I am Chairman of the Insurance

Committee. I also have had a long-standing interest in psychiatric malpractice. Speaking for our Association, I would like to indicate that unlike some of the discussion that occurred earlier in the day, psychiatrists have not had a serious problem in securing professional liability insurance. We've done some surveys in the recent past because we are interested in the frequency of this occurrence and the need for professional liability coverage by psychiatrists, and we've been able to show from these that indeed this is a relatively infrequent occurrence. The exposure with respect to risk is relatively mild as compared with other branches of medicine. However, notwithstanding, there has been a substantial increase in the cost of professional liability coverage for psychiatrists. As little as five years ago, the average practitioner in the Southern California area paid a premium of less than $200. At the present time, if he secures his insurance through the national professional organization, which is one of the primary resources, the cost of his coverage is now $5,000, so there has been a substantial increase.

CHAIRMAN KNOX: Give me those figures one more time, Doctor. From how much to $5,000?

DR. SLAWSON: About two years ago -- I beg your pardon, five years ago, the average premium was $200, and now, for reasonable limits of liability, it's about $5,000. This figure understandably is modest. There wouldn't be a malpractice crisis if all doctors could get insurance for $5,000. However, I think there are important factors to consider. One is that our risk is lower and also the frequency of suit within the area can be shown to be considerably reduced. In addition to this, psychiatrists would have some difficulty sharing with body medicine the cost of these

premiums because, although it is sometimes not recognized, psychiatrists are actually a fairly low-fee specialty and do not share, say with the surgical specialty, the high incomes that would be necessary to support this type of treatment. In any event, on the basis of our activity today, the major point that I would like to bring to the attention of the committee would be the reporting practices of the insurance company. We were very dismayed when we found out that it was almost impossible to find out what the risk was. Probably there were anecdotal reports about what happened to psychiatrists and how they were sued. When we went to the insurers to see what the exposure was, we were dismayed to find two things: one, that we weren't very well segregated as far as our particular type of risk being identified and put aside with the others; and secondly, that the general practices with respect to reporting were really rather -- seemed to be very inadequate; that there were groupings of doctors over periods of time, that the refinement in terms of the law status we had anticipated we might find were simply proved to be lax. It made it very difficult for us to get the kind of information we wanted relevant to just what kind of a risk we present. We did this, not only because we're interested in knowing what it was that we were being asked to pay for, but we were also interested in loss prevention. When I say this I mean that not just so much to look out for the insurance companies, but to try to prevent the type of unfortunate experience that would lead to this type of loss. In any event, it is our feeling that perhaps through the agency of the Insurance Commissioner, there should be a state-mandated reporting system that would provide for the type of detailed reporting that would enable people to make meaningful

estimates of what loss experience has been, to say nothing of attempted projections as to what loss experience might be at a future time. I think that it is fair to say on the basis of our experience that perhaps some sound actuarial consideration of what losses have been paid, rather than some rather interesting, but at times rather nebulous projections based upon anticipated reserves and cases that are incurred but not reported and other rather, to us at least, somewhat obscure policies that at least as insureds and as consumers of this type of liability insurance, we find difficulty understanding. We found, for example, that in many areas the rate for our professions were derived from an industry-sponsored organization called the Insurance Service Organization, and they serve the industry by providing actuarial projections. Talking with people within the industry, we found that while there was a certain amount of actuarial science, there is also a considerable amount of leeway on how these projections are arrived at. Factors of 100% to accommodate for whatever might be encountered are common and make it difficult to understand just what, in fact, is being requested of us and ultimately passed on to consumers in the way of increased professional overhead and expense. The other comments which I will make very brief, have to do with our current assessment of the tort law circumstance. It is our feeling that it may be one solution and certainly a step in the right direction. I was impressed with Mr. Hassard's constructive comments about some of the technical language of that. I think that someone who sits on Loss Control Boards and deals with kinds of things at the hospital-doctor level is impressive.

The things that present us with the greatest problems, I

think, are two in number: One would be a series of what one might call frivolous and unjustified claims which have a kind of nuisance value but are very consumptive of our time. One might think in terms of perhaps some remedial type of legislation that would either allow a clearinghouse for these in some other sector or perhaps some way of suppressing their interest. Perhaps the most significant and final point that I will make is that we are concerned about the matter of the distinction between malpractice which means that the doctor did a bad job, that he practiced in what the lawyers say is a negligent manner; a negligent, reckless and irresponsible manner with what we are inclined to call an untoward result, which I understand other people are now calling a maloccurrence. When you couple these two entities to the sort of common sense approach that you aren't supposed to be in relatively good health, walk into a hospital and come out dead, you get into very difficult areas. There is almost a need for the doctor to certify that he is going to be able to achieve a good result; in fact, even the elements of malpractice law point out that doctors can't and shouldn't guarantee performance and that what is at issue is negligence and not an unfortunate outcome. This, I think, at least in our setting at UCLA, has become a very, very difficult problem. The consumer expectation is enormously high, particularly in a university setting, and we are all now becoming products of high technology. We are in expectation of good results and significant intervention leading to outcomes that just couldn't have been anticipated or expected years ago but are now commonplace. I think that in summary our contention is that some form of state-mandated reporting and refinement of reporting that would allow a clear understanding of what is being paid for

in a professional liability market would be most helpful in properly assigning the amounts of premiums that each of the various participants in such markets should properly pay. I would like to stop and I would be happy...

CHAIRMAN KNOX: Doctor, I just had one question, and I won't ask you to answer the question right now, but I am curious, and if your association or somebody else has done something along this line, I would be interested in seeing the product of the work, and that is, what kind of records or testimony is available from the psychiatrist about his patient when the patient files a suit putting his mental condition in issue? I understand there is a good deal of dispute about this and I would be very interested if you have some briefs, legal and otherwise, about your views in that matter, if you could send them to our committee, I would appreciate it very much.

DR. SLAWSON: I would be happy to do that. If I understand you correctly, that speaks right to the issue of the Caesar case...

CHAIRMAN KNOX: That's correct.

DR. SLAWSON: Mr. Caesar spent the weekend in jail preferable to that issue. It has to do with the Evidence Code 1015, and we do have material on that.

CHAIRMAN KNOX: Well, I would be interested in your views of that matter, and secondly, I am interested -- apparently to practice psychiatry as named, you need a medical doctor degree, an M.D. degree and an internship. Is that correct?

DR. SLAWSON: Yes. Psychiatrists are physicians. We have physicians and surgeons...

CHAIRMAN KNOX: So they are physicians, but on the other hand, you very particularly don't want to be grouped with the remainder of your brother physicians with respect to spreading the risk on malpractice coverage?

DR. SLAWSON: I would say yes and no to that. We are physicians. We are a recognized medical specialty. We have been going to the same medical school; we have the same internship, except instead of taking...

CHAIRMAN KNOX: You don't become an orthopedist or specialize in internal medicine, you become a psychiatrist. I understand that.

DR. SLAWSON: The problem that we had is what we call in our commentary a so-called compression factor. One of the reasons that we were opposed, not vehemently, but as an association of physicians, to the Berman bill was the so-called compression practice, the compression effect of this. That is, where the low limit and the high limit would be pushed together, which meant that many of our people who had at that time enjoyed very low rates would be suffering up to maybe 400% increases in the rates that they would be expecting. This would offer a kind of economic parity, but on the other hand, it doesn't take into consideration that there is imparity in terms of income.

CHAIRMAN KNOX: But you are saying that at least up to a point that psychiatrists are willing to share in the troubles of their colleagues in the profession. Up to a point. Any questions? Thank you very much, Doctor. We appreciate your being here. Mr. Jack Long of the California Legislative Council of

Professional Engineers. Mr. Long.

MR. JACK LONG: Chairman Knox, members of the committee, ladies and gentlemen, I represent the California Legislative Council of Professional Engineers comprised of 18 organizations and about 30,000 engineers. I have been in the field of the industry since 1935, and had my own office and practice since 1945, in Oakland, California. The construction industry, from the standpoint of assigned professionals, has the same problem that the doctors do, only actually more complex. Consumer protection has created the professional liability problem as far as I am concerned, and I believe it has gone beyond the reasonable thing. The pendulum has gone too far in consumer protection. In design and construction, several suits were employed naming everybody or anybody who had any relationship with the project, and really without researching the case and establishing the truth. For example, a testing firm in the Oakland area broke a cylinder, a concrete cylinder. It had nothing else to do with the project except the cylinder of the contracting firm that brought it in was broken. The president of that firm had to spend two days in court on a case that he knew nothing about and didn't have anything to do with. This is the kind of thing we are up against. I hope you people have had a chance to look at what I consider a landmark case in Florida about a surgeon who sued his patient and the patient's attorney for false suit.

CHAIRMAN KNOX: We are familiar with the case, Mr. Long.

MR. LONG: I think it is quite important and hopefully it will be upheld. As far as cost of insurance, I was talking to

a friend of mine the other day who has a three-man office. Twenty years ago the cost of insurance was $360 a year. Now it is over $8,000. The larger offices are $25,000, $40,000, $50,000...

CHAIRMAN KNOX: $50,000 for all three engineers?

MR. LONG: Yes.

CHAIRMAN KNOX: That's not too bad.

MR. LONG: Well, in his office, he is the responsible person. He just has two people working for him. Nobody else is responsible except the one I mentioned. Now, I have two recommendations: one, that we establish that the plaintiff bear all costs of the suit in the event that the suit fails, rather than the person being sued having to go back and sue this person to get indemnified. The other recommendation is to require the insurance companies to defend a professional if he elects to defend; that the settlement be only with his support. Now too often these cases are settled by the insurance company because it is economically sounder to them. But it is damaging to the reputation of the professional and, as in this case in Florida, they even dropped the man's insurance. So I feel that certainly all insurance laws should provide at least with this type of insurance, professional liability, the fact that a man can be defended for his reputation as well as for the monetary aspects.

CHAIRMAN KNOX: Let me ask you a short question, Mr. Long. Suppose that you had one of your engineers sued for $400,000 and he had $200,000 worth of liability insurance and they could settle the case for $150,000. Now, to protect his reputation, should he expose himself to the additional $200,000?

MR. LONG: That's a hypothetical case, of course, Mr. Knox.

CHAIRMAN KNOX: It happens all the time.

MR. LONG: I understand that. I would go to defend it.

CHAIRMAN KNOX: You would?

MR. LONG: Yes, sir.

CHAIRMAN KNOX: You're crazy. It is not relevant to anything, but I think it is interesting.

MR. LONG: Well, I have been sued many times and I haven't lost a case yet and I don't intend to.

CHAIRMAN KNOX: That's true of any lawyer you talk to, but if you get into the details, sometimes it doesn't work out that way.

MR. LONG: At any rate, I think I said enough, but I do want you to know that it is just as important in our field, architectural engineers, as it is for the others; and ours, I think, is a little more complex. Thank you for your time.

CHAIRMAN KNOX: I didn't mean to be -- I was being a little outgoing, but I couldn't resist giving you that.

MR. LONG: I appreciate that.

CHAIRMAN KNOX: I certainly appreciate your attendance, sir, and I think it was very nice of you. If you have anything further to tell us, I hope you will get in touch with us. Thank you very much.

MR. LONG: I will be in touch with your office if we have anything.

CHAIRMAN KNOX: Thank you very much. Is Dr. Gampell from the State Bar here? He will be along shortly. Mr. Gilbert Jones, of Bonnie and Jones. Is Mr. Jones here? Don Zuk and Sanford Rothenberg.

Mr. Zuk is with Johnson and Higgins; Dr. Rothenberg is representing the Southern California Physicians Insurance Exchange. Gentlemen, thank you very much.

MR. DON ZUK: Mr. Chairman, I helped arrange Dr. Rothenberg's attendance today, and it was not explained to me that a statement was desired by this committee...

CHAIRMAN KNOX: No problem.

MR. ZUK: ...so I really have nothing prepared...

CHAIRMAN KNOX: Oh no, this is being recorded, sir, so we will have the full advantage of your testimony. Besides hearing it, we will have it printed for us.

MR. ZUK: ...and I arranged the meeting for Dr. Rothenberg.

CHAIRMAN KNOX: Oh, you are introducing Dr. Rothenberg.

MR. ZUK: That's right.

CHAIRMAN KNOX: Proceed with your introduction. We are glad to have you here.

MR. ZUK: This is Dr. Sandy Rothernberg. He is a member of the Board of Governors for the Southern California Physicians Insurance Exchange. Dr. Rothenberg.

CHAIRMAN KNOX: Doctor.

DR. SANFORD ROTHENBERG: Thank you. My name is Sanford F. Rothenberg. I am a Doctor of Medicine. My specialty is Neurosurgery and for the past 26 years I have been actively engaged in the neurosurgical care of my patients in Los Angeles. Approximately two years ago, I appeared before the Assembly Select Committee on Medical Malpractice, which was chaired by the Honorable Howard L. Berman. I have had the opportunity to meet many of those who were

scheduled to be here today before today. Two years ago I appeared on behalf of the 10,000-member Los Angeles County Medical Association. I was then serving as its President. Today I appear before you representing the Southern California Physicians Insurance Exchange of which I am a member of its Board of Governors. I am sure you know that the Southern California Physicians and Insurance Exchange, called SCPIE, is a nonprofit physician-owned reciprocal. We have over 3,000 policyholders in Southern California. Our company came into existence just a year and one-half ago. Participating in and sponsoring the SCPIE program are medical associations from the following counties: Kern, Los Angeles, Orange, San Bernardino, San Luis Obispo, Santa Barbara and Ventura. The cooperation of the medical associations has proved to be of great advantage to our company. An integral part of our underwriting examination and review of claims is provided by the doctor committees from each of the sponsoring medical associations. This provides equity for both the doctor applicant and his colleagues who are already in the program. The philosophy of our Exchange is to provide prompt settlement of meritorious claims and the vigorous defense of unwarranted and frivolous claims. The settling of non-meritorious incidents only encourages the filing of more and more claims and it is expensive and frustrating to the doctor policyholder. This philosophy established at the beginning of the SCPIE program will continue. It assures the company and its policyholders of integrity in professional liability settlements and judgments. In addition to very active physician participation through committee structures, SCPIE utilizes the services of consulting actuaries, a broker, administrator, and legal advisors. We feel that superior underwriting

and an aggressive but fair claims settlement posture, coupled with realistic rate levels will help stabilize the malpractice premiums in our Exchange. We believe, however, that meaningful tort reform is necessary for any long-term solution to this most important problem. You will, or you have already heard testimony from the California Medical Association. We vigorously support their position. It would serve no purpose to repeat their recommendations. I don't intend to give you an abundance of figures today but would be happy at your request to provide whatever reports and statistics that are available. Mr. Chairman, we have records on all malpractice claims dating back to 1970 in the seven-county areas. We know, for example, that the Hartford Company in 1970 collected approximately $2,600,000 in premiums. We also know that for that same year they paid out just over $4,330,000 and still have reserved an additional $2,000,000 for known claims. In 1971, which was the first full year of the Hartford program in the seven-county area, a total premium collected was approximately $13,400,000. As of March 1977, for 1971 they have paid out over $13,000,000 and have approximately $7,000,000 in reserve for known claims. These are the kinds of statistics and numbers that we can make available to you to demonstrate the need for tort reform. I will repeat that we also believe that in the SCPIE program we are doing all we can to help stabilize rates for physicians. We are deeply concerned about the thousands of physicians who are going bare. Many of the bare physicians whom I have talked with personally simply state that they cannot afford to pay the premiums. We still believe that what the Los Angeles County Medical Association suggested two years ago is in order. There should be a strict but equitable dollar limit on liability and all the

rhetoric about professional liability, runaway awards and settlements must be realistically contained. We suggested at that time a patient compensation system which fairly compensates patients. Giant strides toward improvement of the malpractice system, as we know it today, could be made if we would resolve to compensate the wronged patient with fairness and equity and remove from the system prohibitive costs generated by relatively few attorneys whose enthusiasm obscures reality. In closing, I would say once again that we on the Board of Governors of the Southern California Physicians and Insurance Exchange will do all we can to help in the insurance area itself and to improve the present tort system. We hope you will give every consideration to suggestions offered by the California Medical Association. We are pleased with SCPIE's progress to date in the professional liability insurance field. Because the program is in its infant stage, SCPIE statistics are not as meaningful as those we have available from our previous medical association's sponsored programs. I wish to thank you for allowing me to appear before you today. I would be happy to answer any questions you may have.

CHAIRMAN KNOX: Doctor, your Exchange is working on a claims-made basis, I guess; it is not occurrence basis?

DR. ROTHENBERG: Correct.

CHAIRMAN KNOX: What would you consider the liability if you were to purchase the tail from Hartford on all the liability they have going back over however many years it is? What would you consider a fair price to have to pay for that?

DR. ROTHENBERG: I really couldn't answer that statistically at present.

CHAIRMAN KNOX: What I am saying is that the amount paid

as we mentioned this morning, the amount paid in premiums in a given year and the amount paid in claims is not really relevant, is it, for that particular period?

DR. ROTHENBERG: Yes. For example, the amount of money they collected in premiums was multiplied by two for the cost to date in that 1970 year, plus generating a reserve that is equal to about the amount they originally collected, so we are talking about a cost to the carrier for that 1970 year of about three times that which they collected.

CHAIRMAN KNOX: I see. Now, the principle suggestion you make today is that we make a limit on the amount of liability on professionals?

DR. ROTHENBERG: Yes, sir.

CHAIRMAN KNOX: In other words, no matter how badly someone is hurt, if they reach that threshold, that's it. That's as much as they get.

DR. ROTHERNBERG: In response to you, I think that this is a societal problem. It is a serious problem. It is one that we have not, as you know, taken lightheartedly; but as you know, the government hasn't as yet come out with a catastrophic health insurance. Certainly the fraction of population the physicians are in this country cannot subsidize the catastrophic accidents that net us an inheritance, and so we have to have a limit of liability because if we don't, it certainly will in all ways proliferate, as well as impair the delivery of medicine in the future. And I would like to add in this respect, Mr. Chairman, that I think that it is appropriate to say that if there was a limit in liability and if it were exceeded that it would be appropriate for public assistance to come

to the fore for that injured patient if it were in excess of the limit of liability because it is a societal problem...

CHAIRMAN KNOX: So the rest of the taxpayers pay it.

DR. ROTHENBERG: Only because it is inconceivable that a physician can continue to subsidize a catastrophic health problem.

CHAIRMAN KNOX: Let me ask you another question, and I don't ask this in an antagonistic manner, I assure you, I am just trying to explore your view in the matter. We just had a representative of the engineers with us and they have malpractice problems as well. Suppose there is a building that costs a few million dollars to build and the engineers, through carelessness, built it in such a way that after five years it fell down killing 300 people and destroying a $50,000,000 investment and it is all the engineers' fault. Would you apply the same limitation of liability to the engineer and put the balance of the burden on the taxpayers?

DR. ROTHERNBERG: Well, to begin with, I do not believe that we can correlate an engineering catastrophe with the biological poor one hundred that we have to deal with in medicine. Our biological one hundred, Mr. Chairman, as you probably know and the members of your committee probably know, is somewhere between 60% and 80%, depending upon what medical and surgical problems we are dealing with. I think the accuracy in engineering far exceeds that biological one hundred that we have to deal with. So I think in fairness I may respond to your question by saying that we really can't correlate that. You know there is no way of telling about the unexpected bad results or poor results or catastrophic results. We all know and anticipate expected complications: we know that there

is going to be a certain incident of postoperative infection; of wound infection. We know as a result of the anesthesiologist's incubating a patient, putting a tube down his trachea, that you can have a certain incident of laryngitis or impaired speech or bronchial pneumonia or pneumonia. We know we are going to have a certain incidence of cardiac arrest and I can go on ad infinitum, but these are anticipated complications that are entirely divorced from the concept of negligence.

CHAIRMAN KNOX: I understand. Thank you very much. Any questions? Thank you, sir, very much. We appreciate very much your attendance.

DR. ROTHERNBERG: Thank you.

CHAIRMAN KNOX: I see Dr. Gampell is here, President of the State Bar of California, a very retiring fellow. Good afternoon, Ralph.

DR. RALPH GAMPELL: Mr. Chairman, ladies and gentlemen, my name is Ralph Gampell and I am the President of the State Bar of California. I am appearing in my personal capacity, though I believe that most of the propositions that I will advance have the support, at least in principle, of the Board of Governors of the State Bar. I have been spending some time trying to advance proposals for dealing with the malpractice problem as it affects the legal community and I started from the empirical base of certain proposals that were made at the time of the medical problem of two years ago, and if I could, I would like to extrapolate from those figures to certain figures for the legal community. Essentially what I am proposing is a form of mandatory risk-spreading, except, putting it simpler, instead of collecting reserves against an unknown contingency and leaving those

in the pockets of the insurance carrier until the contingency may or may not occur, the reserves would not be collected, would be left in the pockets of the membership until such time as it is necessary to collect them for the ongoing and immediate payment of losses. That's the theoretical concept and if I could, let me underpin it for you with the only figures we have which are the figures out of the medical situation. The reason that I say I can't give you any legal figures is that we know, for example, that the carrier who is still carrying the Bar -- the State Bar of California program -- has collected better than $20 million of earned premiums and has paid out either $800,000 or $1,800,000. I was told the figure at the weekend and I promptly forgot. Now that isn't to say that maybe he is not going to pay out $200 million, which is what he claims it is going to be, and lose his shirt. But the only way we will ever know what he does pay out is when he pays it. Until then, any attempt to develop any figures is as conjectural as looking at chicken entrails. So we do know what the figures are for our medical colleagues and the reason we know that with certitude is that under the statutes, the carriers have to report all settlements and judgments over $3,000 to the Board of Medical Quality Assurance, which in turn must report to the Legislature. We know that in '74 the payout by all carriers over $3,000 was just over $32 million, and in '75 the payout was just over $39 million. It is hard to determine what the risk population was for that amount of money. I think there were about 46,000 medical licensees living in California. It seems to me that a fair distribution figure might be to say on the topside there are 35,000 treating patients and on the low side, 30,000. The actual payment

per doctor in '74 was in the order of $1,100; in '75, was on the order of $1,300. The next and very mysterious figure is how much should be the add-on for the pay-out of that amount of money. A committee of the American College of Trial Laywers which, as you are all aware, is a very prestigious legal fraternity in the United States, assured me in private conversation that under no circumstances could the add-on be more than 100% and almost certainly should be less than a hundred. That is, the add-on for all costs, for brokerage, for home office expense, for adjustment, for legal fees and the whole ball of wax, would be less than 100%. So if you look at those figures, you can say that the actual cost per doctor for malpractice in '74 was about $2,200 and in '75 was about $2,600. Now, if we assume nonvenality on the part of the carriers, and I am certainly willing to make that assumption, at least for this argument, the only way that that translates into the $20 and $30 and $40,000 premiums is that the carriers are collecting money against an unknown contingency which the worst contingency is the inflation of the dollar. But when they say we are collecting the big bucks now because we are going to have to pay out -- the $100,000 now is a million down the line. I think what they are saying is that we are afraid that we will have to pay out in inflated dollars. That then brings me to what seems to me the only logical way to solve this problem, and that is to collect money exactly as you need it. But you can't do that on a day-to-day basis, so the proposal that I am presently advancing, which you, Mr. Chairman, are well aware is embodied in AB 209, is at the first of the next following year you collect from your whole at-risk

group, namely the whole of the legal profession, the actual cost of malpractice the year before, plus a carry-over of 10% or 15% for cost of living, or whatever. You exempt from your at-risk group the publicly employed lawyers because presumably they have solvent employers so I think that may be at least open to some question, and you exempt house counsel because similarly they work for a single employer and presumably have solvent employers who will be liable for their act under responding superior. The figures are rather remarkable, though again, I wouldn't, in all honesty, ask you to put stock in the figures because we are looking 15 years down the road -- 16, and I don't believe anybody can do that. I have no idea what's going to happen to the tort law. I don't have much idea what's going to happen to the State of California, but we could begin our proposal something like this. You recognize that if you set up any program, in the first two or three years you are going to spend no money because none of the cases are going to come to fruition and have to be paid up, so if we began a nominal collection of, say, $400 a lawyer, or maybe dropped to $450 the next, or $500 the next, $550, you wouldn't begin to see a rising curve until the fifth year. We have extrapolated as best we can, but by the 16th year, that is in 1993, the premium would be $5,000 per lawyer. Before that, we would be offering an indemnity of $250,000 and legal fees up to $250,000. Five hundred thousand dollars, that would be per occurrence, that is so a huge law firm down here could not pay a $20 million judgment by piling on $250,000. However, the big law firm would get the very critical advantage of having their legal fees paid up to $250,000, so that when they deal with their excess carriers, as almost everybody would have to, they would be

coming in essentially not with a primary and looking for secondary coverage but looking really at a deductible. They can go to their carrier and say, I have a deductible of $250,000 or $300,000 of primary indemnity. I have a deductible of $250,000 of legal fees. Now I want you to write the next layer. We have been told by our consultants that the next layer is available. I must tell you, in all honesty, if the next layer is not available, then the plan fails because I do not visualize the whole group being risked for the $10 million judgment or the $20 million judgment because of the SEC failure in an offering, something of that sort. Now, I recognize that you can make the argument that this is postponing the inevitable. But, of course, that's the essence of insurance generally. Whether you collect the money at the front end or at the back end, you still have got to pay. All I can say for this proposition is that we will be paying against the known happening rather than collecting money against some unknown happening. That's the proposition. I can flavor it up for another hour, but that's really all it is.

CHAIRMAN KNOX: Go ahead.

MS. GORMAN: In the draft that is going to be received in our office tomorrow on AB 209, it would not limit it to $250,000 per occurrence if more than one lawyer is involved and that's because the original actuarial figures were based on per attorney, not per occurrence. It would also assist in the actuarial, I mean the excess coverage being obtained by large law firms.

DR. GAMPBELL: There are several ways you can approach this. The one thing that has to be avoided is being able to say, yes, twenty lawyers in our firm were involved. I carried the main

burden, but all you nineteen answered the phone and are all, therefore, technically liable and therefore, between the twenty of you, you owe $5 million. I think there may be a certain amount of confusion. The indemnity would run to every member of the law firm, that is, supposing we had a law firm as are here in Los Angeles with two hundred lawyers. Theoretically, each one of those could commit a separate tort and each one of them could collect whatever the sum of money is. But I, for one, would not be in favor of accumulating twenty of those two hundred and fifty in connection with one single act. I think that would beggar the fund. Now, whether you want to say the per occurrence for a big firm you want to run it up to a half million, that doesn't seem to me to be actuarially any problem, but I personally would be very opposed to running it up to $10 million for the acts of forty people.

CHAIRMAN KNOX: This, of course, would be claims-made insurance?

DR. GAMPELL: Yes, but with a continuous guarantee that it is going to be renewed year after year. That is the essence of the case. The other thing, of course, which is bothering everybody is what happens at the end of time. Now, I have taken the proposal this will last as long as the State Bar lasts. The State Bar this year has presently lasted fifty years. I hope it will at least find under my presidency its life expectancy has not been diminished. If at any time the fund has got to be wound up, it is quite clear there will be an unfunded liability and that will have to be paid off over a period of years or sold to another carrier. I make no suggestion that this is some new variation of "which shell is the pea under." It is going to cost money. But the essential merit of this propo-

sition is the amount of money it costs is going to be known. It is going to cost what it costs, not allowing the carrier to accumulate money and blow it in the stock market as happened in '75.

CHAIRMAN KNOX: Are you going to allow the lawyers to advertise under the new decision that they are a member of the fund, or will the fund cover false advertising?

DR. GAMPELL: No. I suspect to that extent that it would be fraud. I take it the fund would not cover, as no policy covers now. We've tried in offering to you as the author certain State Bar amendments to make our proposals track with standard policy and I believe that that would be an exclusion. It is a neat idea.

CHAIRMAN KNOX: Oh, I've got my name on it, Ralph, I'm all for it. Any questions of Dr. Gampell? Thank you very much.

DR. GAMPELL: Thank you very much.

CHAIRMAN KNOX: Dr. David Rubsamen, Doctor of Medicine and Juris Doctor.

DR. DAVID RUBSAMEN: Mr. Chairman and members of the committee, I am David Rubsamen. I am editor of the Professional Liability Newsletter and I am a medical legal consultant. I am just going to address myself to one topic here and this deals with the incidence of nuisance suits that insurance carriers are subject to. I know this has been discussed previously today and I will put a new slant on it, I hope. In the course of speaking with claims managers of a variety of insurance companies and reviewing many, many cases, I am impressed with how many cases there are which a well qualified Plaintiff Malpractice Specialist simply would not bring, cases which simply lack merit. Now, the attorneys to bring these are usually men in general practice and they are people who

listen to a patient's story of injury and their initial reflex action seems to be to file a summons and complaint without really evaluating the case, certainly without evaluating it with anyone competent to evaluate it. The National Association of Insurance Commissioners reported 64% of claims closed throughout the country without any indemnity paid. In California, that figure ranges around 70% to 80% depending on the company. I am not suggesting that all cases that are closed without indemnity paid are without merit in the sense that one cannot justify the filing of the claim and pursuing the case. I am suggesting this is a large number of cases closed without merit and I can assure you from my own experience of working in the medical malpractice areas of consulting for seventeen years, that there are numerous cases which shouldn't be brought in the first place. I think these number perhaps 30% to 40% of the total number brought. These cases reflect the following: A patient who had a blood pressure taken got a few little petechial hemorrhages on the skin -- sued the doctor. That case actually went through trial. A patient who had a vasectomy and had some soreness for a week found a lawyer who would file a claim. A patient who got an enema when it was intended for the patient in the adjoining bed found a lawyer who would sue and in the summons complaint, the words "wrongful enema" actually appeared. Oh, it was a terrible thing! I might add there was utterly no injury from this fellow's experience. There was a consulting orthopedist who was sued because the traction apparatus fell on a patient without really any significant injury. He did not set up the traction, he had nothing to do with it, he was one of the consultants but nevertheless, he was sued. The peripheral defendant

such as the pathologist was sued in a wrongful death action -- his participation in the case was doing the autopsy. And that was actually taken right up to trial and it was dropped just before trial. The patient who died from a so-called berry aneurysm. This is an aneurysm in the brain. It is congenital. It can appear at any moment, mowing the lawn or whatever. It happened, unfortunately -- this appeared a few hours after elective minor surgery. It was clear that the case -- death had nothing to do with the minor surgery. This is one of the more complicated examples of what I would regard as a totally non-meritorious suit. It would require some intelligent work-up to come to that conclusion, but it is obvious. The individual who had a carotid arteriogram and felt tired before the arteriogram, felt tired for weeks after, and found an attorney to sue the doctor because of the tiredness, and in the summons complaint, the attorney said the arteriogram must have destroyed the thyroid. This was based on the fact that there were about 5 cc.s of hematoma around the arteriogram, which was discontinued because of the patient's discomfort. And finally, the patient who had a perfectly successful mamilliplasty deep breast enhancement procedure by a plastic surgeon, but the breasts weren't large enough, so she found an attorney willing to bring the suit. Now there is already a partial solution to this type of problem. I do want to emphasize that if I am correct that a third or even more cases that an insurance company deals with represent the totally non-merit cases. That expense is very, very substantial, so I am not talking about something as trivial as the impact of the case examples brought. The case examples are ludicrous. Their effect is not ludicrous. The solution exists in the abuse of process action or more appropriately

usually the malicious prosecution act. Now, the doctor can bring a malicious prosecution action, as you know, after the successful termination of his case. Now, in the malicious prosecution action a standard does exist. That is, the plaintiff's attorney must have probable cause for bringing his action. If he lacks the probable cause, then malice will be inferred from that lack, by Norton vs. Hines, and he can then succeed in proving his case. But the problem is that proving a lack of probable cause is very difficult. In the illustration I gave you of the pathologist who was sued in the wrongful death action where he only did the autopsy, he sued. He collected $10,000 shortly before the case went to trial. I am here to suggest, and this is the sole point of my testimony, that the number of attorneys that we have in the state, the rapidly increasing number, the very large incidence of malpractice claims, requires a more reasonable standard of care than just the lack of probable cause, or at least a method of proving the lack of probable cause which will give the injured doctor a chance to retaliate when he is subject to one of these nuisance claims. I feel that it is rational in the present medical malpractice climate where we have many, many competent plaintiff malpractice specialists to apply to the lawyer who brings and pursues a malpractice case the same sort of standards that the doctor is subjected to, i.e. the standard of the community quality of care; that is, when the attorney brings that action, if he is sued in a malicious prosecution action, he must defend by showing that a representative member of the specialist malpractice attorneys in his community would also have brought that action. Now, this is no more than the general practitioner is held to in medicine. If he does an orthopedic procedure and gets a bad result,

he is held to the orthopedic standards. I am suggesting by analogy that the plaintiff's attorney must perform at least to the average of competence of the specialist malpractice attorney in the community and I think that with such a standard, the result would be this: I don't think you would have a plethora of malicious prosecution actions. I think you would have a few. Once you had a few, you have the attorney working up his case before he brought his summons and complaint, or if he had to bring his summons and complaint...

CHAIRMAN KNOX: Let me ask you this question, Mr. Rubsamen. You want the attorney to work up his case. Are you also, as a concomitant of your suggestion, saying that without his filing a suit, he would be entitled to full discovery of the doctor and hospital records without filing a suit?

DR. RUBSAMEN: Well, under Section 1158 of the Evidence Code today, my understanding is that he does have that...

CHAIRMAN KNOX: Yes, he has to go through a little trouble to get it though.

DR. RUBSAMEN: ...and under the procedure called Continuation...

CHAIRMAN KNOX: Perpetuation...

DR. RUBSAMEN: ...Perpetuation of testimony, he can also use that.

CHAIRMAN KNOX: Yes, and he's got to go through a lot of trouble to get that. Would you support a situation where he can go to a doctor and say, look, this fellow is coming to see me and claims that he has been injured and I am his attorney and here's a contract signed by him and before I file a suit, Doctor, I would like to talk to you and I would like to examine all of your records and would

like to go into your hospital records and so on, and I will determine whether or not it is a good case for which I am willing to accept liability. Would you support that?

DR. RUBSAMEN: I would be completely supportive of that. I don't know any authority in the...

CHAIRMAN KNOX: That's great. All right. Thank you very much. Any questions? Thank you very much. We appreciate your coming. All right, Mr. Ted Ellsworth of The Doctors' Company.

(See Appendix VII for written testimony.)

MR. TED ELLSWORTH: Thank you, Mr. Chairman. My name is Ted Ellsworth. I live at 9043 Burrough Road in Los Angeles. I am a member of the California Citizens for Malpractice Reform, referred to as CCMR, which two years ago was deeply involved in an effort to secure progressive legislation for the solution of the medical malpractice insurance crisis which existed in 1975.

CHAIRMAN KNOX: Mr. Ellsworth, if you want to summarize your statement, it is all right, and then give us the whole text for our record.

MR. ELLSWORTH: It is a very short statement.

CHAIRMAN KNOX: O.K. Fine. Go right ahead.

MR. ELLSWORTH: My involvement with the Citizens Committee was as a representative of the California Commission on Aging and the Los Angeles County Federation of Labor. Our efforts and the efforts of responsible doctors working with the Legislature resulted in the passage of AB 1XX. We feel that this is equitable and good legislation that will play a major role in the solution of the medical malpractice insurance problems and we are pleased that the leadership of the Legislature has cooperated in instituting a

lawsuit that tests the constitutionality of AB 1XX. I'm sure that you are aware that the large commercial insurance carriers gave no value to the cost reduction effect of the 1975 legislation and continued to increase premiums to the point that many doctors went bare or ceased to practice in protest of the cost of malpractice insurance. In view of the inaction of the commercial companies, doctors throughout the state looked to their own resources for a solution. One responsible group of doctors decided to establish their own doctor-owned nonprofit medical malpractice insurance company. The impetus was furnished by leaders previously active in the California Physicians Crisis Committee. This group of more than 1,900 doctors that worked closely with CCMR had recognized that ongoing consumer input was necessary to make the company serve community as well as doctors' interests. As a result of my efforts to work in the CCMR for a solution, they requested that I continue to work with them as a consumer representative on the Board of Governors of the new company. I accepted and have served since 1975 in that capacity. This company is called The Doctors' Company. It now provides medical malpractice insurance to more than 3,000 doctors throughout the state. It differs from other medical malpractice insurance companies in several important ways. One, we have a policy of selective underwriting. This means we will not insure a doctor with a bad malpractice insurance case history or will place limitations on his...

CHAIRMAN KNOX: Let me ask you this, Mr. Ellsworth. Who is going to insure that doctor?

MR. ELLSWORTH: Who is going to insure him? Well, there are a certain number of doctors who have such bad malpractice histories, we don't think they are insurable, and certainly we wouldn't

insure them. There are a lot more. Our procedure in getting an application is to determine whether the training of the doctor qualifies him to the type of practice that he wants insured. Now, in some cases, the type of equipment he has in his office is unsatisfactory. If he is doing procedures -- let's say a tonsillectomy, for example, with improper equipment, we are not going to underwrite him until he corrects that problem. If it is the lack of training, he can get the training and we would then insure him, but we believe that a doctor that does procedures that he is not qualified to do is not an insurance risk, he is a problem for the Medical Assurance Board, as far as I am concerned. We do turn down doctors. We have a peer review system that they can appeal to. We have had over 100 appeals. Some of these were settled satisfactorily. We were able to see that the doctor had a good argument. We insured them. In some cases we applied deductibles.

CHAIRMAN KNOX: You cancelled doctors that have claims?

MR. ELLSWORTH: We have never cancelled any doctors to my knowledge.

CHAIRMAN KNOX: Could you cancel them under your contract?

MR. ELLSWORTH: We could refuse to renew. We certainly couldn't cancel the period for which we accepted the premium.

CHAIRMAN KNOX: O.K. Go ahead.

MR. ELLSWORTH: We are not sponsored by any medical society or association. We are not under pressure to insure doctors because they are in good standing in an organization. Each applicant is evaluated on his own individual record. I mentioned that they have the right to appeal. The company is really on a truly nonprofit basis. In 1976, the company had an operating gain in

excess of $505,000 after all expenses and the establishment of necessary statutory reserves. Each policyholder of record in 1976 received a dividend of 11.6% of paid premiums as a result of that favorable experience.

The Doctors' Company has a unique claim policy that I, as a consumer representative, find reassuring. When a doctor with our company is obviously at fault, we believe that a prompt and fair offer should be made. Most insurance companies treat most claims, justified or not, as adversary proceedings or make settlement of frivolous claims to the detriment of the practicing doctor. It is our policy as soon as it is reported to investigate it and seek to resolve the issue as speedily and equitably as possible.

The premiums paid by our Company are approximately 50% lower than those offered by some of the commercial carriers. They are adjusted on a quarterly basis, based on the experience of the company. We believe that additional tort reform for doctors may be required as part of the permanent solution of the spiraling costs of medical care. We fully supported AB 1XX and believe that it is constitutional and hope that the Supreme Court so rules. We support several proposals now before the Legislature which would result in the expansion of the "Good Samaritan" philosophy. These proposals are in the best interest of the public as well as the medical profession. From our limited experience, we believe there is a need for a single purpose insurance company such as The Doctors' Company in other lines of professional liability. While it is premature to say that we have solved the medical malpractice problem, we certainly point to a solution. Other professions now facing escalating costs year after year from the commercial insurance

companies might look to the experience of The Doctors' Company.

While the state needs additional carefully drawn tort reform legislation that is equitable to consumers as well as to the professions, it has not occurred to us that we need legislation for new insurance vehicles. The State Insurance Code provides ample law to set up mutual and reciprocal interinsurance exchanges that provide for the necessary regulations for protecting consumers and insured. From my own observation, I think a single purpose company has some advantage in that they don't have to look at their malpractice experience in relationship to other medical policyholders. They don't have to look even in relation to other lines of insurance and how it might affect sales if they develop certain policies.

Thank you, Mr. Chairman.

CHAIRMAN KNOX: Thank you, Mr. Ellsworth. I appreciate your attendance. Any questions from members of the committee? Thank you very much. All right.

MS. GORMAN: Do you renew formally -- you said you renew the premium quarterly...

MR. ELLSWORTH: Yes.

MS. GORMAN: ...so you only insure each quarter?

MR. ELLSWORTH: Yes.

MS. GORMAN: The only thing is, you mention that you review the application made from the doctor's own record and you also set the premium based on the doctor's individual record.

MR. ELLSWORTH: The premium remains constant; for example, the premium in Class 8 would -- say it was around $6,350. That remains constant, but the man's record -- let's say he is part of a large group and he has a fairly bad record but the rest of the

the group has a good record. We would probably put a deductible on it of say, $5,000, whatever our actuaries and underwriters feel is right, but the premium is never changed. We limit the coverage. We do use deductibles.

CHAIRMAN KNOX: Thank you, sir. We appreciate your being here. Dr. J. David Gaynor of the California Dental Association. Dr. Gaynor.

(See Appendix VIII for written testimony.)

DR. J. DAVID GAYNOR: Mr. Knox, ladies and gentlemen, my name is J. David Gaynor. I am Vice President of the California Dental Association, an association made up of 11,600 member dentists in the State of California. I promise to take no more than ten minutes of your valuable time as it is getting late in the afternoon. In this presentation I will give you a description of the program of the association, the past history of claims and premiums, current efforts of the California Dental Association to solve the malpractice problem, and, finally, what we believe must be done in the future to solve the problem for the dentists and their patients within this state. As we have set our rate structures and have accumulated our figures, we basically are operating two classes of individuals. Number one, the general practitioner, and number two, the oral surgeon. Our rates have been set by the history of loss experience and they have shown a significant climb in the last five or six years. In the policy year of 1974, the general practitioner rate was $178. In the current policy year of 1977, which starts July 1st, the rate is now $785, and increase of 441%. In 1974, the oral surgeon rate was $270, and as we started to accumulate loss experience and cost, this year that rate was calculated at $3,040, or an

increase of 1,125%. Now to save time, I think one can make the statement that the dollar amounts involved may not be too significant, but if we continue to carry these graphs up, in the next three, four, or five years at those kinds of percentage increases, we are then talking about the same rate that the physicians are charging and that will become very significant to the patient that we serve. The loss experience is quite interesting as we look at the records, and an interesting part of the records are that for many years there were no records. We were operating with premiums of $150 and $125 and the insurance companies were making money. As long as they were making money at the low premium rate, it didn't seem to make very much sense to spend any money and keep records, so our records really only start dating significantly into the beginning of the '70's. In 1970, the collected premium was $1,519,000. The total estimated payout, which will include all the costs for the 1970 year, is going to be $1,425,000 for the ultimate loss ratio of .94. Now, that is the last year that the insurance company has come out ahead. In 1970, with a premium collection of $1,500,000, the estimated total loss will be $2,300,000, and these figures come down the line. I think a very significant one will be 1974, with $1,595,000 in premium collection. The estimated loss will be $4,900,000. If we add up the total earned premiums and the total estimated losses from 1970 to 1975, we start to see what the problem really is, because in that six-year period of time there will be collected, there is collected $11,344,000 in premiums and an estimated total loss payout of $19,400,000. Now, it is obvious that the insurance company is not going to come out too far ahead with the presentation of those kinds of figures. Now, as part of our program with our

Council -- excuse me, I would like to add just one other thing. The earned collected premium is increasing significantly. In 1976, that premium is approximately $6,000,000, and in this current year, 1977, that premium will be $10,000,000, so you can see the kind of escalation that we are suffering in this problem. The California Dental Association with its Council on Insurance has hired an independent actuarial service and firm, Milliman and Robertson, and they sit in on all of the judgments and all of the meetings of the Council. We utilize their expertise to help us evaluate the fact and figures that are presented to us by our carriers, not just in the liability field, but also in the disability field and the hospitalization insurance.

I would imagine there have been a lot of things said that are perhaps unkind to the various carriers this morning and some this afternoon, and I would like to tell you that we have been very pleased with the Chubb Pacific Company and the way they have worked with the California Dental Association in their method of sharing their information and their cooperation with the program. They gave us a five-year contract five years ago. They honored every portion of that contract, though at some point two years ago they found that in their calculations they included no money for home office expense as an error. And as you know, insurance companies can, if they desire, make those kinds of changes after the contract is signed. They chose to honor every portion of the contract, and we, as the California Dental Association, are appreciative of that.

Current efforts by the California Dental Association to try and decrease the problem: number one, we have started on an experimental basis a Claims Review Program both in San Diego and

San Francisco where cases that are being filed by attorneys are going through the claims review process by peers, by dentists; and they are trying to make their evaluation as to whether that claim has value or not, whether it is justified, and give this information to the carrier. The carrier then utilizes that information to make a decision in terms of whether to settle that claim at the best and most fair method for both the dentist, the company, and the patient; or whether that claim is frivolous and should be fought down the line. This program so far seems to be working very well. As an Association we are holding conferences and publishing articles in our journal to try and increase the quality and the level of care. I think that the most significant thing that we are doing is operating a very effective and a very fair peer review system where when we get complaints dealing with the quality and the level of care, we, as an Association, are investigating those complaints, and in the process, as we identify sub-level practitioners, we counsel those men and we request a continuing education program to upgrade the level of their practice.

I guess our greatest concern with the future is that at some time in the not-too-distant future, and I guess particularly on July 1st of next year when it is our feeling Chubb Pacific will, at the end of their 5-year contract, choose not to renew and we will not be able to secure liability insurance for our 11,600 member dentists at any cost. Not too long ago we surveyed the field and after contacting seventeen companies, the only one that showed any interest was the company that is currently carrying the program. Now obviously, if we can't secure any kind of coverage, the individuals that will be harmed most will be the patients who, under

those cases where malpractice has occurred, deserve to be recompensed and the professionals, the dentists, will some of them go bare and then the patient gets no recompense for an injury that has occurred. I think that is the significant public problem. One of the kinds of things that we believe have to be done to try and solve the problem from the point of view of the dental profession. We have investigated the possiblity of forming a reciprocal company and we are quite pleased with some of the possibilities, but the deeper we get into the discussion, and we get disclosure on information as to what it takes to form a reciprocal, the more difficult we find it is going to become. I think if malpractice insurance is going to be difficult to secure by professionals in this state, I think there has got to be some legislation to make it more meaningful and somehow easier for those professional organizations that must form reciprocals to do so and not make it a very difficult task, one that discourages instead of encouraging that form of insurance.

CHAIRMAN KNOX: What's the most difficult thing about the task?

DR. GAYNOR: Well, part of the problem we have had is in terms of getting good information with the Insurance Commissioner. We find it at times difficult to work with and meet with...

CHAIRMAN KNOX: You find it difficult to meet with the Insurance Commissioner?

DR. GAYNOR: We have had some difficulty the first round in terms of getting a proper appointment.

CHAIRMAN KNOX: You mean you couldn't get an appointment with the Commissioner?

DR. GAYNOR: It was hard at first. We finally got it with

his staff, yes, and then we met with the Commissioner later.

CHAIRMAN KNOX: You mean he turns you down or...

DR. GAYNOR: There just seemed to be a time problem, in terms of timing. The other thing, in evaluating the program, he makes the determination based on actuarial experience as to what the rate has to be, and I have the feeling that in that rate setting mechanism there is a tendency to treat his setting of the rate in a terribly conservative basis, which results in a very high rate for the participants of that insurance.

CHAIRMAN KNOX: It is required by law to determine whether or not a rate is inadequate under the circumstances.

DR. GAYNOR: Yes, but I think that within that parameter there can be some working area.

CHAIRMAN KNOX: I see. You feel that the standards he has are...

DR. GAYNOR: I believe those standards are too stringent. That's right.

CHAIRMAN KNOX: Mr. McAlister.

ASSEMBLYMAN McALISTER: Of course, with the past history of this subject matter, you can well understand why he would be super-cautious, since everybody who has gotten into this business has gotten burned over the past two decades.

DR. GAYNOR: That, of course, brings us to the statement that has been made to us many times as dentists. The question is asked, how do we feel we are going to survive with our own company if the insurance companies who have a great deal of expertise have not been able to make a buck and come out ahead, and that is part of the problem.

CHAIRMAN KNOX: Do you have records of your telephone calls and your attempts to contact the Commissioner?

DR. GAYNOR: I don't think that is that significant a problem. I don't think we can pursue that.

CHAIRMAN KNOX: Well, it is significant. As a representative of State Government, it is significant to me if one of our departments is not available to somebody that needs help.

DR. GAYNOR: Let me check with our staff and I will get that information to you.

CHAIRMAN KNOX: Anything further, Doctor?

DR. GAYNOR: Yes. In the peer review system, at the current time there is legislation that holds that the individuals who render peer review are not liable for legal action as long as what they do is not done in a malicious manner. I believe from the information given to me that the organizations they represent can be liable, such as a component dental society, such as the Los Angeles Dental Society or the parent organization, such as the California Dental Association, and I believe we should have some legislation that also relieves the parent organizations of liability in the peer review system as the individuals themselves are relieved of liability. A suggestion that has been made by many other speakers is a method of pre-review of those cases that don't have any justification to keep them out of the court system where the costs start to mount significantly and then costs to all the participants. And the last suggestion that I have to make relates to the peer review system and to the determination of sub-level practitioners. It is my belief that the Association should have the power through its peer review system to investigate those individuals who practice sub-level

care and there should be a mechanism either for removing licensees from the practice of dentistry, number one, or requiring that they upgrade their practice to a greater degree of...

CHAIRMAN KNOX: You mean you want the private association to have that power to remove...

DR. GAYNOR: To recommend to some appropriate body. But I think there has to be a mechanism that is free from being able to be sued by the individuals who are being evaluated so that all professions can continue to upgrade the quality of care within the state.

CHAIRMAN KNOX: All right. Any questions? Thank you very much, Doctor. We appreciate your attendance. Now we hear from the Certified Public Accountant Association, Mr. Victor McCarty. Mr. McCarty, are you here?

MR. VICTOR McCARTY: Mr. Chairman, my name is Victor McCarty and I am a past President of the California Society of CPA's, which is the professional association or society for 16,000 California CPA's. I am also President of Wynnes & McCarty Accountancy Corporation in Long Beach. Speaking on behalf of the CPA's, we are delighted that the Legislature has formed this joint committee and we fully support it and are delighted to participate in any way we can with regard to your study, because we feel it is greatly needed. We see insurance itself and liability insurance as being a necessity, both from the standpoint of the practitioner as well as the public because the public has to have some remedy when it is injured. Practitioners need some way of paying the attendant expenses to keep them in business and avoid financial ruin or financial injury of a significant nature. With regard to insurance, we see three primary points which we would like to -- or problem areas that I would like

to discuss briefly here this afternoon.

First, our escalating insurance costs. Like other professions, we have realized significantly increasing premiums. The current projections are for accelerated increases in insurance premiums. Just last month the liability, or the professional liability insurance program sponsored by our society realized a 100% premium increase. This was the second increase in a seven-month period and we know from past experience that we can stand by and be ready to expect another increase within a matter of months. Hopefully, it would take as long as a year, but we don't know. We are at the whim of the underwriter in that regard.

CHAIRMAN KNOX: Even though you won the Ernst case?

MR. McCARTY: Even though we won the Ernst case, that's right. That didn't seem to make too big a dent, as a matter of fact, with regard to our problems. We have, over the years, done business -- and I say over the years -- the last seven, eight or nine years, done business essentially with three different insurance companies and since liability problems became something of a crisis nature, we have had an ongoing disagreement with the insurance companies with regard to the justification of premium rate increases. I would dare say that the rate increases are seldom understandable by us and we seldom get adequate explanations and reasoning for the rate increases. But if you are running the only ball game in town, so to speak, it is a little bit tough to deal with.

Number two, the availability of insurance. Many companies have stopped writing accountants' liability insurance in California, most particularly in Southern California. Southern California is kind of a no-no land. I am sure that most any insurance company

would prefer not to have to write accountants' liability insurance in Southern California, but we are fortunate enough to still have one company which is doing it. In connection with the availability of insurance is the availability of insurance limits. This is an increasing problem because although insurance is available to many or most practitioners, the desired limits of insurance protection may not be available and in the case of my own firm, we, up until last year had no trouble getting the amount of insurance, the limits that we desired. We got it for the asking. Last year we had to talk quite a bit to get the limits that we have been incurring. This year we were able to get a basic insurance amount. We were unable to get the next layer of insurance. We had additional layers of insurance which would have been available to us but we couldn't self-insure ourselves for that missing second layer of insurance. As a consequence, we feel we are under-insured but at the present time we have no alternative, no solution to that particular problem. Also, and this is a problem for the small practice units in California as well as the large. I am talking now about the availability of insurance or the degree of difficulty in obtaining insurance as practice units increase in size. My firm is roughly 60 in number of total personnel and we know of two places that we can't go to get insurance just because of the size of our firm. One company that is writing insurance and prefers to write insurance with a very small practitioner, a very small practice unit, will not write insurance for practice units of more than 15 or 20 in terms of total personnel. A proposal by the Society Insurance Committee had indicated that if we were to adopt that program, the company would not write insurance for firms with more than thirty people.

This obviously leaves a lot of firms wanting for, or in need of insurance, and with a rather tough problem. Also, if insurance is unavailable, then I suppose that the public interest suffers considerably. We see this as being a significant problem, one with which we are concerned because the accountant's pockets perhaps are not deep enough to justifiably satisfy the compensation that is deserved by the injured party, at least in many instances. The insurance underwriters are constantly writing in more restrictive conditions into their insurance applications so as to screen out more and more firms or practice units. This we don't quarrel with as long as the criteria are valid.

Thirdly, the quality of the insurance contract or the insurance coverage seems to be slipping. There are conditions that are put into the contract or to the contrary -- let's say that there are conditions not in the contract which make it the weaker contract for the practitioner. The first such change occurred a few years ago when all insurance went from a current basis to claims-made basis. This is a significant change, perhaps understandable as far as insurance companies are concerned, but still in all, a weakening of the contract from the practitioner's standpoint. Now there is a new and increasing trend to eliminate prior acts coverage so that if you do business or buy insurance from a given company and if prior acts coverage is eliminated and not part of that contract, then you can really be in trouble as to any acts that occurred prior to the time that you became covered under a given contract for, let's say a one-year period of time. If you are lucky, you can buy extended period coverage from the company that you just left but the elimination of prior acts coverage can have a disasterous effect on any...

CHAIRMAN KNOX: It doesn't have a disastrous effect if you had an occurrence policy prior to that, does it?

MR. McCARTY: If you had an occurrence policy prior to that, but there are very few...

CHAIRMAN KNOX: You are talking about the uninsured accountant prior to his getting this points made...

MR. McCARTY: We have not, at least through any program sponsored by the California Society -- the currents basis coverage has not been available since, I believe, 1973, so there has been a pretty fair lapse in time.

CHAIRMAN KNOX: There hasn't been a currents policy available for accountants since '73?

MR. McCARTY: In the program that has been sponsored by the California Society of CPA's, now Pacific Indemnity was the carrier and up until 1974, which I think we ran through 1973, perhaps through 1972, the PI contract was a currents basis. Subsequent to that time it was claims-made basis and that's all that we can find now.

CHAIRMAN KNOX: Since '74, you literally have not been able to get a currents policy at all at any price?

MR. McCARTY: I don't want to make a flat statement that there was no company that would write currents basis insurance for CPA's, but the program that our society sponsored, we could not get it, and for any of the larger firms. Perhaps if it were available, it would have been available for the very small practitioners.

CHAIRMAN KNOX: You have made your case about how tough it is to get insurance. What do you think we ought to do about the tort law?

MR. McCARTY: Our insurance committee and other segments of our society have, of course, been concerned with and considering the problem at hand. We have adopted no policy but we have felt that the answer lies in legislation. A couple of years ago an ad hoc committee on this problem, the problem of the accountant's liability, pretty well came to that conclusion realizing that the answer lay with legislation, rested with legislation. How to get that legislation was, of course, a big question.

CHAIRMAN KNOX: What do you think, if you could write the law today, what would you put in it?

MR. McCARTY: Well, we would probably want to see attorney contingent fees limited with regard to liability suits; also, limit on the liability of the practitioner and limit on the amount of the liability. There could also be some gain made perhaps with the method -- in developing a method of self-insurance. We have engaged a large brokerage -- insurance brokerage firm, a consulting firm to come back to us with the proposal with regard to one or more concepts of self-insurance where we would participate in the insurance problem. Also, a statute of limitations on when claims can be made. That seems to go a long way defining the problem and the limit of the problem and drawing a line to the time...

CHAIRMAN KNOX: How long a statute do you think ought to exist?

MR. McCARTY: Well, without having studied the subject, I really don't have an answer. I certainly don't have...

CHAIRMAN KNOX: Is there a group of accountants working on the thing to determine, to help us determine what a fair approach to this would be?

MR. McCARTY: On that particular question, no. There are two -- we have a very active insurance committee. There are two members of that committee which have been assigned to the subcommittee, I believe, of your committee to represent CPA's in that regard and we stand ready to hear from you, and again, our society will muster more than just two individuals. We can muster quite a bit of manpower to go to work on any aspect of this problem.

CHAIRMAN KNOX: Assuming, Mr. McCarty, that if a CPA acting beyond the standard practice of CPA's in California or in this community and as an approximate result of that failure of his duty causes injury to somebody, you can see that he should be subject to lawsuit, should he not?

MR. McCARTY: Yes.

CHAIRMAN KNOX: Well, you think that the amount that can be recovered from him should be limited, is that right?

MR. McCARTY: I see that as one possible solution to the problem in that...

CHAIRMAN KNOX: In other words, a solution for the victim.

MR. McCARTY: How is that a solution for the victim?

CHAIRMAN KNOX: Yes.

MR. McCARTY: Well, it seems that one problem, I think a very real problem, is that many firms, many practice units are over-insured because they run scared; therefore, they will buy all the insurance they can possibly get, and it has been this practice -- well, if a firm has X dollars of insurance or a limit at this point, I think it's a fairly well established fact that the claim or the lawsuit is likely to go to the limits of that insurance. If that insurance limit is doubled the next year perhaps, or if that

insurance limit had been somewhat higher, perhaps the claim would have been that much higher.....I think it's a question of developing reason along with the plaintiff.

CHAIRMAN KNOX: ...to prove his loss. He can't just because the policy is $200,000, he can't say, I want $200,000. He's got to prove that he's been damaged that much, doesn't he?

MR. McCARTY: He has to prove that he's been damaged, but I don't know that all damage is measureable in terms of dollars.

CHAIRMAN KNOX: All right. Any further questions? Mr. McAlister.

ASSEMBLYMAN McALISTER: What is the average premium the CPA would pay, and for what kind of limit?

MR. McCARTY: Premiums in most cases are determined on the basis of the number of personnel in the accounting firm or dollars of payroll and/or gross fees. Now those are common yardsticks in determining premiums. In my firm, we paid in excess of $6,000 for a million dollars of insurance. We couldn't obtain the second million. We would have...

ASSEMBLYMAN McALISTER: Six thousand dollars for a million dollars, did you say?

MR. McCARTY: Yes.

ASSEMBLYMAN McALISTER: And you have thirty employees... no, sixty?

MR. McCARTY: Sixty employees, that's right.

ASSEMBLYMAN McALISTER: And you only paid $6,000?

MR. McCARTY: That's right, for the first million. There was one but that's up significantly and rising. That was paid before the hundred percent increase that I made reference to a few

minutes ago.

ASSEMBLYMAN McALISTER: So it would now be $12,000?

MR. McCARTY: That's right.

ASSEMBLYMAN McALISTER: There are CPA's who practice, in fact, there are many who practice either singly or in small units, are there not?

MR. McCARTY: That is correct.

ASSEMBLYMAN McALISTER: Do they pay less or more for this...

MR. McCARTY: They would pay a lot less than that. Probably in the area of $100 to $150 per person. It could go from $100 to $250 per person. I've seen different rate schedules fall in about that area.

ASSEMBLYMAN McALISTER: What are the typical kinds of errors and omissions a CPA might commit for which a CPA might be sued?

MR. McCARTY: Well, the absence of engagement letters, for example, has given rise to many lawsuits. Countersuits on fee disputes have given rise to liability claims. Allegations of misrepresentation in financial statements have given rise to problems. Any audited or opinion statement rendered by a CPA which is in error or alleged to be in error can give rise to a claim or a suit or damages.

ASSEMBLYMAN McALISTER: What is an engagement letter?

MR. McCARTY: An engagement letter would be a letter setting out.....an engagement letter, in the conventional sense, would be a letter or letter of agreement drafted by the accountant expressing what the scope of the engagement would be and what the

accountant has proposed to do for the client, what the fee would be, what the fee arrangements -- in other words, as many of the detailed aspects of the engagement as possible, so that there would be a thorough understanding on the part of both parties. This has not been used extensively enough, and has been perhaps the cause of some rather significant disputes.

ASSEMBLYMAN McALISTER: What's the biggest judgment against a CPA or CPA firm you've ever heard of?

MR. McCARTY: That I've ever heard of? Well, it's in the millions of dollars. The big eight firms or the international firms of course have had some rather, some very significant suits in the millions of dollars. I guess I would have to try to decide that size firm we are talking about. There have been cases settled out of court without the benefit of insurance for many hundreds of thousands of dollars.

ASSEMBLYMAN McALISTER: Do I understand that there are some ambiguities as to what the statute of limitations would be, depending of course on what type of work you did and...

MR. McCARTY: What the statute of limitations would be?

ASSEMBLYMAN McALISTER: Yes. There is only one statute of limitations for CPA work?

MR. McCARTY: No, I would say that there is -- there is no statute of limitations for CPA work. I suggested earlier that a statute of limitations might be one way to draw a line with regard to the practitioner's liability.

ASSEMBLYMAN McALISTER: Do CPA's have any problem with the so-called long tail which seems to afflict doctors...

MR. McCARTY: Well, that was a problem. That is a problem

inherent in the occurrence basis insurance, and of course, that's why Pacific Indemnity in our case stopped writing and why we can't get that anymore. It is a tremendous problem. It continues to build. We had a couple of very large settlements in that Pacific Indemnity program. We had one stemming out of the equity funding matter and another one in another matter that I don't have the facts on, but it was those large settlements that cause the big problems with the program.

CHAIRMAN KNOX: Thank you very much, sir. We appreciate your being here. Ms. Lora Peluso, the Architects and Engineers Professional Liability Insurance. Ms. Peluso.

(See Appendix IX for written testimony.)

MS. LORA PELUSO: I am Lora Peluso. I am an independent insurance broker, specializing in errors and omissions for architects and engineers. I am a member of the Oakland Association of Independent Insurance Agents, and an associate member of the American Institute of Architects. I would like to try to give you some idea of some of the problems that the architects are facing. A lot of them are assigned to the accountants and the doctors...

CHAIRMAN KNOX: We know that their malpractice costs for insurance are increasing substantially. What we want to know is suggestions for changing the law in such a way that it will be helpful to them and to the public. If you have some ideas along those lines.....we already know there is a problem.

MS. PELUSO: You are aware this is a big problem.

CHAIRMAN KNOX: Yes, we are aware there is a problem.

MS. PELUSO: Do you know how much a typical small architect is paying?

CHAIRMAN KNOX: All right, tell us.

MS. PELUSO: Well, if they carry a million dollars worth of liability, they are paying about $2,000 a year. This is for a small firm. Their fees are based on their gross receipts.

CHAIRMAN KNOX: Do you know how much a small lawyer is paying?

MS. PELUSO: No, a small architect.

CHAIRMAN KNOX: Three thousand dollars for $250,000 and $750,000.

MS. PELUSO: For gross receipts is how much?

CHAIRMAN KNOX: For gross receipts -- it doesn't matter what the gross receipts are. That's how much they pay.

MS. PELUSO: Architects are based on their gross receipts. So you might have a guy paying $2,000 when his gross receipts are $25,000 a year. Another thing that architects do is, they spend a lot of money on engineers as consultants so the actual money they have left in the business to pay insurance -- their insurance costs are sometimes running up to 8% of their net gross receipts.

CHAIRMAN KNOX: What do you think we ought to do about it?

MS. PELUSO: One of the big problems is the workmen's compensation cases, the bodily injury cases where workers are entitled to workers' compensation benefits under their employer's policy and then they sue everyone else on a project. They would sue the general contractors, the owner, all the architects and all the engineers. I feel that if you made workers' compensation the sole and exclusive remedy, period, for claims; if you don't have the worker suing, then you have their insurance company subrogating against the insurance company of the architect...

CHAIRMAN KNOX: You mean the injured worker on a construction job sues the architect as a third party?

MS. PELUSO: That's right.

CHAIRMAN KNOX: I see.

MS. PELUSO: This is a very common practice now, and the whole idea of workers' compensation, which you make now, lies on a strict liability basis, makes the employer liable whether the employee was negligent or not negligent, so he gets his workers' compensation benefits. Then they sue everyone else on the construction project, including the contractors and the engineers and the owners. We paid out substantial claims on that -- the companies have, and I think something should be done to make workers' compensation what it was meant to be, that there are no segregation rights.

CHAIRMAN KNOX: Of course, the worker doesn't work for the architect. He is claiming that the architect so negligently designed whatever it was and that caused the injury to the worker. Right?

MS. PELUSO: That's right.

CHAIRMAN KNOX: And you are saying that regardless of that he should be limited to his workmen's comp benefits?

MS. PELUSO: That's right.

CHAIRMAN KNOX: Why?

MS. PELUSO: Why not?

CHAIRMAN KNOX: Well, I mean, let's say that somebody, the fellows working on the job and the fellow delivering the lumber runs over. Should be be limited to his workmen's comp benefit on that?

MS. PELUSO: Well, so much money in the lawsuit -- when they sue, so very little goes in the indemnity payment to the

plaintiff anyway. One insurance company told me that of their claims costs, the total claims dollar, that the indemnitee only gets about 20% and the attorneys are getting the other 80%, so it seems to me you would be much better off if the benefits to the injured party were increased so that they got a livable wage if they were injured and they threw out all of the other auxiliary suits anyway.

CHAIRMAN KNOX: O.K.

MS. PELUSO: Another thing, the statute of limitations, I believe is now 10 years for latent defects on design areas and this has the effect on people that try to retire from the business as if they had to continue to purchase insurance indefinitely, which runs a great hardship on them, because you have to carry it at least for 10 years and this is to cover all your past acts. And actually third parties, as I understand it, can be brought in at any time. I think some limitations should be put on that because it is unfair to the architect.

ASSEMBLYMAN McALISTER: Mr. Chairman.

CHAIRMAN KNOX: Yes, Mr. McAlister.

ASSEMBLYMAN McALISTER: You are talking about claims-made insurance?

MS. PELUSO: Right. That's the only thing that is available to architects and engineers. Another suggestion is that you raise the threshold of small claims courts from the current limit of $750 to $10,000 and $25,000, so that the length of claim, that they get settled faster. What I see a lot of is most architects carry a $5,000 deductible and I see a lot of claims settled for $5,000 worth of defense costs and then something -- it seems to me many times it is the legal profession that profits much more than

the person who is bringing a lawsuit or the architect and it seems the more money you can get to the injured party and the less to the legal profession, the better off we would be.

CHAIRMAN KNOX: Well, Mr. McAlister and I are lawyers, so we are very open-minded about that.

ASSEMBLYMAN McALISTER: I just have one question on that. That's quite a raise -- $750 jurisdictional limit up to $10,000, $15,000, $20,000, or $25,000 for small claims.

MS. PELUSO: That's what I said.

ASSEMBLYMAN McALISTER: Well, see, the Municipal Court jurisdictional limits now are what?

CHAIRMAN KNOX: Seven, I think it is.

MS. PELUSO: $10,000.

CHAIRMAN KNOX: Is it up to $10,000? Maybe it has gone up again.

ASSEMBLYMAN McALISTER: But you are suggesting going higher for small claims than Municipal Court?

MS. PELUSO: Well, I thought you were here for some ideas.

CHAIRMAN KNOX: You are making a point.

ASSEMBLYMAN McALISTER: You are stimulating. We are just...

MS. PELUSO: And why not? If you have a problem, you have two people and you are arguing about something that is relatively simple. If they go in and present their facts and the other guy goes in and presents his facts and somebody decides it, then it is over. Many clients take three, four or five years and even longer than that. The simplest little claim takes a couple of years to go through court and all that happens is a legal suit built up and built up and built up. I've got a claim in Roseville now where a

guy sued for $1,900 in fees, uncollected fees, and now that the county seat -- there is no municipal court in Roseville so it is in the Superior Court of California, and the original lawsuit was for $1,900. Now, that, to me, should be, you know, it should be in small claims court. The whole thing should be in small claims court. You are wasting a lot of money.

ASSEMBLYMAN McALISTER: You can represent yourself. Of course, there is nothing to assure you that the opposition would have an attorney.

MS. PELUSO: In small claims court, attorneys are not allowed.

ASSEMBLYMAN McALISTER: I understand that. That is the presumed advantage for one of them.

MS. PELUSO: The other big problem are the frivolous lawsuits, are the shotgun suits. I've got a whole list of claims here that are ridiculous, in my opinion. It is like the wrongful enema. We have a guy hit with bill number one hundred. You have suits against architects where they never signed any drawings, there was never any contract but this lawsuit, if they designed a house that looked like the guy's next door. I was talking to some of my clients before they came here. One guy told me they incurred $10,000 of their own defense costs, the insurance company incurred $39,000 worth of defense costs. As they were dismissed by the judge from the suit, the judge said, the inclusion of this firm in this lawsuit is irresponsible. That is not exactly true -- doesn't make you feel well after you have spent $10,000 of your own money.

CHAIRMAN KNOX: Well, as we said this morning, sometimes the attorney is afraid not to join all these people for fear that

he will get sued.

MS. PELUSO: That's true.

CHAIRMAN KNOX: O.K. Thank you very much. We appreciate your attendance and I think you have made some thoughtful comments here. We have one other witness that is not on the list but we have just a little bit of time left. Mr. John Allen. Mr. Allen had to leave? All right. Is Mr. Jones here? O.K. I think we have had an interesting day and we appreciate everybody's attendance. Thank you very much.

The meeting is adjourned.

APPENDICES

Joint Committee on Tort Liability

Professional Liability Hearing

July 11, 1977

APPENDIX I

California Legislature

Joint Committee on Tort Liability

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FOR RELEASE:

Monday, July 11, 1977

ASSEMBLYMAN JOHN T. KNOX
CHAIRMAN

O P E N I N G S T A T E M E N T

John T. Knox, Chairman
Joint Committee on Tort Liability
State Building Auditorium, Room 1138
107 South Broadway, Los Angeles
July 11, 1977

Two years ago Californians were briefly denied essential medical services because many doctors felt unable to pay the high premium costs -- an annual average of over $10,000 per physician -- for professional liability insurance. Now other professionals -- attorneys, dentists and accountants -- are faced with similar skyrocketing insurance premium charges. California attorneys, for example, were recently told that their malpractice insurance premiums would be increased over 300%, from about $600 annually average per attorney to more than $2000.

In response to these escalating insurance costs, the affected professions have ceased practice, raised their fees, gone without insurance -- 20% of our doctors are now "bare" -- or moved to other states. These responses, however logical and understandable for the professions, are not in furtherance of the public interest. Indeed, the only acceptable solution for

California to this crisis facing the professions is to somehow assure that liability insurance is both available and affordable.

The purpose of today's hearing is to learn the reasons for and possible solutions to the problems of exorbitant professional liability insurance costs. Our witnesses are mainly representatives of law and medicine because these professions are facing the most severe problems and the Legislature has already enacted some laws intended to redress their problems. However, we will also hear from accountants and engineers.

This is the first of a series of hearings to be held by our Committee on various aspects of the tort liability problem. On July 18, we will hear testimony in San Diego on products liability; and on July 22, we will meet in San Francisco to hear testimony on insurance company practices.

These and other hearings will form a basis for the interim recommendations we intend to make for legislation before the next session of the Legislature. We are aware that these problems are complex and politically difficult to resolve. Accordingly, we ask witnesses to give primary concern in formulating their proposed legislative solutions to the public interest, recognizing that this may not always coincide with a given profession's best interests.

# # #

APPENDIX II

STATEMENT TO
JOINT LEGISLATIVE COMMITTEE ON TORT LIABILITY
BY
JAMES E. LUDLAM, SENIOR COUNSEL
TO CALIFORNIA HOSPITAL ASSOCIATION

JULY 11, 1977 HEARING

My name is James E. Ludlam, and I am a partner in the Law Firm of Musick, Peeler & Garrett, One Wilshire Boulevard, Los Angeles, California 90017. Having served as the General Counsel to the California Hospital Association since 1953, I have recently been assigned the title of Senior Counsel with responsibility for specified special programs including the Association's group professional liability insurance program covering some 450 hospitals in this state and generating some $135,000,000 annual premiums. In addition, I served as a member of Secretary Richardson's Commission on Medical Professional Liability from 1971 to 1973 and am presently on the Commission on Medical Professional Liability created by the American Bar Association in 1975.

Before discussing the California situation, I would take this opportunity to summarize some of the conclusions that the ABA Commission will incorporate in its report to the ABA at its August, 1977 annual meeting.

It will report that, as of the present time, the malpractice crisis or panic is not at a critical state. Through a variety of mechanisms, including provider sponsored companies (known in the trade as Bedpan Mutuals), Joint Underwriting

Associations created by State Statute and a revived interest by a few major insurance companies to write the risk insurance is generally available. In a few states there has been an actual reduction in quoted premiums. Unfortunately, the cost of insurance is being stabilized at an extraordinarily high level and cost is a major problem leading to substantial distortions in the availability of physician care. By and large, hospitals have been able to pass on the additional costs through increased charges. In California hospitals the cost of malpractice insurance runs from $7 to $12 per patient day. In some areas in the Middlewest and East the cost is greater.

Apparently, the widespread publicity about the medical malpractice problem, as well as the tort reforms adopted by the legislatures in most states, have led to a reduction in the frequency of claims nationwide and, for the moment, seemingly limited the rate of increase of the average cost per claim.

However, the report will point out that there is no assurance that the costs will stabilize at even the current high levels. It is the Commission's gloomy conclusion that the current tort reforms may well not be adequate and that we must face the potential of a total revision of our current mechanisms for compensating individuals for injuries caused by third parties. The full report will give much valuable background on what it calls innovative alternatives to the present system. Future activities of the Commission will be primarily devoted first to monitoring the results of the legislative tort reforms of 1975,

1976 and 1977 and exploring on a demonstration basis certain "innovative alternatives."

It is my understanding that the ABA House of Delegates will have before it at its August meeting a proposal to create a commission to review the total tort system not just the medical malpractice segment. Hopefully, this will follow the California pattern and build on the work that is being done by the Joint Committee as well as by the California Citizens' Commission on Tort Reform.

In its Interim Report of June, 1976, the ABA Commission made several important contributions. First, it established a set of goals for any long-term ideal compensation system. These goals have been reaffirmed and I quote them again for consideration by this Committee:

"1. Encourage the prompt availability of remedial medical services to injured persons;

2. Compensate all persons deemed compensable under the mechanism;

3. Pay a victim of a compensable medical incident at least the net economic loss occasioned by that incident;

4. Provide for the prompt resolution of claims;

5. Charge a minimum of administrative costs (including attorneys' fees) and make a maximum amount available for the injured person;

6. Insure maximum predictability of outcome as an aid to planning by health care providers and insurers;

7. Discourage the bringing of baseless or contrived claims and provide for their prompt elimination if brought;

8. Contribute to the prevention of malpractice incidents by introducing incentives for improving health care and for improving the supervision and discipline of health care personnel;

9. Distribute losses, through insurance or otherwise, in a way which does not leave an unfair burden on any one segment of the health care system; and

10. Disrupt to the least possible degree the relationships of trust and confidence between health care providers and patients."

The Interim Report also recommended certain tort law changes. Although some of these relate primarily to professional liability matters, most may have general application. These recommendations are:

"1. INFORMED CONSENT

(a) A cause of action for lack of informed consent should not be treated as an action in battery but rather as an action in negligence, unless the complainant alleges that the physician acted with intent to harm or to deceive the patient.

(b) In obtaining a patient's consent, the physician should disclose those risks which a reasonable physician in the same or a similar locality would disclose; provided that a patient who asks for additional information has a right to be further informed by the physician, and a patient who asks not to be told of risks has a right not to be informed.

(c) Where informed consent is not obtained, the physician should not be liable if a reasonable patient would have undergone the procedure had he been properly informed.

(d) Specific formulae or forms for informing a patient and obtaining his consent should not be included in legislation.

2. STATUTE OF LIMITATIONS

(a) An action for medical malpractice should be commenced within two years from the time the incident which gave rise to the action occurred, or within one year from the time the existence of an actionable injury is discovered or in the exercise of reasonable care should have been discovered, whichever is longer. Except for cases involving a foreign object or

fraudulent concealment, no action should be brought more than eight years after the occurrence of the incident which gave rise to the injury.

(b) Where a foreign object has been left in the body, a patient should have one year after the object is discovered in which to bring an action.

(c) Where fraudulent concealment of material facts by a health care provider has prevented the discovery of the injury or the alleged negligence, the patient should have one year after discovering that an actionable injury exists in which to bring suit.

(d) The statute of limitations should be tolled during continuous treatment by the same health care provider for the same condition or for complications arising from the original treatment.

(e) The statute of limitations should apply equally to adults and minors alike, except that a minor's representative should have until the minor's eighth birthday to commence a suit, regardless of how many years earlier the cause of action accrued.

3. NOTICE OF INTENT TO SUE

In order to commence a malpractice action, a potential plaintiff should be required to give reasonable (between 90 and 180 days, depending on local conditions) written notice of intention to sue to each prospective defendant. Failure to give such notice should not defeat the plaintiff's action, but may lead to sanctions on the plaintiff's attorney. Where the statute of limitations is due to expire during the notice period, the time for commencement of the action should be extended until the end of the notice period.

4. ACCESS TO MEDICAL RECORDS

Patients should be able to obtain access to their medical records through their legal representatives without having to file a suit; and the health care provider should have five days in which to respond to the request.

5. PANELS OF EXPERTS

Professional medical societies should encourage physicians to cooperate fully in medical malpractice actions and should establish pools from which plaintiffs' and defendants' counsel can obtain expert consultants.

6. ADVANCE PAYMENTS

Any payment made voluntarily to the plaintiff by a defendant or the defendant's insurer prior to a final verdict should not be admissible at trial as

evidence of the defendant's liability. Any such payment should be credited against a judgment for the plaintiff, should such a judgment be entered.

7. AD DAMNUM CLAUSES

Except for allegations necessary to establish jurisdictional limits, a plaintiff's pleadings should not be permitted to allege a total dollar amount claimed; provided that the defendant has a reasonable way a ascertaining the amount the plaintiff is claiming as damages.

8. EXCHANGE OF EXPERTS' REPORTS

Pre-trial exchange of experts' reports should be required. Where reports have not been made, the parties should be required prior to trial to disclose the identity of their experts.

9. GUARANTEES OF RESULTS

A health care provider should not be held liable for promising a particular outcome unless such guarantee is in writing and signed by the party to be charged.

10. RES IPSA LOQUITUR

The Commission approves for the most part the position adopted by the American Medical Association in its Model Res Ipsa Loquitur Law (quoted in Report, infra, Appendix D, page 54), with the qualification that the Commission does not necessarily regard the enumeration of res ipsa loquitur situations therein as an exhaustive list.

11. ITEMIZED VERDICTS

Jurisdictions which do not permit a special verdict or a general verdict with interrogatories should enact legislation patterned on Rule 49(a) and (b) of the Federal Rules of Civil Procedure in order to permit such verdicts in the discretion of the trial judge.

12. CEILINGS ON AWARDS

(a) Economic Loss: No dollar limit on recoverable damages should be enacted which can operate to deny a plaintiff in a medical malpractice action full compensation for economic loss.

(b) Non-Economic Loss: The Commission takes no position on whether it is appropriate to place a ceiling on the recovery of non-economic loss.

13. COLLATERAL SOURCE RULE

Recovery of damages should be reduced by collateral source payments received by the plaintiff as the result of government, employment-related, individually-purchased and gratuitously-conferred benefits. (The Commission has not yet taken a position on whether any forms of life insurance benefits should be set off.) The amounts to be set off should be deducted by the judge from the jury's assessment of damages against the defendant. Subrogation should not be allowed to any collateral source for medical benefits thus set off. (The Commission has not yet taken any position on subrogation as to wage and disability payments.)

14. NON-TAXABLE STATUS OF AWARDS

The jury should be instructed that an award for lost earnings is not subject to income taxation.

15. PRE-JUDGMENT INTEREST

It should be left to each jurisdiction to decide whether or not to allow pre-judgment interest.

16. PUNITIVE DAMAGES

Punitive damages should not be allowed in medical malpractice cases. Rather, the medical discipline system, hospital licensure statutes and the criminal justice system should be relied on for such punitive action against an offending physician as may be justified.

17. PERIODIC PAYMENTS

Legislation should be enacted in all states to permit the payment of future damages in periodic installments.

18. CONTINGENT FEES

A decreasing maximum schedule for contingent fees should be set by court order, provided that such schedule should not be so restrictive, particularly with respect to small to moderate recoveries, that it hampers the ability of injured patients to obtain legal representation."

The supporting reasons for these recommendations are set forth in Appendix D to the Report.

In the year since filing its Interim Report, the Commission has only slightly modified its recommendations on this subject as they will be included in the final report.

Of importance to this Committee is the fact that the Commission generally concluded that the two changes that would have the greatest impact on the cost of insuring tort liability were the change in the collateral source rule to permit only one recovery for the same economic loss and the provision for structured awards calling for periodic payments adapted to the needs of the claimant. Obviously, other changes such as in the statute of limitations and the limitation on the total award for general damages are also helpful.

Of great concern to the Commission has been the role of the insurance companies in contributing to the recent medical malpractice crisis. This information has been difficult to obtain as there is no central source of information. Also, until the last two years there has been segregation of medical malpractice experience from other forms of tort liability. Based upon our studies on this subject, our general conclusion is that the insurance companies were victims of the crisis rather than culprits and took major underwriting losses during the period from 1969 on. Although investment income would offset these losses in part, the overall result was almost disastrous. However, the carriers were suffering serious losses in other lines at the same time which were even more serious because they constituted a larger proportion of premium income.

The malpractice insurance crisis was apparently the result of a combination of factors. Briefly, these were:

1) The insurance companies, because of the lag in reporting of claims, and their closing costs failed to detect

the rapid acceleration in cost per claim and, more importantly, the frequency of claims starting in 1970.

2) Particularly in the medical malpractice field the carriers locked themselves into relatively long-term contracts under which they were limited in the amount they could increase their premium on each annual renewal. (This was a pattern for the doctor and the lawyer malpractice programs in this state.)

3) The Wage-Price Freeze of 1973 and 1974 made it impossible to implement major premium changes that could have otherwise been implemented.

4) The stock market collapse reduced the capital necessary as a base for writing increased premiums. This is a widely misunderstood and misrepresented problem. Stock market losses are not reflected in premium but have a direct impact on the ability of the carrier to write either the same risk at a higher premium or additional risks. As a result, carriers were forced to withdraw from certain risk areas or become more selective in their underwriting. When one carrier withdrew, there was no carrier seeking to take the risk so that the problem snowballed through 1975 and 1976.

Unfortunately, as we looked to the future, the ABA Commission received no assurance that the pattern would not repeat itself. We were assured by the carrier that this reporting and data basis is far more current and will give a better early warning system. Better work is being done in claims handling

and prevention, but there is no global solution, and we can anticipate that the carriers will react in the same way again - they have no choice.

Now, let us look at the hospital situation in California.

As a preliminary matter, may I say that, although we have been primarily concerned with the malpractice problem, we cannot overlook the impending crisis in the cost of workers' compensation. For years the California Hospital Association has sponsored a group program for this coverage and with intensive preventative efforts has enjoyed a satisfactory premium. However, with the recent court rulings on "continuing trauma" and general expansion of the benefit structure, the cost has rapidly accelerated in the last three years and we are deeply concerned about the future. Our premium costs have increased from 10 cents a patient day in 1954 at the start of our program to $2.50 per patient day this year, with no end in sight.

From the professional liability point of view, we wish to emphasize that we not only have our own cost problem, but that anything that affects physicians has a direct impact upon the hospital. For example:

1) It is now estimated that 15 to 20% of the physicians are uninsured. This not only affects their method of practice, greater use of costly preventive medicine, refusal to take extra risks, such as serving on call in the emergency room or taking care of high-risk patients or indigent patients, such as Medi-Cal

patients. Obviously, claimants will follow the deep pocket and we are seeking many highly innovative attempts to establish hospital liability for the acts of the physicians. At the present time our insurance carrier has concluded a 5% premium factor for this additional exposure.

2) It is increasingly difficult to obtain coverage for backup specialties such as orthopedic and neurosurgeons for our emergency departments.

3) General Practitioners have by and large given up practice, creating problems in certain rural areas as well as ghetto areas.

4) There is increased friction between physicians who must work together, such as the anesthesiologist and the surgeon, when one is insured and the other is not.

5) We are just beginning to see the problem in claims handling when an uninsured doctor is faced with the reality of a major claim and attempts to duck his responsibility.

Unfortunately, we are not receiving the full benefits of AB 1XX of 1975. There is no uniformity of provisions for claims occurring prior to December 12, 1975 or as to the constitutionality. Unless there is some early action by the Supreme Court on the action initiated by the legislative leadership and the Attorney General to clarify this issue, we will not have the full benefit of the Act. However, we can also report that, as a direct result of the Act, our premium increase was limited to 11% in October, 1976, as distinguished from the 100% in 1975. We

believe that without AB 1XX we would have had another 100% increase or more.

Experience has already indicated a number of defects in AB 1XX, all of which were anticipated for such an innovative and complex piece of legislation coming out of such a turbulent legislative course. Shortly, we will provide this Committee with a list of problems and suggested changes.

One interesting experience we have had is in the implementation of the requirement of the 90-day notice of intent to file suit. Under Section 365 of the California Code of Civil Procedure the State Bar is given the responsibility of policing violators. Our experience indicates that the effective use of the Section leads to the potential desirable result of claims being settled or dismissed without the trauma and expense of a lawsuit. Under Section 1158 of the Evidence Code, an attorney has immediate access to the hospital and physician records, so it is not necessary to file a suit to obtain the record in its original form. Thus, no plaintiff's rights are adversely affected by the delay in filing an action. However, the California Bar Association has treated Section 365 with outright hostility and to date has done nothing about enforcing it against those attorneys who have deliberately violated it. I would think that this same approach should be required for all claims against professionals, whether doctors, lawyers, architects, or other professionals. I would hope that this Committee will obtain a definitive statement from the California Bar on its attitude

toward implementing this Section. Incidentally, the ABA Commission unanimously approved the concept.

We are finding that the provisions of AB 1XX relating to periodic payments, when fully understood by the attorneys, can be used most constructively. Our experience would indicate that the concept should be equally applicable to all tort claims. Periodic payment settlements and awards are being designed to meet the specific needs of the plaintiff and avoid windfall profits to others. The concept which started here in California is spreading rapidly throughout the nation.

We are just beginning to develop experience with the change in the collateral source rule. As an evidentiary rule, the results may be erratic -- we would prefer a direct offset by order of the court. If the rule is changed as to all torts, then there must be a clear establishment of public policy on the issue of subrogation as well as to what insuring entity shall be primary. This is a controversy that has plagued attempts to develop a rational no-fault automobile insurance program. My own preference is to provide that mandated programs with a broad funding base such as health insurance, workers' compensation insurance, disability insurance, Medicare, Medicaid and the like, should be primary without right of subrogation; similarly, income protection furnished by employers or on a group basis.

Without AB 1XX we can assure you that health care in this state would have been in a complete chaos. In our judgment it was only the hearings and ultimate passage of AB 1XX which

stopped the frequency curve from going out of sight on claims against doctors and hospitals. Attached to this paper is the graph showing what has been the experience of hospitals from 1966 through 1976 on frequency. Where the curve goes in the future will depend on the California Supreme Court's action on the constitutionality of AB 1XX as well as what actions come from this Committee.

Ultimately, this Committee must determine on a basis of overall social good, for what injuries there shall be compensation and for how much. The system must be an integrated one with a minimum of duplication and friction costs.

From the viewpoint of hospitals we have a continued duty to expand and refine our claims prevention programs. In this regard, hospitals in California have had an outstanding record, particularly as related to those incidents directly under the control of hospital personnel. Those incidents which are physician related are much more difficult to identify and attack. There has been a paucity of valid information on which to attack. Fortunately, with the massive study being conducted jointly by the CMA and CHA, entitled "Medical Insurance Feasibility Study," we believe we will have a much better handle on how to approach this problem. We wish to commend the CMA for its courage and foresight in initiating this study and providing its initial major funding. We are proud of our hospitals and their dedicated personnel who, through great personal sacrifice, made the study possible.

On a short-run basis, we would urge this Committee to support the three medical malpractice bills that are presently moving through the legislature.

AB 1275, by Assemblyman Knox, is directed at the potential evils of the so-called "Mary Carter" Agreements under which one defendant may enter into a sliding scale covenant with the plaintiff and against the other co-defendants. The essence of such agreements should be fully disclosed to the finder of fact, whether it be court or jury, so the potential bias of the parties can be fully understood. This bill would accomplish this purpose.

SB 734 and SB 735, authored by Senator Behr, would extend the limited immunity for emergency care at the scene of an emergency to the emergency room physician who has been called in as a backup physician (SB 735). SB 734 would limit the liability of the emergency room physicians to acts or omissions performed in a grossly negligent or intentional manner. Both of these bills would go a long way to alleviate a critical problem faced by many hospitals in properly staffing the hospital emergency room with qualified specialists. The emergency room patient has no prior physician-patient relationship upon which to build a rapport. Furthermore, the patient may also be in a litigating mood as a result of the cause of the emergency care, such as an automobile accident, assault, etc. The physician stepping into such a situation is jeopardizing his insurance record and ultimately his insurance coverage, so is reluctant to participate.

From a long-range point of view the CHA is studying the potentials of alternate compensation systems that will meet

the criteria of the ABA Commission's Interim Report. Such a plan could include a schedule of benefits, be administered by an administrative agency, and be integrated into existing insurance programs. When we are further along with our studies, we will share the results with this Committee.

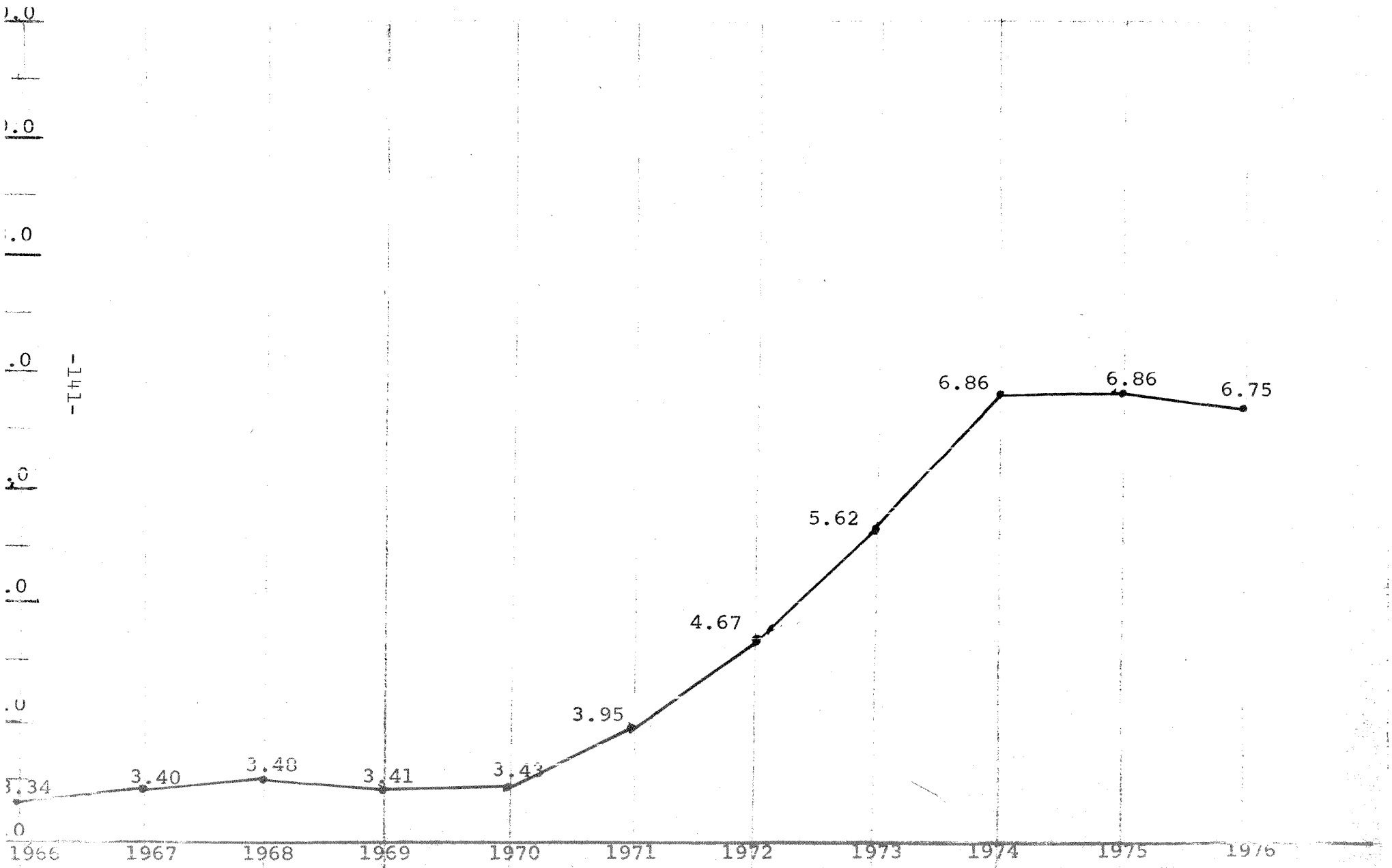
In closing, I wish to commend the legislature, and particularly this Committee, for undertaking this highly significant project. For the first time a public group will be undertaking a comprehensive look at our tort compensation system with the objective of developing a rationalized approach in our modern society.

On behalf of the California Hospital Association, I can assure this Committee and its excellent staff of our desire and willingness to fully cooperate in every appropriate manner.

Thank you for the privilege of presenting this material to you.

CALIFORNIA HOSPITAL ASSOCIATION

ANNUAL FREQUENCY PER 100 BEDS



APPENDIX III

STATEMENT TO
JOINT LEGISLATIVE COMMITTEE ON TORT LIABILITY
BY
GERALD J. SULLIVAN, PRESIDENT
WALKER, SULLIVAN COMPANY

My name is Gerald J. Sullivan and I am President of Walker, Sullivan Company which has handled the California Hospital Association Professional Liability Insurance Program since 1953. The operation of this Program has already been described here this morning by Mr. James Ludlam.

As brokers, it is our role to place coverages and generally supervise the operation of both the primary and excess portions of the CHA Professional Liability Insurance Program, as well as to perform similar duties for several other hospital groups and for numerous individual hospitals throughout the Western United States. We have also acted in an advisory capacity to a number of state insurance departments, legislative groups and actuarial firms in studying various aspects of professional liability.

Mr. Ludlam has already described the general situation here in California so I will not go back over that ground, but do wish to emphasize my complete concurrence with the conclusions expressed by Mr. Ludlam. Rather, I will discuss briefly the present situation in the excess professional liability insurance markets, how they have been affected by the passage of AB1XX and finally, a few words on one of the specific areas of AB1XX which is showing exceptional promise.

Primary Professional Liability Insurance has been the area most widely discussed during the recent malpractice crisis. However, a number of Underwriters absolutely crucial to any commercial insurance program are those who write the upper layers of coverage or what is commonly called "excess insurance".

To explain a little bit more clearly what I mean by excess insurance let me provide you with an example. If an insured requires $500,000 of insurance limits he may buy a single policy providing that entire amount or alternatively, he may buy a policy that will cover the first $100,000 of any loss and then buy a second policy that would provide excess limits in the amount of $400,000 excess of that first $100,000. When I am speaking of excess coverage, I am speaking of any amount of limits over the first layer of coverage provided by the primary insured.

These upper limits can either be written directly with the insureds themselves or as reinsurance of primary insurers who deal directly with the ultimate insurance buyer. In the California Hospital Association Professional Liability Insurance Program the upper limits are provided by placing the excess layers directly on behalf of each hospital.

Excess insurance, whether direct or reinsurance, is significant because it is these Underwriters who bear the brunt of all the large claims and who have born the major brunt of the impact of inflation generally on claims over the last several years. Since there are relatively fewer players in the excess market than are normally found in the primary market, supply and demand coverage problems can be much more dramatic. Additionally, since there are fewer losses to the upper layers, and thus the statistical base is limited, there is typically even less information available for rating purposes.

The California Hospital Association Professional Liability Insurance Program has purchased its excess layers from Lloyd's of London with significant support from domestic insurers in recent years under contracts handled through our office. These coverages are tailored specifically to follow the policy form, engineering

and claims handling of the primary carrier, the Truck Insurance Exchange. Excess rates are directly reflective of the changes in primary rates with periodic review to make any necessary changes in the relationship between primary and excess pricing as required by current experience. In the last several years it has been necessary to increase the pricing for the excess layers at a more rapid rate than for the primary layers - a direct reflection of the difference of the impact of inflation on upper versus lower layers of coverage.

While excess Underwriters have been getting harder to find over the last several years, and while price increases have been significant, realistic measurement of actual experience by the CHA itself, a compilation of extensive claims data, coupled with an excellent amd cooperative working relationship between primary and excess carriers has resulted in the CHA's ability to continue to provide high limits of malpractice coverage for its members here in California. Any hospital in California meeting the eligibility requirements of the California Hospital Association Professional Liability Insurance Program currently has available to it as much as $20 million of coverage for each occurrence with higher limits available on an individual hospital basis. To my knowledge, these sort of professional liability limits are not generally available anywhere else in the United States.

It has been the absence of these higher layers of coverage which has forced many individual hospitals and groups of hospitals in other parts of the country into forming various and unfortunately all too often ill-conceived schemes of self-insurance, captive insurers, and other means to deal with the risks surrounding the malpractice picture.

Let me hasten to point out that I am in no way opposed to self-insurance, captive insurers or any of the various other means used to

handle the risks arising from malpractice and other forms of tort liability as long as these approaches are structured soundly from an engineering, claims and funding standpoint. But when all normal sources of malpractice insurance disappear as has happened in some areas of the country, the insured has little choice but to protect himself. Fortunately, this has not happened as respects hospitals here in California. In this regard you may be interested in knowing the amount of malpractice insurance being written here in California. Exhibit "D" attached is page 52 from the Underwriter's Report-Statistical Review for 1976. As can be seen, this shows approximately 100 insurers writing medical malpractice coverage in California in 1976.

In no small measure the Legislature's passage of AB1XX has contributed significantly to CHA's ability to maintain realistic excess coverage. When the master excess contracts were being renewed two years ago AB1XX was in the process of wending its torturous way through the legislative process. In June of 1975 I took to London at the beginning of the renewal process for the 1975/76 contract year a copy of AB1XX as it had passed the Assembly. At that point in time Underwriters had suffered rather severe losses over the recent past and frankly were expressing great reluctance in renewing the contracts at all.

While it was necessary to increase the rates for the layers comprising limits of $900,000 excess of $100,000 by approximately 118 percent, Underwriters did agree to renewal. This agreement, however, was based solely on the condition that AB1XX would become law in at least as strong a posture as it left the Assembly. Underwriters watched the movement of AB1XX with keen interest and were briefed immediately when any significant progress was made or difficulties were encountered. I can assure you,

Gentlemen, all of us involved in the CHA Professional Liability Insurance Program breathed a great sigh of relief when Governor Brown finally signed the Bill into law, for it meant the continuance of the excess layers for another 12 months.

During the renewal of the 1976/77 Accident Year, which started in June of 1976, there was really little new to report on AB1XX. It had just become law the previous December, and therefore, hadn't been in effect long enough to have any impact. However, Underwriters were much more sanguine for they knew that CHA and the California Legislature were at least working together to try and accomplish something and we were able to renew the covers with an overall increase of approximately 12 percent - certainly a dramatic improvement over prior years.

We are now in the renewal process for the 1977/78 Accident Year. For the layer of $400,000 excess of $100,000 per occurrence, severity is continuing to increase, while frequency appears to have leveled off. For the layer of $500,000 excess of $500,000 both frequency and severity are increasing at fairly rapid rates. The layer of $4 million excess of $1 million has been penetrated several times in the last year - a significant deterioration from the previous situation wherein only the infamous Kelly Niles case had ever even touched this higher layer. But despite these far from settled trends the major price increases over the last several years, coupled with more aggressive handling of claims and significant efforts to clarify the constitutionality of AB1XX, such as the analysis recently completed by Ellis J. Horvitz, has again convinced Underwriters to continue these coverages for an additional 12 months.

While negotiations are far from complete, early indications are that we will be able to provide hospitals with the first $1 million of limits (where 93 percent of their premium is spent) at the same rate levels as

charged last year. This will mean then, that over the last two renewals hospitals in California have been faced with an overall increase in their malpractice insurance costs of under 15 percent - a far cry from what is still going on in many parts of the country where much higher increases in premium costs are still being experienced.

While we are more than aware that the current price levels are a significant burden on hospitals, the efforts of all parties concerned, including the CHA, the primary and excess carriers, as well as the legislative efforts culminating in AB1XX, have resulted in readily available coverage with a virtual leveling of rates, a record unsurpassed to my knowledge by any other state in the Union.

But the battle is far from over; inflation continues its inexorable upward pressure on claim costs, though the frighteningly rapid increases in frequency appear to have tamped out, there is continuing upward pressure on the number of claims being reported and the constitutional attacks which appear to be brewing on AB1XX could possibly destroy all gains of the last several years.

It is easy to generate great activity and support during times of crisis such as malpractice found itself in 18-24 months ago. But we are now past that stage and into the nitty-gritty, dirty-fingernail type day-to-day slogging which is necessary to control this system. Your efforts in assuring the support of the principles laid down in AB1XX and the further tort reform you are considering are urgently needed.

While I have been speaking almost entirely of the area of malpractice, it must be stressed what we have suffered over the last several years is only symptomatic of what is occurring in many other areas of tort liability. While the most significant problem area is that of Products Liability, areas such as Attorneys Errors and Omissions,

Architects Errors and Omissions, Directors and Officers Liability Insurance, all suffer from the same basic problems of an increasing frequency of claims, an increasing cost per claim, and most debilitating, the negative and unacceptable results of a highly inefficient compensation system. Your efforts must address themselves to all these areas.

As far as the statistics of the CHA Program, I have included in the prepared report several exhibits which has been given to the Committee. Exhibit "A" shows the frequency and severity of reported claims for the $400,000 excess of $100,000 layer and Exhibit "B" shows the same data for the $500,000 excess of $500,000 layer. Exhibit "C" shows the actual loss development on an incurred basis, based on the latest data we have available. Rather than to attempt to burden the Committee with exhaustive facts and figures, suffice to say that the data clearly demonstrates that while we have made significant progress over the last two years, the battle is not as yet won.

Next, I would like to discuss briefly one particular area of AB1XX which is having a very significant impact on the improvement of the overall claims situation we are facing and that is Structured Settlements.

Prior to AB1XX, courts and juries were required by law to award only lump sums. However, in effecting a settlement, the means by which most professional liability cases are disposed of, the defendant and plaintiff can enter into any sort of a contractual agreement acceptable to both parties. Therefore, as a step to start taking some of the sting out of the ever-increasingly large settlements, the CHA suggested that we develop a means of disposing of cases whereby a more realistic use of the concept of present value could be utilized. This search was spurred greatly by the Kelly Niles judgment in 1975.

Through a great deal of trial and error the mechanics and procedures and the necessary markets were eventually developed whereby structured settlements are now used quite extensively in many areas of tort liability where significant bodily injury, coupled with continuing medical care are present.

The use of this system results in claimants usually getting their compensation more rapidly, the monies available to them are structured in such a manner as to meet their specific needs, the funds are paid out over time protecting claimants from unscrupulous and unwise use of monies - a significant advantage where minors or incompetents are involved-and finally, the income available to claimants is guaranteed for life. All these steps result in more monies actually getting to the claimant.

At the same time through the intelligent use of the concept of the present value of the dollar, the casualty company, and ultimately the premium payer, gets better mileage out of their dollars. Finally, the plaintiff attorney gets paid either in the traditional lump sum manner or can benefit from certain tax advantages by taking his fee over a period of time. Thus under this system, virtually everybody is better off.

Prior to AB1XX many of those involved fought the use of this concept because it was not usable by the courts. Since the advent of AB1XX this argument has disappeared, even though to my knowledge no court has actually used this particular aspect of the law.

Since the development of this procedure several years ago our office has settled over 300 cases using this concept with savings to the casualty companies, on whose behalf these settlements were made, averaging 35 to 40 percent of the estimated lump sum cost of these cases.

At the same time, claimants are benefiting from all the advantages outlined above. Of all the elements which the Legislature wisely incorporated into AB1XX, this particular area has probably been the most exhaustively researched and most effectively utilized and has resulted in the greatest reduction in malpractice costs to date. Some have claimed that AB1XX has been totally ineffective to date, however, the results evidenced by the use of the structured settlement process strongly indicate that AB1XX has in fact been effective and that more diligent use of additional aspects of that law, such as Collateral Source, can even further reduce the cost pressure on the professional liability system while continuing to assure that injured parties are properly and adequately compensated.

As the concept of structured settlements is relatively new, it seems advisable to explain in some detail how the procedure works.

When a personal injury or wrongful death case goes to trial, the news media often publicize the verdict of the jury -- particularly when the plaintiff is awarded an enormous sum of money. Consequently, the public believes that nearly all cases are handled this way. As you know, however, most personal injury cases are resolved out of court.

Traditionally, the insurance industry has settled cases by compensating the claimant with a lump sum of money. Now structured settlements are available as an alternative to resolve these cases. To become familiar with this new approach, let's consider two actual cases. In some ways the two cases are quite similar. Both involved young boys -- one age 16 and the other age 17. One boy was involved in an auto accident; the other sustained injuries that involved a football helmet. Both became quadriplegics as a result of their accidents.

In these two cases, there was substantial exposure for the casualty companies. In both cases, aggressive and creative claims handling and rehabilitation minimized damages. The one involving the auto accident was settled just prior to trial with a lump sum of $1 million. From this amount the boy received $750,000.

A short time later, he joined a small religious sect. In return for a promise of lifetime care, he donated all of his money to them. One month later, they expelled him. Now, without finances or an income to support himelf, he is suing to get his money back.

The other case -- the one involving the football helmet -- was concluded prior to serious trial presentation with a structured settlement. Over his lifetime, this boy can expect to receive benefits totaling $1,450,000.

- The boy received cash reserves for deposit in his bank.
- A new house was provided.
- The boy was given a monthly income for life amounting to $10,000 annually to start plus a 3 percent increase each year.
- The plaintiff attorney's fee was paid.

The total cost for this structured settlement was $450,000.

The two cases were resolved out of court -- one with a lump sum, the other with a structured settlement. As mentioned earlier, most cases are resolved through negotiated settlement because of the advantages to the individuals concerned. Both parties lose some control over the case when it goes to court. Other factors are the time and expense of a court trial

Let's assume now that we have a case in which the casualty company and the plaintiff attorney agree to negotiate a settlement. One of the first things to work out is the amount of benefits to be provided, whether with a lump sum or structured settlement. Generally, a lump sum is intended to compensate for past, present, and future damages resulting from the accident. Once the defendant has paid the amount agreed upon, the case is closed. Lump sum payments have been criticized because they require speculation as to the injured party's life span, future medical expenses, income loss, and pain and suffering. Because of speculation, there is a good chance the compensation won't be equitable.

For this reason, structured settlements are a useful alternative to lump sum payments. They eliminate much of the speculation since they normally include a guaranteed income for the injured party. As we saw in the case we examined, a structured settlement includes periodic payments as well as up-front money. In other words the compensation is divided into two parts:

- The first part is the up-front money paid when the case is settled. This usually covers medical costs already incurred, lost wages, legal fees, and any other special needs.

- The other part of the compensation is the periodic payments -- usually monthly annuity payments. They are normally provided for the life of the injured party.

Structured settlements are extremely flexible. The periodic payments can be funded in many different ways. Provisions can be made for them to increase or decrease by specified amounts on designated dates or upon certain contingencies. Up-front money or deferred money can be allocated

to cover many kinds of losses and eventualities, such as death benefits and college expenses for dependents.

Although structured settlements eliminate a lot of the guess work in calculating equitable compensation, they are not a panacea. They are not practical for every case of personal injury or wrongful death. But they are particularly useful under the right circumstances. Let's discuss some of them.

Structured settlements are most often used on cases that have a settlement value of $100,000 or more. However, they have been successful on even smaller cases. Structured settlements often are used when the injured party has identifiable and long-term needs. Typically, they are used on cases involving permanent injuries or continuing need for medical attention. They are often used when future earnings of the injured party have been diminished because of debilitation.

The casualty company can realize substantial savings with a structured settlement if, for any reason, a claimant is not expected to live a normal life span. This results from funding the monthly payments based on actual life expectancy as opposed to normal life expectancy. When the injured party is a minor or incompetent, structured settlements are especially practical. Whenever the court has reason to be concerned about protecting the injured party's future finances, structured settlements are attractive.

Wrongful death cases are often excellent candidates for structured settlement. With these cases, the payments generally consitute a guaranteed income for the surviving spouse; in addition, deferred payments to cover various contingencies, such as college expenses of any children. Cases that involve several co-defendants are also good candidates. Negotiating a structured settlement tends to focus the attention of the co-defendants

on the needs of the plaintiff. When the plaintiff's needs are understood and agreed upon, the co-defendants are more likely to cooperate to meet those needs. Most important, when all co-defendants are united in their approach, the case can usually be resolved at less cost to all of them, while fully meeting the claimant's needs.

We have examined some of the situations in which structured settlements apply. The approach works because there are specific benefits for each of the parties involved -- the casualty company, the defense attorney, the plaintiff attorney, the judge, and of course, the claimant. Let's consider the advantages to each of them, beginning with the insurance carrier.

A structured settlement usually costs far less than a lump sum payment. Our experience indicates that a 20 to 40 percent savings is not unusual. Furthermore, the settlement can be structured so that unexpended funds are returned to the casualty company if the plaintiff dies prematurely.

The defense attorney also is likely to benefit from a structured settlement. Of utmost importance to him, structured settlements solve the problem of his client -- the casualty company. Cases resolved with structured settlements generally cost less. Also, the defense attorney can steer the negotiations into a discussion of the plaintiff's needs. This is far more productive than participating in a battle of who can outbid or outshout the other.

Plaintiff attorneys also benefit in several ways. By negotiating a structured settlement, the plaintiff attorney can be assured that his client will receive a guaranteed income for life. The income will be in a form that his client is competent to manage. The payments will not be vulnerable to unscrupulous hands or squandering. Also, when arranged correctly, they probably will have significant tax advantages for his client.

The plaintiff attorney may also benefit from a choice in how his fee is paid. It can be paid in a lump sum or with periodic installments over a number of years. Significant tax advantages for the plaintiff attorney are possible when the fee is paid out over time. Another important advantage to the plaintiff attorney is that he can present a structured settlement to his client as a creative and meaningful solution.

Judges often favor structured settlements because the approach is equitable. For a lump sum payment to be approved by the court, it is usually necessary to estimate how much money the plaintiff needs at present to support him the rest of his life. And there is no way to predict life span accurately. If the plaintiff lives longer than expected and the lump sum funds run out, he could become a ward of the state and a burden to taxpayers. If he lives shorter than expected, his heirs could receive an unintentional windfall. The heirs' needs are most equitably met by the use of death benefits or up-front monies. However, a settlement can be structured to provide an equitable income that meets the needs of the plaintiff regardless of his life span.

The judge may favor the security of a structured settlement because it provides the injured party with a guaranteed income for life. This is particularly attractive when the claimant is a minor or incompetent and there is concern about his receiving adequate care. Structured settlements match benefits to the needs of the individual and reduce the potential for mismanaging finances. The judge often favors a structured settlement because it expedites the case. It saves valuable court time and costs.

Of most importance in the consideration of structured settlements is their consequence on the claimant. A guaranteed stream of income is provided to the claimant as long as he needs it.

Structured settlements are an extremely flexible tool. Almost any need or contingency can be provided for. As an example, the increasing cost of living can be offset with payments that increase over time. The periodic payments, if structured correctly, are not subject to income tax. However, if the plaintiff were awarded a lump sum that he subsequently invested to yield an income, that income would be taxable even though the lump sum would not be.

As previously mentioned, the claimant also is compensated with immediate cash for current needs. This may include out-of-pocket expenditures for medical care, workers' compensation leins, and other needs that are a result of the accident. As a practical matter, the claimant usually receives some cash in hand as part of the up-front money. Each step in the process of arranging one of these settlements can be blocked by obstacles. But these obstacles can be overcome with proper direction. The following obstacles will have to be overcome as the case proceeds.

When a case has been identified as a likely candidate for a structured settlement, the structured settlement specialist must be able to provide and adapt periodic payment schedules -- often in a very short time. Sometimes there are only two or three hours available. To calculate the cost of a payment plan, the specifics of the case must be know. Access is needed to medical and actuarial experts who can evaluate the prognosis and the needs of the injured party. With a week to ten days of preparation, the defense team should be ready to negotiate and adapt to almost anything the claimant requires.

The most important and difficult task for the specialist is to convince all the parties in the negotiation that a structured settlement is to their advantage. The plaintiff attorney, the defense attorney, and the

judge involved in the case are likely to be opposed at first unless they have had previous experience with this type of settlement. The specialist must be able to shown them that their apprehensions are probably based on misconceptions. Specifically, he must demonstrate that a structured settlement can be tailored to meet the needs of the plaintiff. In addition, he must satisfy the plaintiff attorney that the legal fees and the form in which they are paid will be acceptable. Even if the parties involved in the case are willing to accept a structured settlement in concept, the details of the first offer are always rejected. Some things will need to be changed, added, or deleted.

Because the plaintiff attorney is likely to request certain types of payment plans, the specialist has to be thoroughly familiar with all of them. During the negotiations, he has to calcualte the cost of all kinds of income plans on the spot in order to keep the negotiations going. Similarly, he must have a thorough knowledge of the wide range of benefits that can be offered. This enables him to secure agreement on a structured settlement. The specialist must act as a neutral entity to all parties. An offer proposed by a neutral entity is more likely to be accepted than if proposed by an adversary.

Advance payments for the treatment of the injured party at a rehabilitaion center can be an important component of a structured settlement. The primary candidates for rehabilitation are people who have sustained spinal cord injury, brain damage, amputation, and severe burns.

Treatment at a rehabiliation center is designed to deal with several aspects of the disability including physical, psychological, financial and vocational. There are two purposes for rehabilitation: to allow the individual to function at maximum capacity within the confines of the disability,

and to reduce, over the long run, the expenditures required to maintain the injured party.

The emphasize the extreme importance of rehabilitation, let's review a recent case. A designer of go-kart engines was involved in a racing car accident. He suffered spinal cord injury and brain damage. He was paralyzed from the upper lip down. Bedridden with a tube for breathing and a tube for feeding, he couldn't speak or swallow. He also had double vision in one eye. Doctors gave up on him. He was religated to a nursing home for life.

After two and one-half months in the nursing home, the casualty company involved in the case arranged for him to receive treatment at a rehabilitation center. An operation was performed on his throat so that he could speak and swallow. Another operation was performed to rid him of the double vision. With intense physical therapy, the use of his musculature began to return. He also received occupational therapy. After six and one-half months at the rehabilitation center, he was functioning totally -- walking, speaking and eating. Now he is back racing cars and building go-kart engines.

Providing paid rehabilitation sets the stage for continuing support and it is likely to increase the effectiveness of a structured settlement. Rehabilitation is used as a matter of course on workers' compensation cases. We strongly urge that it be considered as a tool for liability cases. By competent case management, the real needs of the injured party become known and therefore realistically and effectively corrected or compensated.

This technique has evolved as a natural corallary to structured settlements.

In summary then, you can see excess malpractice insurance for hospitals is readily available here in California thanks in no small measure to AB1XX.

Additionally, as you can see, AB1XX has already begun to have some impact on the cost of large cases. Progress is being made, but your further assistance in providing additional tort reform is necessary. I can assure you that CHA and the entire team involved in handling their Professional Liability Program, will continue to do averything they can to hold this problem in check -- but they cannot do it alone. Your help in swiftly concluding your deliberations and thus being in a position to support the reforms already accomplished and providing additional tort reform is urgently needed.

I'd like to thank you for this opportunity to address you this morning, and would like to further indicate that I would be happy to provide whatever additional detail and backup information you may require.

GJS:cah
7-9-77

BY REPORTED YEAR

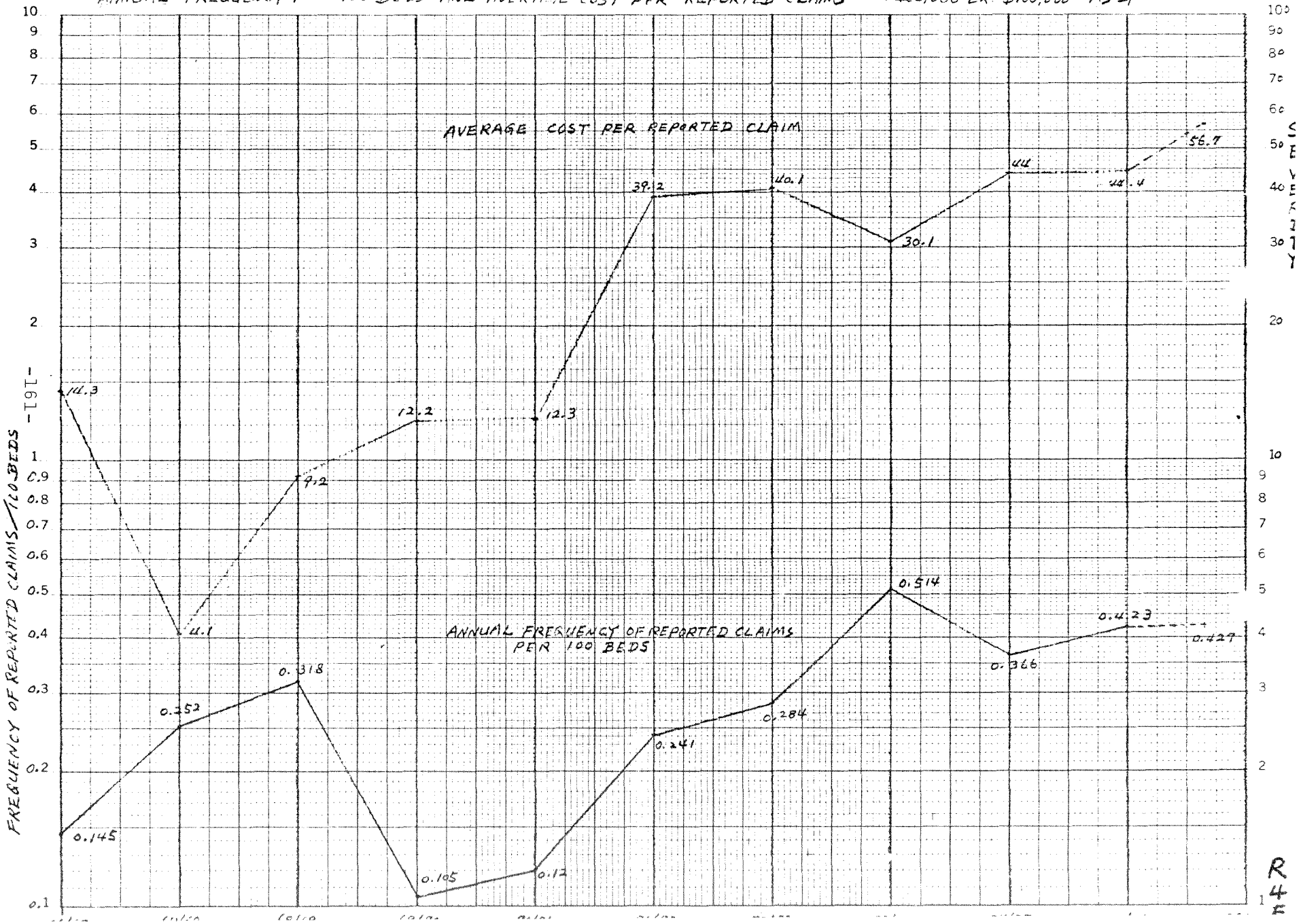
K&E SEMI-LOGARITHMIC 2 CYCLES X 200 DIVISIONS
KEUFFEL & ESSER CO MADE IN U.S.A.

46 5250

EXHIBIT A

THOUSAND DOLLARS

ANNUAL FREQUENCY PER 100 BEDS AND AVERAGE COST PER REPORTED CLAIMS — $400,000 EX. $100,000 AS IF



R 4 E

BY REPORTED DATE

K·E SEMI-LOGARITHMIC 2 CYCLES X 200 DIVISIONS
KEUFFEL & ESSER CO. MADE IN U.S.A.

46 5250

EXHIBIT B

ANNUAL FREQUENCY PER 100 BEDS AND AVERAGE COST PER REPORTED CLAIM — $500,000 EX. $500,000

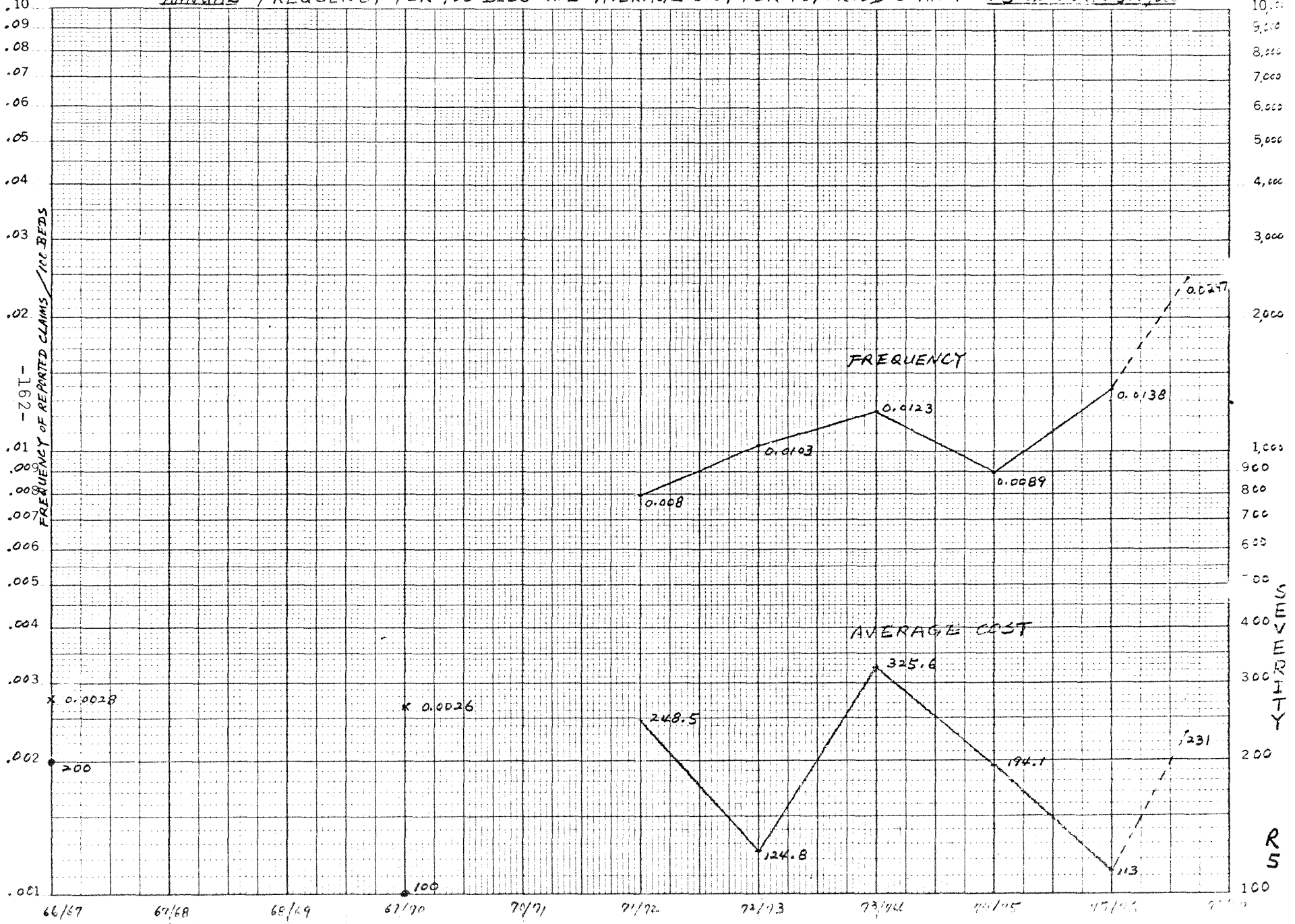


EXHIBIT C

INCURRED LOSSES $400,000 EXESS $100,000 AS OF MAY 31, 1977

CONCTRACT YEAR	END OF 1st YR	2nd	3rd	4th	5th	6th	7th	8th	9th	10th
1967/8	$100,000	$ 90,000	$430,000	$685,000	$1,125,000	$1,075,000	$1,158,750	$1,396,250	$1,926,250	$2,211,250
1968/9	NIL	$655,000	$765,000	$1,662,500	$1,892,418	$2,242,418	$2,177,418	$2,187,418	$2,527,418	
1969/70	NIL	$375,000	$970,000	$2,205,140	$3,660,130	$3,689,500	$4,092,020	$4,337,020		
1970/71	NIL	$580,000	$1,447,610	$2,859,022	$3,511,322	$3,243,332	$3,988,332			
1971/72	NIL	$420,000	$1,434,000	$2,325,250	$2,182.215	$1,867,215				
1972/73	NIL	$1,747,500	$4,282,500	$5,122,500	$5,946,359					
1973/74	NIL	$3,431,529	$6,741,529	$8,481,528						
1974/75	$ 10,000	$1,495,000	$5,265,000							
1975/76	$600,000	$4,205,667								
1976/77	$350,000									

California Medical Malpractice Business, 1976

COMPANY	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID TO POLICYHOLDERS	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
STOCK COMPANIES					
Aetna Casualty & Surety	$ 2,564,166	$ 2,290,350	$ —	$ 1,335,558	$ 1,792,066
Aetna Insurance Company	19,066	3,373	—	—	—
Allied Insurance Company	401	373	—	—	—
Allstate Insurance Company	62	454	—	—	—
American Economy Insurance Company	157	130	—	—	—
American Employers' Insurance Company	92	99	—	100,000	(4,500)
American Home Assurance Company	16,416	14,519	—	—	—
American Insurance Company	5	5	—	—	—
American Motorists' Insurance Company	—	(6)	—	—	—
American Reinsurance Company	—	885	—	(483,784)	74,110
American States Insurance Company	1,759	848	—	—	—
Appalachian Insurance Company	33	1,813	—	—	—
Argonaut Insurance Company	4,896,861	5,201,081	—	2,096,383	2,045,918
Atlantic Insurance Company	—	(1)	—	—	—
Bellefonte Insurance Company	1,323,755	983,179	—	115,500	177,100
Boston O'd Colony	—	—	—	—	1,500
CNA Casualty of California	13,185,912	3,736,815	—	23,111	(2,791,276)
Calvert Fire Insurance Company	106,506	111,717	—	—	158,255
Charter Oak Insurance Company	360	111	—	—	212
Chicago Insurance Company	855,812	644,854	—	80,103	203,838
Commercial Union Insurance Company	369	186	—	—	(1,290)
Continental Casualty Company	143,003	143,003	—	2,832	(12,403)
Continental Insurance Company	193,898	210,380	—	8,123	96,733
Employers' Reinsurance Corporation	26,379	16,146	—	—	—
Federal Insurance Company	2,825	1,764	—	—	6,000
Fidelity & Casualty Co. of New York	829,952	900,497	—	26,340	185,590
Fidelity & Guaranty Underwriters	—	—	—	190	190
Fireman's Fund Insurance Co.	5,197,258	4,864,357	—	26,250	1,464,934
Foremost Insurance Company	904,209	1,263,450	—	45,525	676,280
Forum Insurance Company	5,465	5,465	—	—	—
Fremont Indemnity Company	2,235,224	1,196,302	—	—	—
Gen. Accident Fire & Life Assurance Co., Ltd.	(138)	(12)	—	—	—
General Insurance Co. of America	(54,692)	72	—	—	2,000
Glacier General Assurance Co.	11,198,689	8,177,551	—	69,334	889,660
Glens Falls Insurance Company	259	281	—	—	—
Globe Indemnity Company	18,878	35,247	—	(60)	(9,224)
Gulf Insurance Company	(42,572)	(19,364)	—	(15)	(1,015)
Hartford Accident & Indemnity Company	735,579	733,092	—	666,422	236,196
Hartford Fire Insurance Company	—	—	—	8,650,884	(1,682,180)
Hawaiian Ins. & Guaranty Co., Ltd.	—	—	—	—	17,194
Home Indemnity Company	15	6	—	—	—
Home Insurance Company	693	560	—	—	—
Industrial Indemnity Company	136,365	138,613	—	6,523	(7,397)
Industrial Insurance Company	505,339	450,368	—	—	60,010
Industrial Underwriters	1,096	388	—	—	—
Insurance Company of North America	118,033	390,217	—	1,146,882	5,399,212
Insurance Company of the Pacific Coast	193,264	138,039	—	12,056	61,876
Insurance Co. of the State of Pennsylvania	27,012	8,356	—	—	—
International Insurance Company	8,804	8,913	—	—	2
Jefferson Insurance Company	212,136	148,229	—	—	1,000
Maryland Casualty Company	7,339	10,820	—	81	81
Midland Insurance Company	—	—	—	3,825	42,325
National Union Fire Insurance Co.	3,246,485	1,792,671	—	—	—
New Hampshire Insurance Company	1,419	2,325	—	—	—
North River Insurance Company	1,167	1,621	—	—	—
Northbrook Insurance Company	3,604	7,548	—	—	—
Northern Assurance Co. of America	—	24	—	—	—
Northwestern National Insurance Co.	1,727	2,535	—	—	—
Ohio Casualty Insurance Company	(1,129)	4,914	—	—	—
Pacific Employers' Insurance Co.	13,226	18,019	—	31,836	154,666
Pacific Indemnity Company	7,752,150	5,546,537	—	5,789,957	6,413,119
Pacific Insurance Company	33,926	36,809	—	2,799	(4,561)
Phoenix Assurance Company	416	451	—	—	—
Phoenix Insurance Company	59,558,284	59,558,284	—	2,467,511	43,311,211
Planet Insurance Company	—	21	—	—	—
Reliance Insurance Company	6,030	4,333	—	300,000	163,999
Reserve Insurance Company	134,950	191,779	—	296,066	178,710
Royal Globe Insurance Company	293	427	—	—	—
Royal Indemnity Company	—	—	—	—	15,622
SAFECO Insurance Co. of America	12,731	4,449	—	—	—
St. Paul Mercury Insurance Co.	17,519	47,218	—	—	—
Security Insurance Co. of Hartford	—	—	—	(568)	(21,068)
Select Insurance Company	(2,011)	(979)	—	—	—
Standard Fire Insurance Company	107,919	115,168	—	1,328	5,279
Tokio Marine & Fire Insurance Co., Ltd.	14	15	—	—	—
Transamerican Insurance Company	463	203	—	2,000	3,500
Transportation Insurance Co.	1,051,873	1,105,280	—	—	586,698
Travelers Indemnity Company	57,317	61,000	—	—	34,196
Travelers Indemnity of America	16,684,195	17,180,695	—	1,403,482	27,103,982
United Pacific Insurance Company	3,985	5,593	—	—	30,312
U.S. Fidelity & Guaranty Company	32,525	28,353	—	1,699	25,353
U. S. Fire Insurance Company	2,695	3,748	—	—	249,999
Vigilant Insurance Company	612,757	537,302	—	—	200,750
Western Casualty & Surety Company	1,974	1,761	—	—	(2,000)
Western Fire Insurance Company	2,641	9,885	—	—	57,000
Stock Totals	134,915,091	124,081,514	—	24,228,373	87,679,824
MUTUALS					
American Mutual Liability Ins. Co.	—	—	—	3,740,238	740,792
Central Mutual Insurance Company	255	422	—	—	—
Liberty Mutual Insurance Company	16,990	12,925	—	78,002	285,814
Lumbermen's Mutual Casualty Co.	—	6	—	—	—
National Chiropractic Mutual Ins. Co.	616,460	575,834	—	65,317	235,267
Norcal Mutual Company	15,665,239	12,290,359	—	35,988	6,042,725
WAUSAU	(144)	6,162	—	145	9,958
Mutual Totals	16,298,800	12,885,708	—	3,919,690	7,314,556
RECIPROCALS					
Doctors' Company, An Interinsurance Exchange	4,400,605	4,314,792	—	81,295	2,587,205
Medical Insurance Exchange	6,705,421	6,507,133	—	17,691	868,782
Physicians & Surgeons Insurance Exchange	252,035	168,904	—	—	—
Southern Calif. Physicians Insurance Exchange	9,577,270	7,780,686	—	38,218	711,918
Truck Insurance Exchange	88,560,498	90,598,286	—	7,505,893	38,853,677
Reciprocal Totals	109,495,829	109,369,801	—	7,643,097	43,023,672
GRAND TOTALS					
Stock Totals	134,915,091	124,081,514	—	24,228,373	87,679,824
Mutual Totals	16,298,800	12,885,708	—	3,919,690	7,314,556
Reciprocal Totals	109,495,829	109,369,801	—	7,643,097	43,023,672
Grand Totals	260,709,720	246,337,023	—	35,791,160	138,018,052

APPENDIX IV

TORT REFORM AND ITS IMPACT ON PROFESSIONAL LIABILITY LITIGATION

SAMUEL SHORE

PRESIDENT, LOS ANGELES TRIAL LAWYERS ASSOCIATION

As President of the Los Angeles Trial Lawyers Association, I would like to point out that trial lawyers are always interested in improvement of our system of justice in a constructive manner, intended to make it more efficient, less expensive, or more just. This is consistent with the definition of "reform" which is defined as means of improvement, correction or restoration to purity or excellence. (Merriam-Webster's Third New International Dictionary).

As representatives of the consuming public, however, and as proponents of the principles of our system of justice as guaranteed or protected by the concepts in the Constitution of the State of California and of the United States, the Los Angeles Trial Lawyers oppose measures which deprive the consuming public of it's rights, destroy the concept of equal protection under the law for all persons as set forth in Article I of the Constitution of the State of California, and insist on a concept of fair play and justice as guaranteed by the due process provisions of the same Article of our own Constitution.

To date, each of the proposals, largely originating with special interest groups, such as the California Medical Association, to the Legislature for enactment, are destructive of the entire concept of equal protections under our law for

all members of the public, including doctors and lawyers, as well as the due process principle that is paramount in the philosophy of our system of justice. The proposals to date seem to be directed toward the concept of establishing protected and privileged classes within our society. The privileges and immunizations would protect members of specific professional groups from accountability, to the prejudice of the rights of specific limited individuals among our consumers who have been seriously injured, incapacitated or caused to die, with resulting substantial hardship and loss to them or their loved ones. Privilege and immunity as an endowment of a special class or classes, as an acceptable social philosophy died with Charlemagne. The destruction of the rights and protections of members of society singled out to suffer at the hands of others, without fair compensation and right of redress in a court of law under due process principles was unheard of in the English Common Law and was, in fact, specifically prevented by the protections of the Constitution of the United States, as well as the State of California, at the time of their adoption.

Every imaginable effort has been made by the insurance industry, who collects greater and greater premiums for protection of their insureds within these professions groupls, to avoid doing the very thing for which they collect their ever-increasing profits. Yes, the profits of the insurance industry from professional liability coverage have continued

as one would expect to remain high in spite of their outcry of losing money and unprofitable markets. In the May issue of the Journal of Insurance a summary of all of the insurance companies in the State of California, their profits, their payouts, and their accumulated premiums are provided. I do not subscribe to this Journal, nor am I a recipient of it as one of their favored persons. I therefore was only able to glance at it and only for a brief period. Where else can one find 50% profits reported by an industry in fields wherein they claim to be losing money and asking special protections from the Legislature while esclating beyond the realm of reason extortionistic premiums for coverage which is considered essential for the conscientious responsible profession rendering services? I urge a review of those figures by an accountant who will be able to clearly establish from those figures the profit margins reported by each of the companies. In this fashion, this body would be in the position to make responsible recommendations to the Legislature for reform designed to protect the interests of the consuming public, members of the various professions, and at the same time evaluate the sincerity of needs claimed by the insurance industry "to stay in business."

I submit that a business, protected by law, engaged in legalized gambling, such as the insurance industry, should not be permitted to exploit its advantages and operate a system

or piracy. Las Vegas does not permit it's licensed gambling establishments to operate with crooked dice, change the odds in favor of the house, or to conceal the operating business figures and profits as our Legislature has permitted the insurance companies claiming to be losing money while providing insurance to a captive audience of professional people who are conscientious enough to want to have insurance coverage to protect the consumer as well as themselves. "Skimming" is not permitted in Las Vegas nor should it be permitted in California.

Indeed, if all of the facts were known by the Legislature, and it was proven that insurance companies were unable to provide the kind of protection which the ever-increasing premiums are supposed to produce, without a reasonable profit, then perhaps as a measure of protection to the public and for the common good, that kind of insurance should be provided by some other source, a State operated fund which would be under the scrutiny of the Legislature and all other interested parties. It is well known that disasters can occur as the result of human failings among professional people, doctors, dentists, architects, engineers, and lawyers alike, are essential in our society where the rights of the consumer, the injured individual, as well as those charged with the responsibilities for such injuries, should be paramount.

No single group of professions or otherwise identifiable members of our society should be immunized against charges by injured members of the consuming public of malpractice. People

lose arms, legs and lives in emergency rooms, as well as operating rooms, hospital beds and x-ray departments as a result of human failings on the part of one or more professionals. To exempt them from charges by the injured in any one of those geographical locations is unfair and unequal protection. It is not "reform" that is destruction of rights guaranteed by the Constitution.It's just as injurious to a client for an attorney to permit the statute of limitations to run before filing a lawsuit if the attorney saw him initially in his library at the time his services were sought, as if he had originally seen him in the inner sanctum of his consultation office.

Even governments under our Constitution can be held liable by an injured plaintiff because his sovereign immunity has been dissipated. This second-half of the 20th century, is no time to reestablish the divine right of kings. I speak for attorneys who are interested in the public interest, and seek no special privilege for themselves. Similarly, attorneys specializing in trial litigation, in medical or legal malpractice and other professional liability, though not asking special privileges, are entitled by virtue of our equal protection provisions of the Constitution to the same right as other attorneys, indeed, as doctors, dentists, engineers, accounts and other professions, have their right to enter into private contracts with their clients for their employment, and their right to determination of what their services are worth.

The establishment of fee scheduled that make greater rewards for attorneys more profitable with less effort because it will benefit the insurance industry with lesser rewards for greater efforts performed for legal services as means of punishment for making more adequate recovery are unfair and unjust to the injured party as well as the attorney striving for excellence. That kind of a reform is another extortion plan intended to enrich the insurance industry, and to encourage poor showing on behalf of the legal profession. It is neither fair, nor constitutional. It is a program of theft from the injured calculated to enrich the industry that already owns half of our country. As a matter of public policy, members of the Legislature who undertook the same oath of office with regards to preservation and protection of the Constitution that members of the Trial Bar and judges and, yes, the Governor, should be aware of the definition of the term "reform" before attempting to undertake "tort reform" and should keep in mind principles stated by the Constitution, but more importantly, the spirit of the Constitution as they attempt to strive toward improvement, correction, and restoration to purity or excellence.

We in Los Angeles County are daily aware of court congestion as a major problem. The rights of litigants are long delayed, in a County which grows in population, and social complexity. A backlog of some 53,000 cases needing judicial manpower to unplug it, causes a 36-month delay in

getting to trial for civil cases ready for trial. Crime and those charged with crime, compounds the problem of getting civil cases a judge, hence the criminal cases take priority because of constitutional protection for those charged with crime. If, indeed, this Commission desires to reform the tort system, effort to provide adequate manpower for the judiciary so that court litigation becomes available to the public would be a step in the right direction. An increased compliment of judges so that courts can handle the increase of civil filings of nearly 10,000 more per year since 1972, when the last Legislature dealt with this problem, would permit the court to adequately deal with the problems of a growing population, extension of civil rights, a newly created legislation making the courts responsible for new problems, the complex social problems of our growing society. Delays in access to the courts for the solutions of these civil problems tends to discourage the citizenry to dilute its support and confidence in our judicial system. To do less on the part of the Legislature is to permit the third branch of our government, the judiciary, to become embroiled in politics, and to permit them to be subjected to policical pressures supplied by Boards of Supervisors, legislators and others. This is contrary to the entire concept of an independent court. It is contrary to the policy established

in this great State that all citizens have free and open access to the legal system. Rapid and fair hearing of criminal cases as well as civil cases should be made available.

The cost of our system of justice wherein an injured or damaged plaintiff is able to have access to the courthouse for the resolution of the justice of his claim for damages and awarding of adequate compensation is fair to both the injured party as well as the responsible wrong-doer.

Numerous claims have been made that one of the problems involved in professional liability suits is the filing of the frivolous lawsuit. In the days when professional liability suits were never won, arguably all of those suits were classified as frivolous. The frivolity was on the side of the insurance industry. The lame, the dismembered and the survivors of the dead were not frivolous. It is a tribute to the Trial Bar and the concentrated program of self-improvement by continuing education among lawyers,the impossible burdens were to some extent overcome so that in the occasional outrageous case, justice was achieved. The battle cry of the opposition forces continues to call frivolous lawsuits one of their major concerns requring tort reform.

The so-called frivolous lawsuits are sometimes filed by conscientious, but naive and uninformed members of the Bar. Rarely, if ever, do they result in economic success in the court room for the plaintiff or lawyer. On the other hand, those instance

of success that have achieved notoriety only because justice was done, were usually the result of a meritorious case handled by a competent, trained and experienced attorney who has applied himself and learned all of the essentials necessary to prove his case, complex, technical, and sometime extremely so. The day of specialization in the law is soon upon us. When specialization and recognition of the principle of specialization in professional liability litigation comes accepted, much like specialization in medical and dental professions, the number of "frivolous" cases will hopefully diminish. When that objective is achieved, however, frivolous cases are no longer component of the 80% medical malpractice litigation trials that are lost by the plaintiff, indeed, there may be a complete reversal of those statistics, no power in California will make the insurance remain in the field of professional libaility, if the Legislature now continues to pamper it by responding to the hysterical complaints intended only to produce greater profits, by immunizing the wrong-doer and penalizing the innocent victim.

I urge you to evaluate the reforms that you consider and recommend in the tort system. Evaluate them from the standpoint of basic concepts of fairness to the injured as well as the wrong-doer. A negligent doctor, held responsible

to the extent of "making his victim whole" should not be unjustly penalized threatening his license for an act of mere negligence. A single act of negligence may result in an injury to be compensated to the extent of $2,000.00. The degree of culpability is not measured by the damages suffered. The same act of negligence may result in injures bringing about an adequate award of $150,000.00. Other than his financial responsibility to his victim, such a doctor should not be more penalized simply because his victim became more impaired. Penalties should be limited to circumstances of chronically repeating negligent conduct, or gross negligence. The dollar amount of such damages is not a measure and should not be equated with gross conduct in abridgement of the proprietary right to practice his profession, but more importantly applies a degree of hardship in the practice of a learned and honored profession which makes difficult decisions sometimes impossible. Doctors, like lawyers, are entitled to equal protection under the law. Both are entitled to due process.

"This . . . Constitution (is) intended to endure for ages to come and, consequently, to be adapted to the various crises of human affairs." (Chief Justice John Marshall (1819) McCulloch v. Marylan)). The traditional tort system beginning with the English Common Law is a mechanism for resolving conflicts involving monetary claims of liability, and assigning responsibility for those claims. Through centuries of development the tort system

has become a vary effective means of handling often very complicated disputes, thereby avoiding violence and alleviating hardship based upon fault. The tort system re-enforces our social code of responsibility for our actions. Although there is room for considerable improvement, the reforms which the system need are not achieved by the proposals by a variety of interest groups who seek to exempt themselves from its scope. Tort reform is not a means of shifting the burden of responsibility to the injured party, taxpayer, or those not responsible for the harm caused. Accountability for negligence and wrongdoing must continue to saturate our law otherwise the rule of law will foster irresponsibility and careless disregard for the rights of the innocent individual.

APPENDIX V

Statement of the California Medical Association
before the Joint Legislative Committee on Tort Liability
July 11, 1977 - Los Angeles

The California Medical Association is pleased to comment before the Joint Legislative Committee on Tort Liability. My name is Nicholas P. Krikes, M. D. I am a Family Practitioner from San Bernardino and President-Elect of the California Medical Association, the professional organization representing the vast majority of the privately practicing physicians in this State.

As I am sure you are well aware, the CMA has been deeply involved for the past few years in what has been known as the "professional liability crisis." Actually, physicians in California have been actively seeking solutions to this problem for more than a decade. Experience has taught us one thing -- there are no easy answers to the problems of tort liability, either with regard to medicine or any other segment of our society

We commend the Legislature for establishing this Joint Committee to investigate the full range of tort liability, for the problems of medical liability are only a part of a larger affliction whose roots are deep and widespread throughout our entire society.

There are some fundamental problems underlying this crisis:

- The increase in litigation during the past ten years is phenomenal. Costs and claims frequencies are escalating. In part, this is due to greater emphasis on litigation as a method of resolving social problems.
- The present system of resolving claims is expensive and inefficient. Of the billions of dollars paid in liability insurance premiums, as little as 20 percent actually gets to the injured parties.

- The present system is capricious with regard to compensation. One individual may be more than amply compensated, while another with a similar situation may not receive a penny.
- Our system is inordinately slow. Personal injury cases often take months and sometimes even years before an injured party receives compensation.
- The expansion of certain legal doctrines, mainly through case law, has broadened the scope of tort liability immeasurably, adding a factor of uncertainty in companies' ability to insure against risk.
- Many commercial insurance companies' reserves were disastrously affected by stock market plunges in 1973 and 1974. This has resulted in even greater increases in premiums -- which does not necessarily reflect increased losses in the risks they are insuring against. Further, insurance companies' records have not clearly reflected their actual experience in any casualty liability lines.

In addition, with reference to medical liability, we believe that there are a number of special factors contributing to the increased cost:

- The growing complexity of modern medicine, coupled with the increased availability of care, creates a greater risk of untoward results.
- Media coverage of medical advances describing care and technology not even known 10 or 15 years ago, in conjunction with medical entertainment television programming, has fostered unrealistic expectations of success for all treatments. Often,

patients appear to be conditioned to underestimate the complexities and difficulties of the procedures physicians undertake and to overestimate the availability of compensation for results which are less than hoped for regardless of the reason for such results.

- The doctor-patient relationship has changed dramatically in recent years, because of increased medical specialization, the effects of urbanization, patient transiency, third party financed medical care, and the public's attitude that any untoward results should be compensated.

In the past five years in California, the rise in the number and size of claims has produced tremendous increases in physicians' liability insurance premiums -- an average of over 600% since 1972. These premiums are felt by patients in their doctors' fees, in health insurance costs and in the cost of medical care generally.

The tort liability crisis has a negative impact on both cost and availability of medical care. Defensive medicine is a term applied to the alternative of medical practice to avert the threat of possible lawsuits. Positive defensive medicine is the conducting of tests or other procedures which may be only marginally medically indicated but which are carried out because of the ever present threat of suit for professional liability. Such defensive medicine obviously adds substantially to the costs of medical care. However, there is also a negative aspect to defensive medicine, and that is the choice by physicians not to undertake certain procedures or types of practices. This negative defensive medicine has an increasingly greater effect on the availability of care -- often most strongly felt in rural or other already under-served areas.

For the past ten years, CMA has aggressively sought to reform the liability system. Unfortunately, it took a major crisis to bring the Association close to achieving any of its long standing goals. Assembly Bill 1xx, hailed by many as one of the most progressive pieces of tort reform legislation passed in America to date, fulfills some of the objectives sought by CMA. However, even with these reforms, California doctors still pay the highest professional liability premiums in the country and the number of claims and amount of awards continues to be far above the national average. Despite the passage of this legislation, insurance companies have continued to raise premiums. Only when the reforms embodied in the 1975 Medical Injury Compensation Reform Act are constitutionally confirmed will they lower costs for doctors and their patients. The California Medical Association is pleased that the question of the constitutionality of AB 1xx is now before the courts. Because of the tremendous stake physicians have in this case, the CMA is appearing as an amicus curiae. We strongly believe that the outcome of this case will be a key factor in determining the future of tort reform efforts -- though we remain uncertain as to the real dollar impact this suit will have upon medical professional liability premiums.

As you are aware, the CMA, by means of a sizeable grant, initiated the independent California Citizens' Commission on Tort Reform. We hope the Commission will recommend conceptual changes both in the broad subject of tort law and specific areas of liability as well. In addition to the Commission we are supporting another major study which is nearing completion. This is the California Medical Insurance Feasibility Study. It will determine -- without regard to negligence -- the type, frequency and

severity of events occurring in the course of medical management which might be compensable under an alternative system. Until now we have had only limited data with regard to medical adversities, with or without negligence. Most of this data is in the form of closed tort claims studies, which do not provide adequate measurement for the costs of possible alternative compensation systems, such as "no-fault." The results of this study will be publicly announced in the near future, and your Committee will be among the first to receive this information.

With regard to medical professional liability insurance, it is important to note that there has been a significant change in the type and source of coverage available to California physicians in the past few years. Nearly all of the major commercial carriers have withdrawn from this market or indicated their intention of leaving. American Mutual, Pacific Indemnity, Casualty Indemnity Exchange, Starr Insurance, The Hartford, Signal-Imperial and Aetna are no longer writing in California. The Travelers has indicated their intention to leave at the termination of their present contracts. With the commercial carriers withdrawing from the market, California physicians have been forced to set up their own insuring mechanisms, offering claims-made or claims-paid cooperative trust forms of coverage.

Until recently medical malpractice insurance was written on an occurrence basis -- covering incidents arising out of practice in the policy year without regard to the reporting or settlement of a claim. The claims-made form of insurance covers only those incidents reported during the policy year and resulting from acts in previous years during which the insured was covered by the same company. To cover claims

in years after the termination of coverage with that carrier, the physician must purchase a "reporting endorsement." Another type of coverage recently proposed is the claims-paid cooperative trust. Since the "co-ops" are fully assessable, the physician's ultimate liability is unknown. The effect of both these forms of coverage is to shift a portion of the risk from the insurer to the insured physician, because the cost of coverage of future claims is not set at the time of purchase of the original policy. Because of these considerations, the California Medical Association has worked hard to provide its members with the alternative of occurrence coverage, but has been unsuccessful to date partially due to the stringent reserve requirements of the California Department of Insurance.

The medical liability crisis involves legal doctrines and insurance, but it also involves a complex equation of medicine, doctors, nurses, hospitals and patients. Any discussion of this problem must involve an acknowledgement of the fact that modern high-quality medicine carries with it an inherent risk of untoward results regardless of the degree of skill and judgment applied. The CMA and its member physicians are constantly working to reduce any avoidable risk through a wide variety of means. CMA supported the passage of AB 1xx,which created the new Board of Medical Quality Assurance. CMA is working with the Board and its three Divisions. The Division of Licensing has recognized CMA's continuing medical education program as a proper mechanism, at no cost to the State, for accrediting educational programs and verifying compliance by individual physicians with the educational requirements for relicensure. Physicians are paying markedly higher license fees to pay for the increased disciplinary activities. However, in this regard, it should be noted that the Governor has yet to complete his appointments

to the regional medical quality review committees, though they were required to become effective more than 18 months ago on December 12, 1975. We have a liaison Committee that works directly with the Executive Committee of the Board. Also physicians representing our key committees relating to quality of care, continuing medical education and health manpower attend and take part in meetings of the Board and its Divisions.

The medical profession in California has a long history of peer review activities -- the physicians' own system to monitor and enhance the quality of care. A wide variety of voluntary programs exist to promote high quality health care and the efficient use of medical resources. We have hospital admissions committees, which may require specialty board certification for a physician to perform certain procedures. We have hospital tissue committees which retrospectively review the need for surgical procedures. There is also peer review through utilization review committees, health facilities planning groups, and county medical foundations. These local peer review activities are based on the principle that practicing physicians can best judge what constitutes good medical practice and, moreover, have the responsibility to do so. In addition, the CMA's Peer Review Commission coordinates statewide peer review activities. It provides a comprehensive information exchange for physicians. It also functions as an information resource for local peer review committees and helps resolve disputed peer review decisions.

Since 1961 practicing physicians from CMA's Medical Staff Survey teams have been invited by hospital medical staffs to help evaluate themselves and the care they render. Today California hospitals undergo Consolidated Accreditation and Licensure Surveys that are jointly conducted by CMA, the Joint Committee on Accreditation of Hospitals and the California Department of Health.

Together with the California Hospital Association the CMA co-sponsors a program of patient care audit workshops -- intensive training sessions for hospital teams of physician trustees, administrators, nurses and medical records personnel. This is not, strictly speaking, peer review since it deals with trends in patient care, not with individual cases. Team members learn to develop criteria for evaluating patient care in their own institutions. Since 1972 these workshops have trained teams from more than 350 hospitals. They have provided a valuable resource and impetus for enhancing patient care.

We believe that in spite of all of the efforts to date, the medical liability crisis has NOT diminished and problems in other areas of liability are looming ever larger on the horizon. However, we look to this Committee with confidence -- it stands as tangible recognition by the Legislature that the tort reform problem is, indeed, a deep one adversely affecting society as a whole. We hope that you will affirm the direction set by the Legislature in the passage of AB 1xx -- reforms that if allowed to stand may begin to contain costs and provide some degree of equitability and predictability in adjudication. We urge this Committee to:

- Complete its investigation as rapidly as possible in recognition of the crisis nature of this problem.

We further urge this Committee to:

- Give full consideration to the recommendations developed by the California Citizens' Commission on Tort Reform to increase the likelihood that the various segments of society and the legislative leadership can go forward together to resolve this pervasive problem. We subscribe to resolving all of the tort law ills if humanly possible. Your timely involvement in the receipt,

review, exposure and response to their recommendations is therefore crucially important. We believe that the work of your Committee will greatly benefit from the fullest possible exposure of the forthcoming CCCTR report.

Thank you for this opportunity of addressing you today. I will be happy to answer any questions.

APPENDIX VI

HOWARD HASSARD
JOSEPH S. ROGERS
ROBERT D. HUBER
SALVATORE BOSSIO
DAVID E. WILLETT
JOHN I. JEFSEN
WILLIAM B. STURGEON
GLENN L. ALLEN
GARY A. GAVELLO
JAMES N. PENROD
RICK C. ZIMMERMAN
A. ROBERT SINGER
CHARLES F. BOND, II
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HARTLEY F. PEART
(1901-1954)
GUS L. BARATY
(1910-1966)
ALAN L. BONNINGTON
(1948-1972)

July 8, 1977

Assemblyman John T. Knox
Chairman, Committee on Tort Liability
State Capitol - Room 2148
Sacramento, California 95814

Dear Mr. Knox:

I have several suggestions for legislative changes on certain portions of AB lxx (enacted in 1975 at the 2nd special session), as follows:

1. Civil Code Section 3333.1 (the collateral source statute). Section 3333.1(a) permits the introduction of evidence of collateral source benefits. Section 3333.1(b) provides:

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

The foregoing provision is at best ambiguous. What happens when the case settles before trial or before evidence of collateral source benefits is introduced pursuant to Section 3333.1(a)? Seemingly, subsection (b) would not apply. No useful purpose is served by requiring the litigants to go to trial in order to invoke subsection (b). Consideration should be given to amending subsection (b) to abrogate the subrogation rights of the collateral source in all circumstances.

2. Civil Code Section 3333.2 ($250,000 limitation for non-economic loss).

Two questions have been raised concerning this section:

a. First, where the injured plaintiff's action is joined by a Rodriquez claim by the spouse, does the $250,000 limitation provided in Section 3333.2 apply to both actions, or does each spouse have a claim for $250,000. Similarly, in a wrongful death action are all heirs limited to a maximum of $250,000 for non-economic loss? I should think so. A wrongful death action is single and unitary. However, Section 3333.2 is not entirely clear in this regard.

b. Some plaintiffs' attorneys have argued that Section 3333.2 does not apply to wrongful death actions. In my mind, the statute applies. Section 3333.2(c)(2) defines "professional negligence" as an act or omission which proximately causes personal injury or wrongful death. Application of this section generally to wrongful death actions should be reviewed in light of the Supreme Court's recent decision in Krouse v. Graham, 19 Cal.3d 59.

3. Code of Civil Procedure Section 667.7 (periodic payments). I think there is a possible question concerning the constitutionality of Code of Civil Procedure Section 667.7 under some circumstances. If the trial court's award of periodic payments under 667.7 substantially impairs or reduces the lump sum awarded by the jury, it could result in an impairment of the plaintiff's right to jury trial under Article I, Section 16 of the California Constitution. This problem would not exist if the jury were permitted to return a verdict for periodic payment.

One of the earlier drafts of Section 667.7 provided that ". . . the jury or the court, in the event the trial is without a jury, shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages." It seems to me that if the jury is allowed to determine the amount of periodic payments, the constitutional question is abated.

I am informed that evidence has been admitted in a couple of cases concerning the lump-sum cost of furnishing periodic payments by way of annuity. If the jury were permitted to determine the amount of periodic payments, it would furnish a solid basis for admitting such evidence and at the same time eliminate the constitutional question.

Other questions may arise in the future regarding implementation of AB 1xx and, if so, I will supplement this letter.

Sincerely yours,

Howard Hassard

Howard Hassard

HH:cw

APPENDIX VII

THE DOCTORS' COMPANY
An Interinsurance Exchange

July 12, 1977

Mr. Fred J. Hiestand
11th & L Building
Suite 950
Sacramento, California 95814

Dear Mr. Hiestand:

This is the typed copy of the testimony given by Ted Ellsworth, a member of our Board of Governors at your hearing on July 11, 1977. We hope it will be of help in the transcription of the tape if needed.

Very truly yours,

Leon Bluestone

Leon Bluestone,
Vice President, Marketing
Underwriter for the Professions
Attorney-in-Fact for
The Doctors' Company

LB/slb
encl.

P.S. It was a pleasure meeting you at the hearing yesterday and I look forward to working with you during the coming year on Tort Reform questions.

HOME OFFICE: 233 WILSHIRE BOULEVARD, SANTA MONICA, CA 90401 • (213) 451-9936 • (800) 352-7271
NORTHERN CALIFORNIA OFFICE: 1900 POWELL STREET, SUITE 965, EMERYVILLE, CA 94608 • (415) 654-8237

7/11/77
testimony

Good afternoon, Mr. Chairman & members of the Committee. My name is Ted Ellsworth. I live at 9043 Burrough Road, Los Angeles, California. I am a member of the California Citizens for Malpractice Reform (CCMR) which group two years ago was deeply involved in an effort to secure progressive legislation for the solution of the Medical Malpractice Insurance crisis which existed in 1975-76. My involvement with the Citizens Committee was as a representative of the California Commission on Ageing and the Los Angeles County Federation of Labor.

Our efforts and the efforts of responsible doctors working with the Legislature resulted in the passage of AB-1xx, the Tort Reform legislation of 1975.

CCMR feels that this is equitable and good legislation will play a major role in the solution of the medical malpractice insurance problems and we are pleased that the leadership of the Legislature has instituted the lawsuit to test the constitutionality of AB-1xx.

I'm sure that you are aware that the large commercial insurance carriers gave no value to the cost reduction effect of the 1975 legislation and continued to increase premiums to the point that many doctors "went bare" and others reduced or ceased to practice in protest of the cost of malpractice insurance.

In view of the inaction of the commercial companies, doctors throughout the state looked to their own resources for a solution. One responsible group of doctors decided to establish their own doctor-owned non-profit medical malpractice insurance company. The impetus was furnished by leaders previously active in the California Physicians Crisis Committee. This group of more than 1900 doctors had worked closely with CCMR and recognized that ongoing consumer input was necessary to make the company serve community as well as doctors interests. As a result of my efforts at work in CCMR for a solution they requested that I continue to work with them as a "consumer representative" on the Board of Governors of the

new company. I accepted and have served since December 1975 in that capacity. The company is called "The Doctors' Company". It now provides medical malpractice insurance to more than 3,000 doctors throughout the State. It differs from other medical malpractice insurance companies in several important ways.

1. We have set a policy of "selective underwriting". This means that we will not insure a doctor with a bad malpractice insurance case history and we review closely the medical practice characteristics of every doctor who applies. Before we issue a policy we limit the coverage to the procedures experienced underwriters feel the doctor is fully qualified to perform. This often results in a doctor ceasing to do procedures for which he has not had adequate training when he becomes aware that it is the only way we will insure him. We have had more than that 4,500 doctors apply to our company but over 1,000 applicants have been declined or not accepted the limitations required by our underwriting.

2. We are not sponsored by any medical society or association and therefore are not under pressure to insure doctors because they are in good standing and active in that organizations activities. Each applicant to The Doctors' Company comes as an individual and is evaluated by a highly experienced medical and insurance underwriting team.

3. Every applicant who has been denied or offered limited coverage has the right to appeal to an independent committee of his medical peers. More than 100 doctors have requested such review and in some cases this democratic process has resulted in a favorable revision of our initial evaluation of the applicant.

4. The company is run on a truly non-profit basis. In 1976 the company had an operating gain in excess of $505,000 after all expenses and the establishment of necessary statutory reserves. Each policyholder of record in 1976 received a dividend of 11.6% of paid premium back as a result of that favorable experience.

5. The Doctors' Company has a unique claims policy that I, as a consumer representative find reassuring. When an insured doctor with our company is obviously at fault we believe that a prompt and fair offer should be made. Most insurance companies treat most claims, justified or not, as adversary proceedings or make settlement of frivolous claims to the detriment of the practicing doctor. It is our policy as soon as an incident is reported to investigate it and seek to resolve the issue as speedily and equitably as possible.

The premiums paid by our insureds are currently less then 50% of the premiums of the commercial carriers. They are adjusted quarterly based on the actual expenses of running the program subject to approval of the Insurance Commissioner of the State who closely reviews the operations of all of the doctor owned companies set up since the new law was passed.

We believe that additional tort reform for doctors may be required as part of a part of the permanent solution of the spiraling costs of medical care. We fully supported AB-1xx and believe that it is constitutional, and hope that the State Supreme Court so rules.

We support several proposals now before the legislature that would result in expansion of "the Good Samaritan" philosophy. These proposals are in the best interest of the public as well as the medical profession.

From our limited experience we believe that there is a need for the "single purpose" insurance company such as The Doctors' Company in other lines of professional liability. While it is premature to say that we have solved the medical malpractice problem, we feel we certainly point to a solution. Other professions, now facing escalating costs year after year from the commercial insurance carriers, might look at the experience of The Doctors' Company.

While the State needs additional carefully drawn tort reform legislation that is equitable to consumers as well as to the professions, it does not appear to us that we need legislation for new insurance vehicles. The State Insurance Code provides ample law to set up mutual and reciprocal interinsurance exchanges that provide for the necessary regulations for protecting consumers and insureds.

My observation is that a single purpose company has one important advantage in that the Board of Governors of such a company can devote all of its attention to this one purpose. It does not get involved with such problems as the effect of its medical policies on its other lines of insurance coverages or the effect of its policies on other important insureds in other lines of coverage.

APPENDIX VIII

CALIFORNIA DENTAL ASSOCIATION

TISHMAN AIRPORT CENTER • P.O. BOX 91258 • LOS ANGELES, CALIFORNIA 90009 • TELEPHONE (213) 776 4292

August 2, 1977

The Honorable John T. Knox
Member of the Assembly
State Capitol, Room 2148
Sacramento, California 95814

Dear Assemblyman Knox:

I am writing to clarify in part the testimony presented by Dr. David Gaynor at the hearing of the Commission on Tort Reform regarding professional liability held in Los Angeles on July 11, 1977.

Dr. Gaynor has asked me to correspond with you since I am the past Chairman of the Council on Insurance for the California Dental Association and was involved with the meetings with the State Insurance Commissioner's Department. I did not find the Department to be unaccessible or unavailable. The only difficulty may have arisen in trying to arrange for a mutually agreeable meeting date.

After my discussion of the matter with Dr. Gaynor after the hearing, he indicated it was his intent to express our frustrations regarding the overall problem of providing adequate professional liability coverage at a reasonable rate for the 13,000 plus members of the California Dental Association. Although our rates cannot be considered to have caused a crises situation, over the past several years we have seen overall increases of 70% in 1975, 112% in 1976 and 27.5% in 1977 totalling ten million dollars just in our basic coverage. In soliciting other insurance carriers to submit a bid to cover our Association members, we are alarmed to find seventeen have declined the Group. Among these were Aetna Life & Casualty, Hartford, Travelers, St. Paul, Kemper and INA. At this point, Chubb/Pacific Indemnity Company has agreed to provide coverage through June, 1978. Chubb has indicated to us, however, that they might sever their relationship as of that date. We are concerned that the dental profession will soon follow the trend set by the medical profession and we will make every effort not to allow this to happen.

The California Dental Association is seeking other alternatives. Specifically, we have completed a feasibility study regarding the formation of a reciprocal exchange company (a type of self-insurance). However, we have been frustrated on two points:

1. Insurance Commissioner's Department denying CDA the estimated initial surplus and written premium to surplus ratio of 1.0 to 0.6 as projected by the actuarial firm of Milliman and Robertson; and

2. Unavailability of re-insurance at reasonable costs. Lloyd's of London has declined our request. As you know, without re-insurance, CDA could not assume the total risk. The American market has shown very limited interest.

It disturbs us further that the CDA may very well be forced to go into the insurance business in the near future in order to assure our practicing members liability protection at a reasonable cost.

I am hopeful that this information will help clarify any misunderstandings that may have developed from the hearing. I might add that Dr. Gaynor and I discussed the contents of this letter and he is in full accord. I will be most happy to answer any further questions you may have in the future.

Very truly yours,

Kenneth F. Fat, D.D.S.
Council on Insurance,
California Dental Association

KFF:dt

APPENDIX IX

Testimony For Joint Legislative Committee For Tort Liability Reform

Los Angeles 7/11/77

I am Lora Peluso, an independent insurance broker, specializing in errors and omissions, or professional liability insurance for architects and engineers. I am a CPCU, a member of the Political Action Committee of the Oakland Association of Independent Insurance Agents, and an associate member of the American Institute of Architects. It is primarily on behalf of the architects that I am speaking.

I would first like to address myself to the scope of the problem. Firstly, Professional Liability insurance for design professionals is very expensive. Architects use engineers as consultants for their mechanical, electrical and structural engineering on projects. The fees paid to consultants amounts to between 10%and 50% of their gross receipts. Therefore, since their insurance rates are predicated on their total gross receipts, and the rate for professional liability is approaching 3% or more the actual cost in net fees is between 5-7%. The minimum premium for firms is now between$1200 and$1500 for a limit of $100,000 with a $5000 deductible,and $2000 or more for 1 million

The deductible includes not only any actual judgements, but also any claims and claims adjustment expenses. What this actually means is if a firm is grossing $50,000, pays 20% to consultants and encounters a claim which uses up their $5000 deductible, their insurance costs are almost 20 % of their "net" gross receipts.

One company currently writing professional liability policies estimates that they receive one claims situation for every 3 policy-holders. Three years ago the figure was 1 in 4. Other professional liability carriers are also experiencing an increase in frequency of claims. This accounts in part for the rate increases seen in the past

three years. For two companies they are as follows:

	CNA	DPIC
1977	36.9	35
1976	15.5	12.5
1975	46.4	35

Some architects and engineers are choosing to "go bare", streaking as it were, because of the increased costs of insurance. This not only makes recourse difficult in the case of legitimate claims, but also exposes the assets of the firm and owners in the event of any judgement or lawsuit. This fails to protect the public and the firm from real errors and omissions.

One problem that architects have that is indigenous to their profession is what I call the lack of exclusitivity. For instance if you need surgery, you have no choice but to go to a surgeon, regardless of what his fees are. If you need a lawsuit filed, you have to consult an attorney and if you need your financial statement audited for the SEC you have to consult a CPA. However, if you want a building built, you can consult a contractor, a building designer, your next door neighbor, or a civil engineer. If architects raise their fees to fully reflect the increased costs of insuranee, they would price themselves out of the market.

Another problem is the small amount of actual compensation paid to a claimant in a claim. Of all costs which go into a settlement, it is estimated that the claimant gets approximately 20% and attorneys get 80%. This occurs when based on a contingency fee of 50%, the claimant only gets 50% of the damages anyway. In order for the insurance company to pay a dollar in indemnity, they incur legal expenses of $1.50. This is because of all claims expenses in a company, 60% is for legal fees and only 40% in indemnity payments. Therefore in order

for a claimant to get $5000, the insurance company must pay $25,000. $10,000 in indemnity of which the plaintiff's attorney gets $5000, and $15,000 in its own attorneys'fees. Surely, everyone would be better off if a more expedient system were found for indemnifying the plaintiff.

Worker's Compensation incorporating the doctrine of strict liability whereby an employee cannot seek future redress from his employer in lieu of the compensation benefits has long been the law in California. However, there is nothing in the law to prevent the injured worker from suing everyone else except his employer. For instance, a plumbing sub-contractor's worker is injured and receives worker's compensation benefits. He can then sue the owner, general contractor, other sub-contractors, architect, and all engineers on a project. This is not an uncommon practice. Of course each firm must respond with their own attorney therefore incurring defense costs to the business.

Not only do the injured worker's sue, but also their insurance companies. One of my clients in Roseville was sued by the worker's compensation carrier for the city, when the city building inspector, aged 64½ was walking the wrong way down a mechanical stair and fell, re-activating and old back injury. The architect was sued for allegedly designing an unsafe stairs. The suit was dismissed, but only ~~here~~ after substantial defense costs had been paid.

Another problem encountered by architects and engineers is the problem of "run-off " coverage. Since all professional liability policies are written on a "claims made" basis, it is the policy that is in force when the claim is made that responds to the claim. Therefore, when an individual, partership or corporation dissolves or retires. they must continue to purchase insurance if they want to protect their assets. "Run-off" coverage is currently being charged at a rate of

80% of the last year's premium, and is reduced in increments of 20% each year until a 20% level is achieved. Since the statute of limitations runs for 10 years for latent defects, I believe, and does not apply at all to third party claims, a firm almost has to insure itself forever in order to have protection, even if they go out of business.

One of the major problems is that of frivolous or "shot-gun" lawsuits. The following examples are what I consider blatant miscarriages of justice and/or the right to sue, and are only the tip of the iceberg. I am only giving brief synopses and if you want more details I can document them more fully.

1. A structual engineer is sued on a bodily injury claim in Oakland, and he is Doe # 100.
2. An architect in San Mateo had to pay $6000 in fees when his insurance company defended him under a "reservation of rights" for acting as an attorney when he provided his clien with standard AIA forms for an agreement between owner and contractor. Not only was he never paid his fees of $20,000 on the job but also was out of pocket the $6,000, plus untold expense of investigation, depositions, ulcers, etc.

3. Another architect is being sued when the only services he provided were very general schematic drawings for a home. The contractor built another home nearby which is allegedly the same and for which the architect submitted no drawings. The architect signed no drawings, and there was no contact involved yet, extensive defense costs will be incurred.

4. An architect in Lafayette is being sued by a woman, and

it turns out she has filed over 10 claims in the past several years in the same community all alleging bodily injury.

5. In Roseville, an engineer sued for $1900 in uncollected fees and is being countersued for an undetermined amount by the debtor. This is a common problem. One claims attorney told me that approximately 30% or more of their claims come from countersuits where the design professional has sued for fees. In a profession which is not only one of the oldest, but one of the lowest paid, an architect must weigh carefully any collection actions.
6. In Monterey, a drunk fell out of a second story window, the architect and structural engineer were sued for unsafely designing the window.

Surely something must be done to curb the frequency and proliferation of unjustified claims. One of our clients after incurring $10,000 in defense costs under his deductible and the insurance company incurri costs of $39,000 all in defense costs, was told by the judge as they were dismissed from the suit, " The inclusion of this firm in this lawsuit is irresponsible recklessness".

If I were a criminal and shot the attorney in the action named above, I would be entitled to:

1. A speedy trial
2. defense counsel provided free is needed
3. a presumption of innocence until proved guilty
4. no need to testify in by own behalf

However if I were a small business person, or any size one,I have to:

1. Provide by own defense
2. Have to testify against myself
3. Many complex suits last 3 to 5 years or more
4. Must prove my innocence to be dismissed from the suit

It makes one wonder why the great disparity in the way we treat our criminals as opposed to those trying to contribute to society.

What are some of the possible remedies?

WORKERS COMPENSATION

The Worker's Compensation law should be strengthened so that it is the sole and exclusive remedy for claims. If the money being spent at present were used to raise the benefits, everyone would profit.

STATUTE OF LIMITATIONS

Thought should be given so that a design professional does not have liability forever for their designs.

SMALL CLAIMS COURT WITH HIGHER THRESHOLD

If the threshold of small claims court were increased from $750 to perhaps $10,000 or $25,000, many smaller, less complex claims could be handled more speedily, efficiently and with more money going to the indemnity payment and less to attorneys.

FRIVOLOUS LAWSUITS

Some method for punishing or restricting the filing of frivolous and shot-gun lawsuits must be found. Perhaps a large bond payable to the defendant in the event the plaintiff is unsucessful or some other means of discouraging unjustified lawsuits.