WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

(Form Updated: 11/20/2008)

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ANALYSIS OF PROPOSED WISCONSIN LEGISLATION

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The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.370(2)(dj) of the statutes is created to read:

20.370 (2)(dj) Solid waste management – navigable waters. All moneys received under s. 292.71 for activities under ch. 292 related to remedial action in and adjacent to navigable waters.

SECTION 2. 292.71 of the statutes is created to read:

292.71 Fees related to removal of contaminated materials from a navigable water. The department may assess and collect fees from a person responsible, under this chapter or the federal Comprehensive Environmental Response, Compensation, and Liability Act, 42 USC 9601 to 9675, for remedial action involving the removal of at least 10,000 tons of contaminated material from the bed or banks of a navigable water. The

department may not assess a fee under this section that exceeds 25 cents per ton of contaminated material removed from the bed or banks of a navigable water. Fees collected under this section shall be credited to the appropriation account under s. 20.270 (2) (dj).

Comment:

The proposed bill authorizes the collection of certain additional fees from a responsible party for the removal of contaminated materials from navigable water. It is unclear whether such fees would be considered damages under a liability insurance policy.

SECTION 3. 632.28 of the statutes is created to read:

632.28 Environmental claims under general liability insurance policies. (1) DEFINITIONS. In this section:

(a) "All-sums policy" means a general liability insurance policy under which the insurer agrees, using such words as "all sums," "those sums," "the total sum," or similar words, to indemnify or pay on behalf of the insured all sums that the insured becomes legally obligated to pay as a result of a covered risk.

Comment:

The defined term "all-sums policy" serves in this statutory scheme to define those insurance policies under which insurers will, by virtue of the statute, face joint and several liability for 100% of a loss that takes place in part during the policy period. See SECTION 3(3). The definition is troubling in a number of respects. First, and most generally, it advances the misnomer that there exists a type of general liability coverage that is an "all-sums policy." Second, it reads words such as "all sums," "those sums," or "the total sum" out of their context in the insurance contract, ignoring the boundaries provided by other policy language. Third, it equates different policy language such as the words "all sums" with "those sums," "the total sum," or what is vaguely referenced as "similar words." The defined term "all-sums policy" is

confusing and at odds with the meaning the majority of courts have given to the policy language referenced in this provision.

An Oregon statute passed in 2003 relating to liability coverage for environmental claims (hereinafter "the 2003 Oregon Statute") applies to "general liability insurance policies," which the Statute defines as "any contract of insurance that provides coverage for the obligations at law or in equity of an insured for bodily injury, property damage or personal injury to others." ORS SECTION 1.465.475(2). The 2003 Oregon Statute definition of "general liability insurance policy" specifically includes pollution liability insurance policies, general liability policies, and excess and umbrella liability policies, and specifically excludes such policies as "claims-made policies or portions of other policies relating to claims-made policies or specialty line liability coverage such as directors and officers insurance, errors and omissions insurance or other similar policies." ORS SECTION 1.465.475(2).

Unlike the Wisconsin bill, the 2003 Oregon Statute also includes a definition of "policy" as "the written contract or agreement, and all clauses, riders, endorsements and papers that are a part of the contract or agreement, for or effecting insurance." ORS SECTION 1.465.475(5). The 2003 Oregon Statute also includes a definition of "insured" as "any person included as a named insured on a general liability insurance policy who has or had a property interest in a site in Oregon that involves an environmental claim." ORS SECTION 1.465.475(3).

(b) "Environmental claim" means a claim for defense or indemnity that is submitted under a general liability insurance policy by an insured and that is based on the insured's liability or potential liability for bodily injury or property damage arising from the presence of pollutants on the bed or banks of a navigable water in this state as a result of a release of pollutants in this state.

Comment:

The definition of "environmental claim" encompasses the term "pollutant," which is defined in Section 3(1)(e). It is limited to coverage claims under "general liability insurance" policies, and therefore would not appear to compass EIL or other specialty coverages. It requires a "release of pollutants in this state." In addition, the definition of "environmental claim" contains the requirement that pollutants be present on the bed or banks of navigable water in the state of Wisconsin.

Under the 2003 Oregon Statute, "environmental claim" means "a claim for defense or indemnity submitted under a general liability insurance policy by an insured facing, or allegedly facing, potential liability for bodily injury or property damage arising from a release of pollutants onto or into land, air or water." ORS SECTION 1.465.475(1). Contrary, under the Wisconsin bill, an "environmental claim" is limited to liability arising from pollutants on "the bed or banks of a navigable water in the state as a result of a release of pollutants in this state."

(c) "Extended underlying assertion" means an assertion by a governmental entity or other 3rd person that a person who is or was insured under one or more all-sums policies is liable for bodily injury or property damage arising from pollution in this state as a result of a release of pollutants in this state and the injury or damage occurred or is alleged to have occurred partially but not entirely during the policy period of any one all-sums policy.

Comment:

The "extended underlying assertion" definition is apparently intended to be a shorthand reference to pollution claims involving injury or damage taking place for a period of time including but not limited to during the insurance policy period. This definition is confusing in that it is unclear whether it applies to all such claims arising from damage in Wisconsin arising from the release of pollutants in Wisconsin or should be more limited, as with the definition of

"environmental claim to pollution on the bed or banks of navigable water." There is no limitation to the claimant, which may be a governmental entity or other third person. Furthermore, an "assertion" is not defined and could broadly encompass informal, unwritten allegations.

(d) "Governmental entity" means any federal, state, or local government, or any instrumentality of any of them, or any trustee for natural resources designated under 42 USC 9607 (f) (2) or 40 CFR part 300, subpart G.

Comment:

The 2003 Oregon Statute does not define "governmental entity," but rather refers throughout the Statute to the Oregon Department of Environmental Quality and the United States Environmental Protection Agency.

(dm) "Navigable waters" has the meaning given in s. 30.01 (4m).

(e) "Pollutant" means any solid, liquid, or gaseous irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalies [sic], chemicals, asbestos, petroleum products, lead, products containing lead, and waste.

Comment:

This definition of "pollutant" does not parallel the words of the definition widely used in liability policies. It explicitly references "chemicals, asbestos, petroleum products, lead, products containing lead, and waste."

(f) "Pollution" means the presence of pollutants in or on land, air, or water.

Comment:

The definition of "pollution" reveals that the scope of the terms goes beyond pollution in or on the bed of navigable waters.

The 2003 Oregon Statute does not define the terms "pollutant" or "pollution."

(2) GENERAL INTERPRETATION PROVISIONS. Except as otherwise provided in the policy, all of the following provisions apply to the interpretation of general liability insurance policies under which environmental claims are made:

Comment:

Casting the statutory provisions as "general interpretation principles" appears to be an effort to suggest that they do not retroactively alter insurance contracts, but merely "interpret" them. However, the provisions that follow do substantively alter the meaning and intent of insurance contract terms and therefore present serious state and federal constitutional concerns. Furthermore, the only qualification noted in the bill is that these provisions apply "except as otherwise provided in the policy." This is a narrow statement, which could be understood to allow an "interpretation provision" to override the clear intent of the parties, so long as the policy's exact words did not conflict with the proposed statutory provision.

The 2003 Oregon Statute states that its general interpretation provisions do not apply "if the application of the rule results in an interpretation contrary to the intent of the parties to the general liability insurance policy." ORS SECTION 2.465.480[3](7).

(a) Wisconsin law shall be applied in all cases involving environmental claims, regardless of the state in which the general liability insurance policy under which the claim is or was made was issued or delivered. Nothing in this section shall be interpreted to modify common law rules governing choice of law determinations for claims for defense or indemnity that are submitted under general liability insurance policies and that involve bodily injury or property damage arising from pollution outside this state.

Comment:

The proposed rule is an unnecessary intrusion on the ability of Wisconsin courts to determine the appropriate state law to apply to a coverage dispute. Wisconsin courts apply a "grouping of contacts" approach to choice of law questions, applying the law of the state with the most "significant contacts" with the subject matter, including the place of contracting, the

place of performance, the location of the subject matter, and the place of the parties' business. Belland v. Allstate Ins. Co., 140 Wis.2d 391, 397-98, 410 N.W.2d 611, 613-14 (Ct. App. 1987). The proposed bill improperly assumes that the location of the subject matter always has the most significant contact to a coverage dispute, which may or may not be the case. Id. ("a qualitative analysis of the contracts should be made in light of the policies of the competing jurisdictions"). Wisconsin courts must be allowed to maintain the authority to decide the appropriate law to apply.

By requiring the application of Wisconsin law to all cases involving an environmental claim, unless they arise from pollution outside the state, the statute creates serious concerns about overriding the interests of other states and the authority of other states' courts. What result is intended, for instance, where a Michigan court is determining coverage for a corporation that obtained coverage in Minnesota from a Minnesota insurer for all of its operations, which included a pollution spill that impacted both Minnesota and Wisconsin?

The 2003 Oregon Statute similarly provides for the application of Oregon law "in all cases where the contaminated property to which the action relates is located" in Oregon. ORS SECTION 2.465.480(2)(a). That statute also provides for the application of common law choice of law rules to sites located outside of Oregon.

(b) Any action taken by a governmental entity against, or any agreement by a governmental entity with, an insured in which the governmental entity, in writing, notifies the insured that it considers the insured to be potentially liable for pollution in this state, or directs, requests, or agrees that the insured take action with respect to pollution in this state, is equivalent to a suit or lawsuit as those terms are used in the general liability insurance policy.

Comment:

The Wisconsin Supreme Court addressed the meaning of "suit" in Johnson Controls, Inc. v. Employers Insurance of Wausau, et al., 264 Wis. 2d 60, 665 N.W.2d 257 (2003). The proposed language provides a meaning of "suit" that is different from Wisconsin court authority. Under the proposed bill, a government agency's written notice to a policyholder of a potential for liability for pollution, absent government compulsion and even absent a formal PRP letter, would initiate an insurer's defense obligations, despite the terms of the liability insurance policy and Wisconsin law regarding the meaning of "suit." Similarly, certain agreements between a government entity and an insured would be deemed "equivalent to a suit or lawsuit as those terms are used" in a policy, although there is no support in the policy or Wisconsin law for such a result.

Note that the provision regarding the meaning of "suit" addresses governmental claims of the policyholder's potential liability for pollution in Wisconsin.

The 2003 Oregon Statute contains a provision that states "any action or agreement by the Department of Environmental Quality or the United States Environmental Protection Agency against or with an insured in which the Department of Environmental Quality or the United States Environmental Protection Agency in writing directs, requests or agrees that an insured take action with respect to contamination within the State of Oregon is equivalent to a suit or lawsuit as those terms are used in any general liability insurance policy." ORS SECTION 2.465.480(2)(b). That statute further specifically defines "suit" or "lawsuit" as including but not limited to "formal judicial proceedings, administrative proceedings and actions taken under Oregon or federal law, including actions taken under administrative oversight of the Department

of Environmental Quality or the United States Environmental Protection Agency pursuant to written voluntary agreements, consent decrees and consent orders." ORS SECTION 2.465.480(1)(a).

(c) The insurer may not deny coverage for any reasonable and necessary fees, costs, and expenses, including costs and expenses of assessments, studies, and investigations, that are incurred by the insured under a voluntary written agreement, consent decree, or consent order between the insured and a governmental entity and as a result of a written direction, request, or agreement by the governmental entity to take action with respect to pollution in this state, on the ground that those expenses constitute voluntary payments by the insured.

Comment:

This provision purports to require that an insurer provide coverage for all costs incurred by the policyholder even absent legal compulsion and without the insurer's consent. This would violate clear terms of many liability policies, which exclude coverage for voluntary payments by a policyholder and provide coverage only for "damages." Moreover, despite the introductory statement in Section (2) that the general interpretation provisions apply "except as otherwise provided in the policy," this paragraph seemingly purports to override "voluntary payments" provisions.

The 2003 Oregon statute contains a provision also requiring coverage for such costs voluntarily incurred by a policyholder, providing that "[i]nsurance coverage for any reasonable and necessary fees, costs and expenses, including remedial investigations, feasibility study costs and expenses, incurred by the insured pursuant to a written voluntary agreement, consent decree or consent order between the insured and either the Department of Environmental Quality or the United States Environmental Protection Agency, when incurred as a result of a written direction, request or agreement by the Department of Environmental Quality or the United States

Environmental Protection Agency to take action with respect to environmental contamination within the State of Oregon, shall not be denied the insured on the ground that such expenses constitute voluntary payments by the insured." ORS SECTION 2.465.480(2)(c).

(3) RULES FOR INTERPRETING ALL-SUMS POLICIES. In the absence of an express provision requiring proration of losses for an environmental claim that is based on an extended underlying assertion, all of the following rules apply to the interpretation of all-sums policies under which environmental claims that are based on extended underlying assertions are made:

Comment:

Again, the bill purports to apply rules for "interpretation" of policies, rather than to alter insurance contract terms. However, the provisions seek to fundamentally alter the risk assured by insurers and impose joint and several liability for damages when any portion of the harm takes place during the policy period. Further, the qualification making the provision inapplicable only in the event of "an express provision requiring proration of losses for an environmental claim that is based on an extended underlying assertion" contains such narrow language that it may be interpreted not to encompass language limiting coverage to damage taking place "during the policy period" or even other insurance clauses. Therefore, this provision may have the affect of retroactively altering the terms of insurance contracts presenting serious state and federal constitutional concerns.

(a) An insurer may not reduce coverage otherwise available to an insured under an all-sums policy because the claim involves bodily injury or property damage that occurred, in part, outside the policy period of that all-sums policy, regardless of whether other valid or collectible insurance is available to the insured for the injury or damage that occurred outside that policy period.

Comment:

Wisconsin appellate courts have not yet addressed the proper method of allocating continuous and indivisible property damage liability among multiple triggered policies issued by different insurers. See, e.g., Society Ins. v. Town of Franklin, 233 Wis. 2d 207, 218 n. 1 (Ct. App. 2000) ("Because one insurer issued all [of] the policies here, we need not address how liability would be allocated were there multiple insurers."). This provision seeks to impose liability up to the full policy limits on insurers for all harm when any portion of the damage takes place during the period insured regardless of whether the majority of the damage took place outside of the policy period. This provision appears to hold that an insurer cannot allocate damages to uninsured policy periods (including periods where the insured chose to go without coverage or missing policy periods) or prorate the amount of coverage under the policy based on time-on-the risk or other recognized allocation law.

The 2003 Oregon Statute explicitly provides for allocation to a policyholder for periods in which the policyholder "failed to purchase and maintain" coverage for environmental liabilities, which the insurer bears the burden of proving. ORS SECTION 2.465.480 (4)(d), ORS SECTION 2.465.480(b). This is further discussed in the Contribution provisions at (6) CONTRIBUTION AMONG INSURERS below.

(b) If an environmental claim is submitted under one or more all-sums policies and involves bodily injury or property damage that occurred, or that may have occurred, during 2 or more policy periods, all of the following apply:

1. Each insurer that provided coverage for a policy period and that has a duty to defend under the policy is jointly and severally liable to the insured for the full amount of the insured's costs of defending against the extended underlying assertion, subject to any applicable limits of liability.

Comment:

As in (a) above, this provision appears to override policy language and case law providing for each insurer to pay a share of costs in accordance with the risks it assumed. It is not clear whether the restriction to the "applicable limits of liability" refers to a policy's explicit limits of liability for defense costs or a policy's limits of liability generally.

The 2003 Oregon Statute provides that an insurer that "has a duty to pay all sums arising out of a risk covered by the policy, must pay all defense or indemnity costs, or both, proximately arising out of the risk pursuant to the applicable terms of its policy, including its limit of liability, independent and unaffected by other insurance that may provide coverage for the same claim." ORS SECTION 2.465.480(3)(a).

2. Each insurer that provided coverage for a policy period and that has a duty to pay any costs of a settlement or judgment under the policy is jointly and severally liable to the insured for the full amount of the settlement or judgment for the extended underlying assertion, subject to any applicable limits of liability.

Comment:

This provision addresses indemnity as opposed to defense costs, but otherwise parallels Section 3(3)(b)1.

3. The insured may designate a policy period, and the policy or policies providing coverage for that period, including primary, umbrella, and excess coverage, shall provide full coverage, subject to any applicable limits of liability. If the environmental claim is not fully satisfied from policies covering that policy period, the insured may designate the order of other policy periods, and the policy or policies providing coverage for each of those periods, including primary, umbrella, and excess coverage, shall provide full coverage, subject to any applicable limits of liability, in that order until the environmental claim is fully paid.

Comment:

This provision allows an insured to "pick and choose" the policy period that it would like to cover its defense and indemnity costs for environmental injury, regardless of whether a majority of the alleged damage actually occurred outside that policy period. The provision allows the insured to pick the order of policies that it would like to exhaust. Once the policy period is chosen, the provision apparently allows the insured to stack its policies and avoid horizontal exhaustion. Although it is not clear, the provision appears to require the vertical exhaustion of the policy period that the insured picks to apply before the insured can pick another period.

This provision goes much further in imposing a pro-policyholder, coverage-maximizing result than even the Oregon law. The 2003 Oregon Statute provides a method in which the policyholder must choose the policies that respond, based on "(A) The total period of time that an insurer issued a general liability insurance policy to the insured applicable to the environmental claim; (B) The policy limits, including any exclusions to coverage, of each of the general liability insurance policies that provide coverage or payment for the environmental claim; or (C) The policy that provides the most appropriate type of coverage for the type of environmental claim for which the insured is liable or potentially liable." ORS SECTION 2.465.480(3)(b)(A)-(C).

The 2003 Oregon Statute also requires the policyholder to provide notice of the claim to all insurers that issued "all-sums" policies for the applicable periods, stating that, "[i]f an insured who makes an environmental claim under general liability insurance policies that provide that an insurer has a duty to pay all sums arising out of a risk covered by the policy has more than one such general liability insurance policy insurer, the insured shall provide notice of the claim to all

such insurers for whom the insured has current addresses." ORS SECTION 2.465.480(3)(b). Under the 2003 Oregon Statute, the policyholder, if requested by an insurer, must also "provide information regarding other general liability insurance policies held by the insured that would potentially provide coverage for the same environmental claim." ORS SECTION 2.465.480(3)(c).

4. If the insured makes a designation under subd. 3., the coverage available to the insured under a policy providing coverage for a designated policy period, including primary, umbrella, and excess coverage, may not be reduced by the actual or potential availability of coverage for other policy periods.

Comment:

This provision requires payment under any policy that the insured "picks and chooses" without regard to whether the damage mostly occurred outside the policy period and that other policies cover such periods. This provision therefore conflicts with policy provisions limiting coverage to damage "during the policy period" or addressing other insurance. It also conflicts with the majority view of courts nationwide, which provides for allocation of liability where harm occurs in multiple policy periods, requiring an insurer to pay only its fair share.

(4) SUIT ON ENVIRONMENTAL CLAIM. In any lawsuit involving an environmental claim, all of the following apply:

(a) The insured may elect to file suit against fewer than all insurers providing coverage for the claim, notwithstanding ss. 803.03 and 806.04 (11).

Comment:

This provision sets up a situation that will require additional judicial and private resources for subsequent litigation to properly allocate liability among all insurers and the policyholder.

(b) All of the following are rebuttable presumptions:

1. That the costs of preliminary assessments, remedial investigations, risk assessments, feasibility studies, site investigations, or other necessary investigation are defense costs payable by the insurer, subject to the provisions of the general liability insurance policy under which there is coverage for the costs.

Comment:

Unless the policy specifies otherwise, an insurer's defense obligations are expanded to include the insured's preliminary and investigative studies, even if such costs were not incurred to actually defend the suit. This may expand an insurer's potential obligations because the policy may not provide for a limit of liability for such "defense costs."

2. That the costs of removal actions, remedial action, or natural resource damages are indemnity costs and that payment of those costs by the insurer reduces the insurer's applicable limit of liability on the insurer's indemnity obligations, subject to the provisions of the general liability policy under which there is coverage for the costs.

Comment:

The proposed bill expands the scope of an insurer's indemnity obligations, broadening damages to include "removal actions, remedial action, or natural resource damages" which count towards the applicable limit of liability, apparently even if such costs were incurred prior to legal compulsion, unless the insurer can show that such costs are not covered "damages." It would appear to be unnecessary and inappropriate for the bill to address this issue because the Wisconsin Supreme Court in Johnson Controls, Inc. v. Employers Insurance of Wausau, et al., 264 Wis. 2d 60, 665 N.W.2d 257 (2003), held that "an insured's costs of restoring and remediating damaged property, whether the costs are based on remediation efforts by a third party (including the government) or are incurred directly by the insured, are covered damages under the applicable CGL policies, provided that other policy exclusions do not apply."

The 2003 Oregon Statute similarly provides that "[t]here is a rebuttable presumption that payment of the costs of removal actions or feasibility studies, as those terms are defined by rule by the Department of Environmental Quality, are indemnity costs and reduce the insurer's applicable limit of liability on the insurer's indemnity obligations, subject to the provisions of the applicable general liability insurance policy or policies." ORS SECTION 2.465.480(6)(a).

(c) The court shall award to an insured the sum of the costs, disbursements, and expenses, including accounting fees and reasonable attorney fees notwithstanding s. 814.04 (1), necessary to prepare for and participate in an action in which the insured successfully litigates a coverage issue for an environmental claim.

Comment:

This provision provides for the payment of an insured's attorneys fees, in addition to other costs associated in successfully litigating a coverage claim involving an insured's environmental claim. There is support in current Wisconsin law for insureds to recover attorneys fees in litigating coverage claims. See Elliot v. Donahue, 169 Wis.2d 310, 485 N.W. 2d 403 (1992). On the other hand, this approach is contrary to the American Rule, requiring each litigant to bear its own costs and exceptions to that rule should be narrowly read and applied.

(d) 1. An insurer under a general liability insurance policy under which an environmental claim is made that has not entered into a good faith settlement and release of the environmental claim with the insured is liable, up to the amounts stated in the policy, to any governmental entity that seeks to recover against the insured for pollution in this state, irrespective of whether the liability is presently established or is contingent and to become fixed or certain by final judgment.

Comment:

This provision appears to create a direct right of action by any governmental entity against any insurer against whom an environmental claim is made that has not entered a settlement with the insured.

2. An insurer under subd. 1. may be proceeded against directly and may be joined in any action brought by the governmental entity against the insured.

Comment:

The proposed bill authorizes direct actions by a governmental agency to recover from an insurer against whom an environmental claim is made and that has not entered into a good faith settlement with the policyholder. Wisconsin law, by statute, allows tort claimants with a negligence claim a right of direct action against insurers. Decade's Monthly Income & Appreciation Fund by Keierleber v. Whyte, 173 Wis. 2d 665, 671, 495 N.W. 2d 335, 337 (Wis. 1993) (sec. 632.24, Stats provides that "any . . . policy of insurance covering liability to others for negligence makes the insurer liable . . . to the persons entitled to recover against the insured . . . irrespective of whether the liability is presently established or is contingent and to become fixed or certain by final judgment against the insured"). Accordingly, Wisconsin has departed from the general rule prohibiting direct actions against insurers in other settings. This provision would create substantial dislocations, since the insurer is not well-situated to develop the policyholder's defenses to underlying liability.

(5) EFFECT OF SETTLEMENT. An insurer that enters into a good faith settlement and release of an environmental claim, or an insurer that has entered into a good faith settlement and release of an environmental claim before the effective date of this subsection . . . [revisor inserts date], shall not be liable to any person for the claim. Entering into a good faith settlement and release of an environmental claim with an insurer does not reduce or otherwise impair the right of an insured to recover the full balance of its actual loss as provided in this section from an insurer that has not entered into a good faith settlement and release of the claim.

Comment:

This provision appears to protect settling insurers from contribution or other claims. Instead of applying a set off for their share of liability, however, it purports to make other insurers liable for any amount the policyholder compromised in settlement.

(6) CONTRIBUTION AMONG INSURERS. An insurer that pays an environmental claim, or an insurer that paid an environmental claim before the effective date of this subsection . . . [revisor insures date], may seek contribution from any other insurer that is liable or potentially liable for the claim and that has not entered into a good faith settlement and release of the environmental claim with the insured.

Comment:

This provision allows contribution claims against other insurers, except those who have entered into good faith settlements and releases with the insured. It does not address allocation of liability to the policyholder.

The 2003 Oregon Statute allows for an insurer "that has paid an environmental claim [to] seek contribution from any other insurer that is liable or potentially liable." ORS SECTION 2.465.480(4). That section provides that, "[i]f a court determines that the apportionment of recoverable costs between insurers is appropriate, the court shall allocate the covered damages between the insurers . . . based on . . . : (a) The total period of time that each solvent insurer issued a general liability insurance policy to the insured applicable to the environmental claim; (b) The policy limits, including any exclusions to coverage, of each of the general liability insurance policies that provide coverage or payment for the environmental claim for which the insured is liable or potentially liable; (c) The policy that provides the most appropriate type of coverage for the type of environmental claim; and (d) If the insured is an uninsured for any part

of the time period included in the environmental claim, the insured shall be considered an insurer for purposes of allocation." ORS SECTION 2.465.480(4)(a)-(d). The contribution provisions further permit allocation to an insured for uninsured periods for defense costs, providing that "[i]f an insured is an uninsured for any part of the time period included in the environmental claim, an insurer who otherwise has an obligation to pay defense costs may deny that portion of defense costs that would be allocated to the insured under [the contribution provisions] of this section." ORS SECTION 2.465.480(5).

The 2003 Oregon Statute defines an "uninsured" as "an insured who, for any period of time after January 1, 1971, that is included in an environmental claim, failed to purchase and maintain an occurrence-based general liability insurance policy that would have provided coverage for the environmental claim, provided that such insurance was commercially available at such time. A general liability insurance policy is 'commercially available' if the policy can be purchased under the Insurance Code on reasonable commercial terms." ORS SECTION 2.465.480(b). However, the 2003 Oregon Statute provides that, "[n]otwithstanding any other provision of law, an insurer that is a party to an action based on an environmental claim for which a final judgment as to all insurers has not been entered by the trial court on or before the effective date of this 2003 Act and in which a binding settlement has been reached on or before the effective date of this 2003 Act between the insured and at least one insurer that was a party to the action may not seek or obtain contribution from or allocation to: (a) The insured; or (b) Any other insurer that prior to the effective date of this 2003 Act reached a binding settlement with the insured as to the environmental claim." ORS SECTION 5.465.475(3)-(4).

(7) LOST POLICY. (a) In this subsection, "lost policy" means "all or any part of a general liability insurance policy that is subject to an environmental claim and that is ruined, destroyed, misplaced, or otherwise no longer possessed by the insured.

Comment:

The 2003 Oregon Statute defines "lost policy" as "any part or all of a general liability insurance policy that is alleged to be ruined, destroyed, misplaced or otherwise no longer possessed by the insured." ORS SECTION 1.465.475(4). The 2003 Oregon Statute further defines "policy" as including "all clauses, rides, endorsements and papers that are part of the contract or agreement, for or effecting insurance." ORS SECTION 1.465.475(5).

(b) If, after a diligent investigation by an insured of the insured's own records, including computer records and the records of past and present agents of the insured, the insured is unable to reconstruct a lost policy, the insured may provide notice of the lost policy to the insurer that the insured believes issued the policy. The notice must be in writing and in sufficient detail to identify the person or entity claiming coverage, including the name of the alleged policyholder, if known and any other material facts concerning the lost policy known to the person providing the notice.

Comment:

The provision does not define a "diligent investigation" of the insured's own records, "including the records of past and present agents of the insured." Furthermore, to provide written notice to any insurer that the insured believes issued a lost policy, and the insured must only provide the identity of the person claiming coverage, the name of the alleged policyholder, if known and any other known material facts. Section 3. 632.28 (7)(b).

The 2003 Oregon Statute similarly provides that "[i]f, after a diligent investigation by an insured or the insured's own records, including computer records and the records of past and present agents of the insured, the insured is unable to reconstruct a lost policy, the insured may provide a notice of a lost policy to an insurer." ORS SECTION 4.465.475(1). The 2003 Oregon

Statute also provides that "notice of a lost policy" means "written notice of the lost policy in sufficient detail to identify the person or entity claiming coverage, including information concerning the name of the alleged policyholder, if known, and material facts concerning the lost –policy known to the alleged policyholder." ORS SECTION 4.465.475(10).

(c) An insurer must thoroughly and promptly investigate a notice of a lost policy and must provide to the insured claiming coverage under the lost policy all facts known or discovered during the investigation concerning the issuance and terms of the policy, including copies of documents establishing the issuance and terms of the policy.

Comment:

This provision imposes on the insurer duties to investigate and to provide the insured with information and documents. There are lesser obligations on the person claiming coverage.

The 2003 Oregon Statute similarly provides that "[a]n insurer must investigate thoroughly and promptly a notice of a lost policy. An insurer fails to investigate thoroughly and promptly if the insurer fails to provided all facts known or discovered during an investigation concerning the issuance and terms of a policy, including copies of documents establishing the issuance and terms of a policy, to the insured claiming coverage under a lost policy." ORS SECTION 4.465.475(2).

(d) For facilitating reconstruction, and determining the terms, of a lost policy, the insurer and the insured must comply with the following minimum standards:

1. Within 30 business days after receipt by the insurer of notice of a lost policy, the insurer shall commence an investigation into the insurer's records, including computer records, to determine whether the insurer issued the lost policy. If the insurer determines that it issued the policy, the insurer shall commence an investigation into the terms and conditions relevant to any environmental claim made under the policy.

Comment:

As noted above, this provision imposes duties on the insurer but not on the person claiming coverage.

The 2003 Oregon Statute contains an identical provision stating "[w]ithin 30 business days after receipt by the insurer of notice of a lost policy, the insurer shall commence an investigation into the insurer's records, including computer records, to determine whether the insurer issued the lost policy. If the insurer determines that it issued the policy, the insurer shall commence an investigation into the terms and conditions relevant to any environmental claim made under the policy." ORS SECTION 4.465.475(3)(a).

2. The insurer and the insured shall cooperate with each other in determining the terms of a lost policy. The insurer and the insured shall provide to each other the facts known or discovered during an investigation, including the identity of any witnesses with knowledge of facts related to the issuance or existence of the lost policy, and shall provide each other with copies of any documents establishing facts related to the lost policy.

Comment:

In this section, both the alleged insured and insurer must cooperate in determining the terms of a lost policy and disclose facts known or discovered during investigation, including the identity of witnesses and any documents establishing facts related to the lost policy.

The 2003 Oregon Statute contains an identical provision, requiring that "[t]he insurer and the insured shall cooperate with each other in determining the terms of a lost policy." ORS SECTION 4.465.475(3)(b). That provision states that "[t]he insurer and the insured: (A) Shall provide to each other the facts known or discvoered during an investigation, including the idnetify of any witnesses with knowledge of factgs related to the issuaance or existence of a lost policy [and] (B) Shall provide each other with copies of documents establishing facts related to the lost policy." ORS SECTION 4.465.475(3)(b)(A),(B). Unlike the Wisconsin bill, however, the

2003 Oregon Statute provides that the parties "[a]re not required to produce material subject to a legal privilege or confidential claims documents provided to the insurer by another policyholder. ORS SECTION 4.465.475(3)(b)(C).

3. An insurer that discovers information tending to show the existence of an insurance policy that applies to the claim shall provide an accurate copy of the terms of the policy or a reconstruction of the policy. If the insured discovers information tending to show the existence of an insurance policy that applies to the claim, the insurer shall provide an accurate copy of the terms of the policy or a reconstruction of the policy upon the request of the insured.

Comment:

This section erroneously presumes the existence or ability to reconstruct a policy if information "tending to show" its existence is found.

The 2003 Oregon Statute does not require the insurer to provide a copy of the terms of the policy in any instance. Instead, the 2003 Oregon Statute provides "If the insurer or the insured discovers information tending to show the existence of an insurance policy applicable to the claim, the insurer or the insured shall provide an accurate copy of the terms of the policy or a reconstruction of the policy, upon the request of the insurer or the insured." ORS SECTION 4.465.475(3)(c).

4. If the insurer is not able to locate portions of the policy or determine its terms, conditions, or exclusions, the insurer shall provide copies of all insurance policy forms issued by the insurer during the applicable policy period that potentially apply to the environmental claim. The insurer shall identify which of the potentially applicable forms, if any, is most likely to have been issued by the insurer to the insured, or the insurer shall state why it is unable to identify the forms after a good faith search.

Comment:

This provision is not appropriately limited and may impose undue burdens on the insurer.

The 2003 Oregon Statute contains a nearly identical provision that states "[i]f the insurer is not able to locate portions of the policy or determine its terms, conditions or exclusions, the insurer shall provide copies of all insurance policy forms issued by the insurer during the applicable policy period that are potentially applicable to the environmental claim. The insurer shall state which of the potentially applicable forms, if any, is most likely to have been issued by the insurer, or the insurer shall state why it is unable to identify the forms after a good faith search." ORS SECTION 4.465.475(3)(d).

However, unlike the Wisconsin bill, the 2003 Oregon Statute contains further provisions that provide: "(4) Following the minimum standards established in this section does not create a presumption of coverage for an environmental claim once the lost policy has been reconstructed [and that] (5) Following the minimum standards established in this section does not constitute: (a) An admission by an insurer that a policy was issued or effective; or (b) An affirmation that if the policy was issued, it was necessarily in the form produced, unless so stated by the insurer." ORS SECTION 4.465.475(4)-(5).

e. If, based on information discovered in the investigation of a lost policy, the insured can show by a preponderance of the evidence that a general liability insurance policy was issued to the insured by the insurer but cannot produce evidence that tends to show the policy limits applicable to the policy, it shall be assumed that the minimum limits of coverage, including any exclusions to coverage, that the insurer offered during the period in question under such policies apply to the policy purchased by the insured. If, however, the insured produces evidence that tends to show the policy limits applicable to the policy, the insurer has the burden of proof to show by a preponderance of the evidence that different policy limits, including any exclusions to coverage, apply to the policy purchased by the insured.

Comment:

This provision introduces a "preponderance of the evidence" standard for proof of policies. Wisconsin courts have previously applied a "clear and convincing" standard with respect to lost policies. See Menasha Electric and Water, et al. v. American Employers Ins., et al., No. 93-CV-625 (Wis. Cir. Ct. Aug. 14, 1995)(noting that "it's well established that . . . the contents of a lost instrument must be shown with particularity by strong and convincing evidence" and that "[a] party seeking to recover upon a lost instrument must not only prove by clear and convincing evidence the instrument is, or the instrument formally existed, but also that the instrument contains certain language").

If a preponderance of the evidence shows that a policy was issued but the policy limits are unknown, the provision states that the applicable limits shall be the minimum limits that the insurer was offering at the time. This would apparently eliminate the need to show any evidence or policy limits, and creates an unfair and unworkable standard by referring vaguely to the "minimum" limits of coverage. If the insured produces evidence showing policy limits, the provision shifts the burden to the insurer to prove that different policy limits apply. This is inconsistent with the majority view on proof of policy issues.

The 2003 Oregon Statute contains similar language providing "[i]f, based on the information discovered in an investigation of a lost policy, the insured can show by a preponderance of the evidence that a general liability insurance policy was issued to the insured by the insurer, then if: (a) The insured cannot produce evidence that tends to show the policy limits applicable to the policy, it shall be assumed that the minimum limits of coverage, including any exclusions to coverage, offered by the insurer during the period in question were purchased by the insured[;] (b) The insured can produce evidence that tends to show the policy

limits applicable to the policy, then the insurer has the burden of proof to show that a different policy limit, including any exclusions to coverage, should apply." ORS SECTION 4.465.475(6)(a)-(b).

Unlike the Wisconsin bill, the Oregon statute further provides, however, that "[a]n insurer may claim an affirmative defense to a claim that the insurer failed to follow the minimum standards established under this section if the insured fails to cooperate with the insurer in the reconstruction of a lost policy under this section." ORS SECTION 4.465.475(7). The 2003 Oregon Statute also provides that "[v]iolation by an insurer of any provision of this section or any rule adopted under this section is an unfair claim settlement practice under ORS 746.230." ORS SECTION 4.465.475(9).

(8) PUBLIC RIGHTS AND INTEREST. In applying the provisions under this section, any party or court acting under this section shall ensure that public rights and interests are considered for the purpose of furthering the public trust in navigable waters.

Comment:

This provision may be seen as urging that insurers be treated as a deep-pocket to finance clean ups, although the public interest actually will be served through straightforward application of insurance contracts terms.

(9) ENFORCEMENT. Any person who is injured by a violation of this section by an insurer may bring a civil action against the insurer to recover damages together with costs, disbursements, accounting fees, if any, and reasonable attorney fees incurred in bringing the action, notwithstanding s. 814.04 (1).

Comment:

This provision creates a new course of action against insurers.

(10) APPLICABILITY. (a) This section applies to all environmental claims that are not settled or finally adjudicated on or before the effective date of this subsection . . . [revisor inserts date], regardless of when the claim arose.

Comment:

This section does not eliminate constitutional and equitable concerns about the retroactive application of provisions of the proposed legislation.

The 2003 Oregon Statute contains a provision stating that the Statute "appl[ies] to all claims, whether arising before, on or after the effective date of th[e] 2003 Act." ORS SECTION 5.465.475(1). The 2003 Oregon Statute further provides that the Statute "do[es] not apply to any claim for which a final judgment, after exhaustion of all appeals, was entered before the effective date of this 2003 Act." ORS SECTION 5.465.475(2).

The 2003 Oregon Statute further provides, however, that "[n]othing in [the Statute] may be construed to require the retrying of any finding of fact made by a jury in a trial of an action based on an environmental claim that was conducted before the effective date of this 2003 Act." ORS SECTION 5.465.475(3).

(b) This section applies to all environmental claims specified in par. (a). regardless of the state in which the general liability insurance policy under which the claim is or was made was issued or delivered.

Comment:

This provision again raises concerns about overriding the interests and rights of other states and courts of other jurisdictions.

The 2003 Oregon Statute does not contain a specific provision stating that the section applies to all claims "regardless of the state in which the general liability insurance policy under

which the claim is or was made was issued or delivered," although the provision generally states that the Statute "appl[ies] to all claims." ORS SECTION 5.465.475(1).

(11) CONSTRUCTION. Nothing in this section shall be construed to raise or support any inference that it is the intention of the legislature to change the common law of this state with respect to the interpretation of general liability insurance policies not subject to this section.

Comment:

This section underscores a serious concern about the selective and inconsistent application of the legislation, which could lead to inconsistent construction of the same policy and inconsistent treatment of policyholders.

(END)

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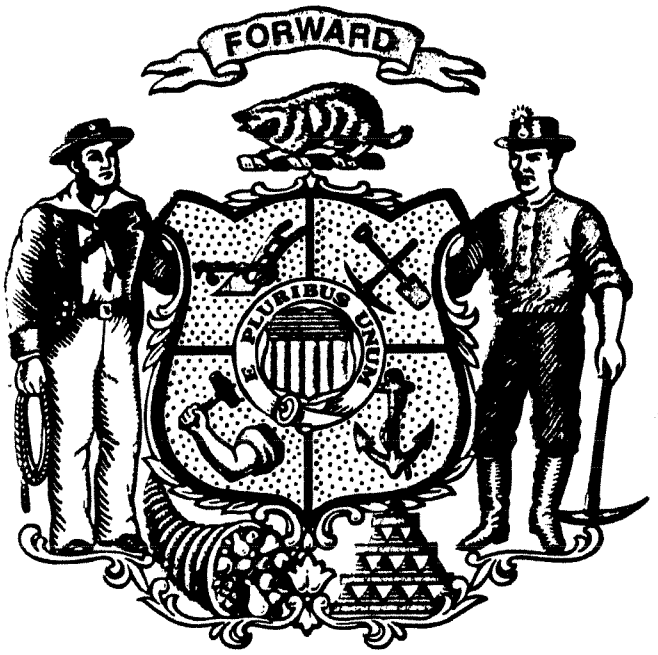
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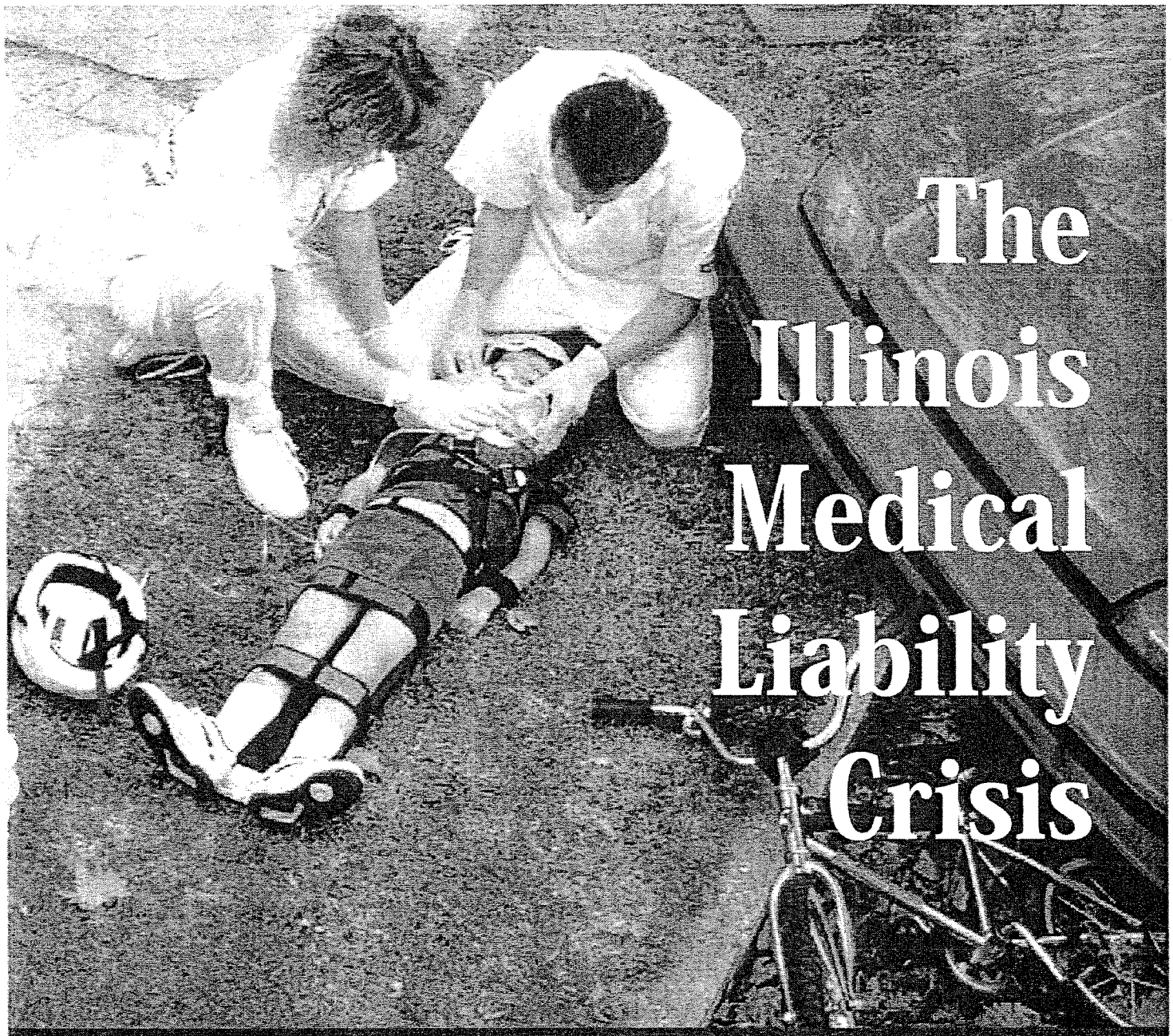


The Illinois Medical Liability Crisis

Keep Our Doctors in Illinois

www.conditioncritical.org

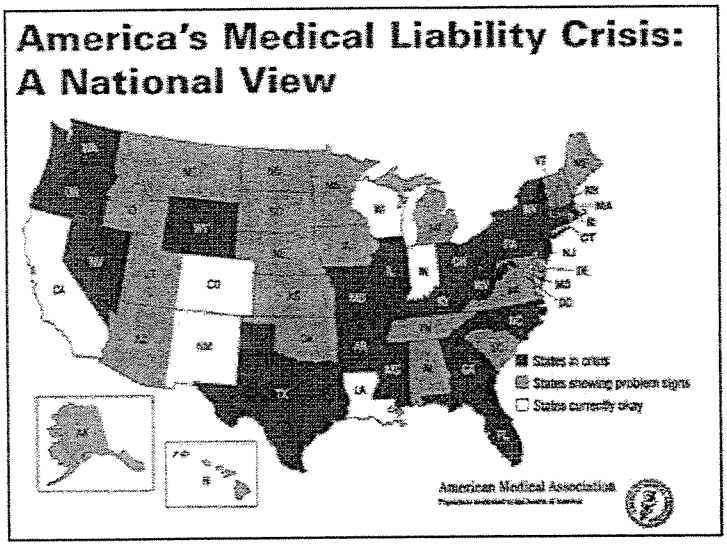
Illinois Hospital Association IHA

Contents

The Root Cause of Illinois' Medical Liability Crisis: The State's Inefficient and Unpredictable Judicial System

The Medical Liability Crisis Endangers Patients

Illinois doctors are cutting back on high-risk services, retiring early, or leaving to practice in another state. The ability of hospitals to provide care is compromised. Patients are endangered. Illinois is one of 20 states identified by the American Medical Association as being in a full-blown medical liability crisis, jeopardizing patient access to the health care they need.



Consider the following all too typical consequences of the current medical liability system in Illinois:

- Physicians are leaving Illinois for states with more reasonable approaches to medical liability.
- Women with difficult pregnancies are struggling to find and maintain relationships with their obstetricians.
- Patients with serious brain injuries are waiting longer to find brain surgeons to treat them.
- Fewer doctors are available to treat emergencies of all kinds in hospital emergency rooms throughout the state (trauma patient transfers to St. Louis from Illinois have doubled in the past three years).
- Every patient visit to a doctor costs more.
- Every hospital stay costs more.
- Every health insurance premium is higher.

The Judicial System is Causing the Crisis

Why are these things happening? Skyrocketing medical liability costs are causing the problem, but what's causing these costs to spiral out of control?

The answer is a **dysfunctional and inefficient judicial system** that leads to excessive and unpredictable awards. Excessive and unpredictable medical liability awards drive up the cost of medical liability insurance for doctors and hospitals. About two-thirds of the money being awarded comes in the form of non-economic damages. So the big driver of big awards is not medical costs or lost wages. It is the incalculable losses attributed to pain and suffering. As a result, we are seeing awards in excess of $1 million in Illinois increase at an alarming rate.

What makes these awards excessive? Consider the following:

- Awards for a patient's non-economic damages, such as pain and suffering, are inherently arbitrary by definition.
- Juries are not given the ability to award damages for future medical care through life insurance annuities at a fraction of the cost awarded today.
- Juries are not told that awarding damages to punish providers is not allowed in Illinois.
- Juries are not told that awards are tax-exempt.
- Juries are not told that pain and suffering damages may not be based on the actions or wealth of the provider.

A judicial system with these defects costs all of us money and reduces access to life-saving health care. A well-informed jury that is given a reasonable range for awarding non-economic damages and a structure for calculating future medical damages using annuities is less likely to reach excessive or inappropriate verdicts.

The Insurance Industry is Not Causing the Crisis

All individuals, businesses, physicians and hospitals purchase insurance for essentially the same reason: to protect against catastrophic financial loss. Without insurance, a catastrophic loss may be devastating to the one incurring it. When insurance becomes unavailable, individuals and enterprises must cease engaging in the activity that exposes them to great loss or risk financial ruin. That is the situation facing Illinois hospitals and physicians today.

Medical liability insurers are abandoning Illinois. In Cook County, where most of the medical liability litigation in Illinois takes place, hospitals have become de facto insurers for medical liability claims. The few and diminishing number of hospital insurers in Cook County are requiring hospitals to assume huge amounts of liability before the insurer bears any of the loss. In other words, the first ten to fifteen million dollars of each claim must be borne by the hospital no matter how many claims

the hospital may experience during the coverage period. Hospitals have no insurance for claims up to these massive amounts; they are their own insurers. They are forced to undertake an insurance activity and assume a risk that a massive national or multi-national insurance company refuses to assume.

As a result, about 70 percent of the hospitals in Illinois are either self-insured or insured by risk pooling trusts that they own and control. These not-for-profit hospitals that issue no stock are not maximizing profits for shareholders. Nor are they overcharging or gouging themselves to make a profit. The medical liability costs of hospitals in Illinois reflect what the actual current medical liability system costs. Insurers have nothing to do with these costs. Insurers have simply left the Illinois market, leaving hospitals to fend for themselves.

Several years ago, more than 30 insurance companies competed to insure physicians in Illinois. In 2001, that number shrank to only 17. And since then another dozen have left the Illinois market. Compounding the problem of insurance scarcity in Illinois, the state's largest physician insurer is not offering coverage to physicians who are not part of a group it already insures or is not a new physician just starting out in the practice of medicine.

The premium setting challenge. In June of 2003, the General Accounting Office found that anticipated losses of medical liability insurers are "the primary determinant of premium rates." Premium setting is a complicated, multi-factored exercise that involves a considerable degree of forecasting. The key predictions that must be made in this process include the following:

- How often will the insured be sued during the coverage period? (claim frequency)
- How expensive will these claims be? (claim severity based on future calculations of economic and non-economic losses)
- How much will it cost to resolve these claims? (attorneys' fees, administrative expenses)
- What will be the claim frequency and severity for this geographic region?
- How much premium will the company need to collect today to pay claims brought in future years?
- What will the company's investments in stocks and bond yield over time?
- How will the company's premiums compare to the competition?

The Medical Liability Crisis: A Tragedy Barely Averted

On April 2, 2004, 15-year old Alex, a freshman at Naperville Central High School, went to a local elementary school with friends to play whiffle ball on the asphalt playground that is immediately adjacent to the brick school building.

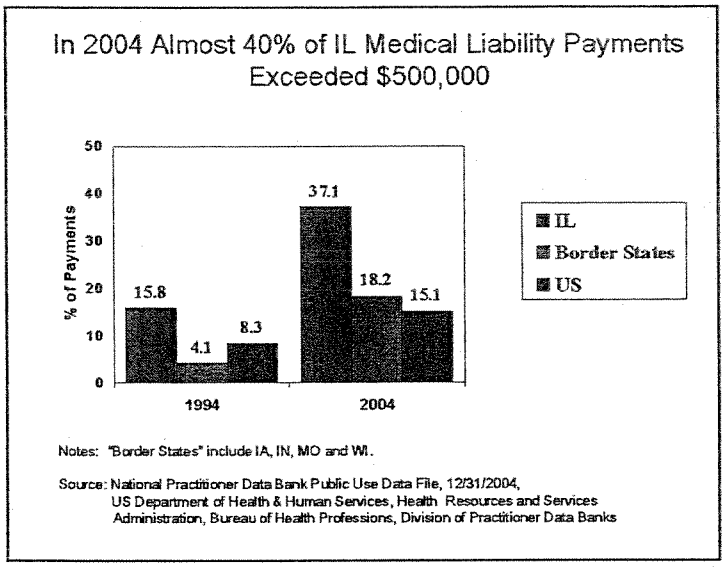
As Alex was running to catch a fly ball, he overestimated his distance from the school building and ran full force into the brick wall. Stunned, he told his friends he was going home, hopped on his bike, and was screaming in pain by the time he arrived home.

His mother, not seeing a wound or swelling, gave him an ice pack. Hearing that he was nauseated, she took him to an emergency clinic. X-rays at the clinic showed nothing wrong. But his pain kept increasing with each passing minute, so they called 911 and transferred Alex to Edward Hospital. A CT-scan revealed a large hemorrhage in Alex's brain that required immediate surgery. Part of his skull had splintered during the impact, which cut some of the arteries in his brain, causing the hemorrhage.

The nearest neurosurgeon was called from his office in Geneva to come to Edward. Because this was during rush hour on a Friday afternoon, backup plans were also made to airlift him to Children's Memorial Hospital. The doctor arrived at Edward in just 30 minutes, but Alex had already slipped into a coma before surgery began. The surgery lasted 3 hours, during which the neurosurgeon removed a section of Alex's skull. He replaced the piece of skull with four titanium plates that Alex must have for the rest of his life. Alex was in intensive care for the next 4 days and then spent a week on the pediatrics floor. For several months, he had to take anti-seizure medicine.

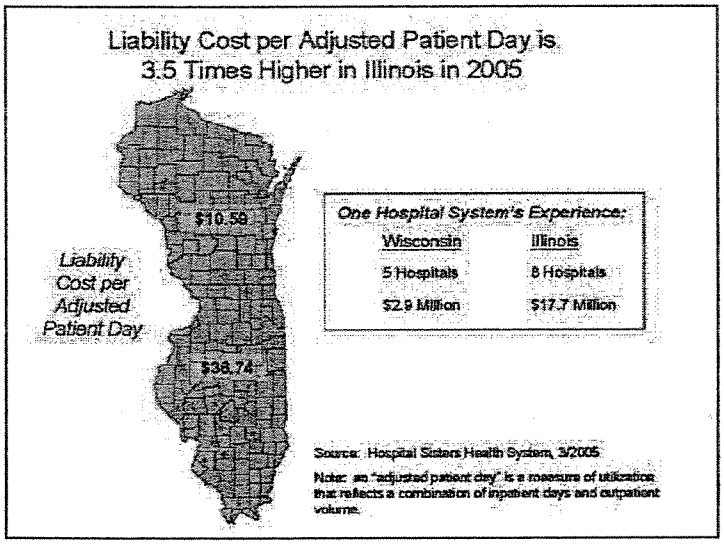
Alex is only alive today because he had access to a neurosurgeon near his home. Had he been airlifted to Chicago (if no neurosurgeons were available in his hometown of Naperville), he would have died while necessary preparations were being made to get him there. Today, there are only three neurosurgeons in the Naperville area (just a few years ago there were 15).

Prediction difficulties in Illinois. Predictions about these key factors are based essentially on the assumption that the future will be like the past. Unfortunately, the past is not always a valid reflection of the future. For example, medical liability claim inflation in Illinois is outpacing any reliable predictive measure. The percentage of medical liability payments over $500,000 has risen by 135 percent in Illinois since 1994. During the same period, medical inflation rose by about 53 percent. Almost 37 percent of all Illinois medical liability payments were over $500,000 in 2004 – but only 18 percent of payments in neighboring states were this high.



The cost of claims for similar injuries also varies substantially from county to county and even courtroom to courtroom (e.g., similar birth-related injuries do not yield similar claim costs). When insurers are forced to make big guesses about these matters, they are likely to err in favor of charging much higher premiums or leave the market.

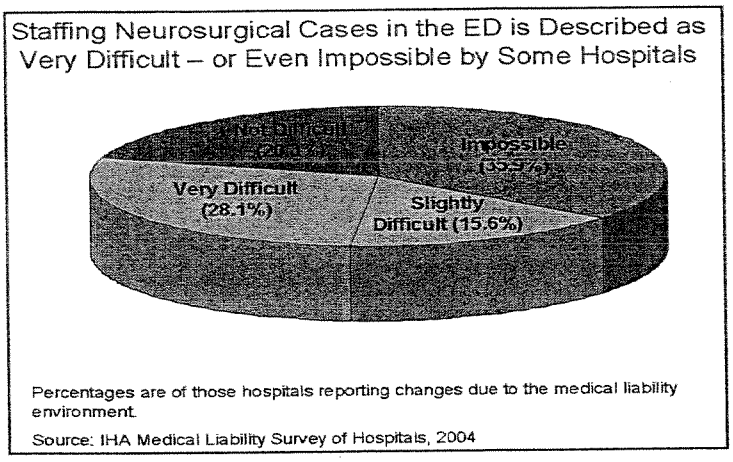
Investment losses are not a factor. Investment losses affected all insurance companies equally nationwide (i.e., they all have similar investment portfolios), yet insurance premiums vary wildly from state to state, despite the fact that many carriers provide coverage in multiple states. For example, in Wisconsin, an OB/GYN pays between $23,000 and $37,000 for medical liability insurance, while an OB/GYN in Illinois pays between $74,300 and $230,428. One system with hospitals in both states found its liability costs per patient day in 2003 were 5 times higher in Illinois than Wisconsin.



Investment returns and losses offer no explanation for why coverage in Illinois is so much higher than its neighboring states. The differences in the underlying judicial system explain the disparity.

Overcharging is not a factor. A free market economy guards against excessive profiteering by any company. If any insurer in Illinois were "gouging" doctors by taking in more than it needs to cover them adequately, other carriers would enter the market at lower premiums. Such a competitor would quickly get physicians to leave the so-called "gouging" insurer and the lower premiums would either drive that insurer out of business or cause it to lower its premiums. The sad and simple truth is that Illinois is a horrible market for medical liability insurance. There are only a handful of companies remaining, with one dominant insurer covering 56 percent of all physicians in this state.

Medical Liability Crisis Impact on Hospitals



- With medical liability costs exploding, 70 percent of the hospitals in Illinois are now either self-insured or insured by risk pooling trusts because they are unable to obtain insurance coverage. Some hospitals must set aside tens of millions of dollars for self insurance – funds that could be used for providing care to the indigent, hiring additional nurses, obtaining new technology, or making facility improvements.
- The annual medical liability insurance premiums paid by Illinois hospitals increased by 84 percent from 2001 to 2003 (from $1.5 million to $2.8 million).
- One hospital system with hospitals in Illinois and Wisconsin is paying **three and a half times** more in medical liability costs for its Illinois hospitals compared to its Wisconsin hospitals.
- In Cook County, neurosurgical coverage in hospital emergency rooms has declined by 50 percent (from 40 to 20 hospitals); hospitals in Kankakee County have experienced a 100 percent decline, leaving them with NO neurosurgical ER coverage.
- In a survey of Illinois Hospital Association member hospitals conducted in 2004, nearly two-thirds of responding hospitals reported that staffing neurosurgical calls in their Emergency Departments had become "very difficult" or "impossible" because of the medical liability crisis.
- The survey also found 65 percent of the responding hospitals in Cook and Will counties indicated that physicians on staff had reduced the services they offer (e.g., OB/GYNs deciding to practice only gynecology) in response to the medical liability climate.
- Memorial Hospital in Chester closed its OB unit on August 27, 2004 when the doctors who delivered babies and provided backup quit, after facing a 76 percent increase in medical liability insurance premiums.
- Red Bud Memorial Hospital discontinued offering labor and delivery services on November 1, 2004 because current obstetrics volumes were not sufficient to offset skyrocketing medical liability insurance and operating costs.
- Since June 2003, the number of patients being transferred from St. Elizabeth's Hospital in Belleville to other hospitals for trauma and neurosurgery has more than doubled because of the lack of neurosurgical coverage.
- The number of trauma patients being transferred from Illinois to St. Louis University Hospital has more than doubled in the past three years because of the medical liability crisis.

The Medical Liability Crisis: A Personal Tragedy

On February 2, 2004, Lisa Kasten's 84-year old active father slipped in his front yard. He went inside, told his wife that he had fallen, but he seemed fine. Two hours later he complained of nausea, so his wife called 911. Lisa got to her parents' house before the ambulance, and her father was barely able to communicate. Finally the ambulance arrived and drove the eight miles to Belleville's hospital.

One of the two neurosurgeons examined him and determined that he needed immediate surgery to keep him alive. However, both of Belleville's neurosurgeons had recently terminated performing surgeries because their medical liability insurance premiums were so excessive.

Lisa's father was stabilized, and arrangements were made to airlift him to Saint Louis University Hospital (about a 10-minute flight). But because of a snowstorm, the helicopter was grounded. An ambulance took him on the 45-minute drive to Saint Louis University Hospital. Upon arrival at the hospital he was comatose and close to death. As decisions were made about what procedures should be done, he became unable to breathe on his own. The next morning he was brain dead and later that evening, Lisa's mother decided to cut off her husband's life support after 62 years of marriage.

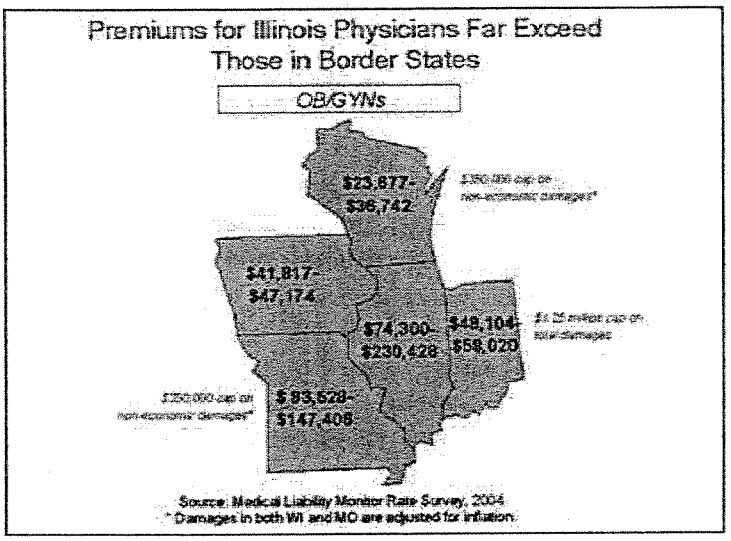
Lisa – who is a nurse – believes that we need to stop the loss of patient access to quality health care so there will not be any further tragedies like her father's. She urges state legislators to take action and pass meaningful medical liability reform legislation.

Medical Liability Crisis Impact on Physicians

Skyrocketing Insurance Premiums for Physicians

Illinois is among the top 3 states in the country with the highest medical liability premiums for the following specialties:

- Obstetrics/Gynecology: $74,300 – $230,428
  (equivalent coverage is available for less than $60,000 in Indiana and Wisconsin, which have caps on non-economic damages)
- General Surgery: $51,876 – $183,560
- Internal Medicine: $17,778 – $58,514 *(Medical Liability Monitor, Oct. 2004)*



Examples of Physician Flight

- Dr. Scott Hansfield, formerly vice chairman of obstetrics and gynecology at Evanston Northwestern Healthcare, left his practice when he learned his 2003 rates would hit $140,000. He is now practicing in Wisconsin and paying half that amount for medical liability insurance.
- 3 physicians on staff at Advocate Lutheran General Hospital in Park Ridge moved their practice to Kenosha, WI. After the move, their combined medical liability rates dropped from $510,000 to $50,000 a year.
- Dr. G. Wesley White, director of infectious diseases at Resurrection Medical Center in Chicago and Advocate Lutheran General in Park Ridge moved his practice to Rhinelander, WI and reduced his liability insurance costs from $40,000 to $4,000.
- At Edward Hospital, Naperville, a neurosurgeon covering the Emergency Room has left to practice in Wisconsin. Only 3 neurosurgeons remain on staff and providing ER call; only a few years ago, the hospital had 15 neurosurgeons on staff.
- According to the Illinois State Medical Society, a thoracic surgeon from Chicago commutes to Tulsa, OK every week to practice medicine rather than move his family because it is less expensive to commute and pay insurance in Oklahoma than it is to live and practice in Chicago.

The Medical Liability Crisis is Hitting Cook County

While it is well known that the medical liability crisis has had a devastating impact on southern Illinois and Madison and St. Clair counties, the crisis is now hitting Cook County.

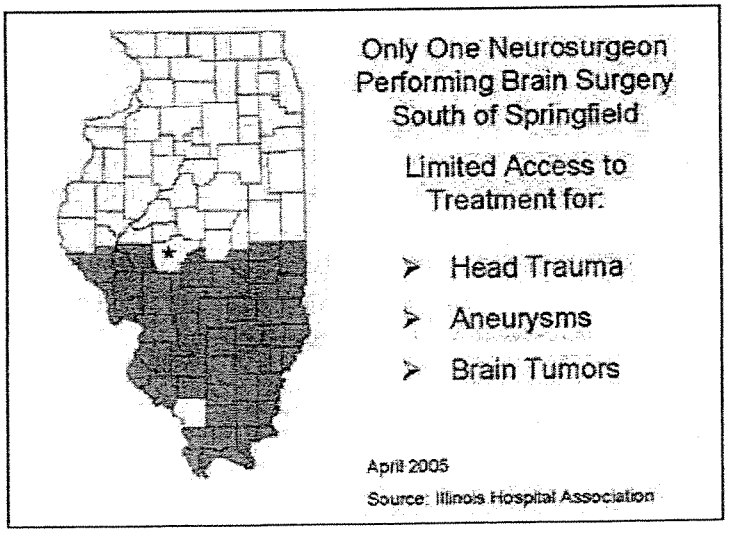
The number of hospitals in Cook County with neurosurgical emergency room coverage has dropped precipitously from 40 to 20 and is putting a major strain on academic medical centers in Chicago – which traditionally have acted as safety nets for community hospital emergency rooms. In addition, neurosurgical ER coverage has declined by 100 percent in Kankakee County and by 50 percent in Kane County.

One major academic medical center in Chicago has experienced a nearly 100 percent increase in the total number of transfers of neurosurgical patients from other hospitals in the past two years and a 400 percent increase in neurosurgical transfers from hospitals without neurosurgical ER coverage. Most of those transfers originated from other hospitals in Cook County.

The lack of neurosurgical coverage in Cook County and some surrounding counties is straining the emergency care system. As a direct result, patients are being adversely affected when their treatment must be delayed while appropriate care for them is sought – delays can lead to a patient's death or a less successful recovery.

The outlook does not look promising if the medical liability crisis continues. According to the American Association of Neurological Surgeons Journal of Neurosurgery, the average neurosurgeon retires at about the age of 61. At 14 of the 20 community hospitals in Cook County that still have neurosurgical coverage, the average age of their neurosurgeons is 61.

- Dr. Eileen Murphy closed her Chicago office last year, abandoning obstetrics to become a junior high school science teacher. While Dr. Murphy's annual salary was $170,000, her insurance premium jumped to $138,000 last year. Dr. Murphy had been delivering babies for 18 years, including Governor Blagojevich's daughter, Anne.
- At St. Anthony's in Chicago, which treats mostly Medicaid patients, OBs are reimbursed by Medicaid approximately $900–$1,000 per delivery. Therefore, a physician must deliver 150 babies (about the total delivered yearly in a normal OB practice) just to pay the $150,000 medical liability premium.
- Joliet has lost six obstetrician-gynecologists since 2002, at a time when Joliet's population has increased by 14 percent or 14,500 people over the past three years.
- After 28 years of treating women and delivering thousands of babies without a medical liability judgment against him, OB/GYN Dr. Ramon Lopez closed his Joliet practice last year, after receiving a six-figure bill for his medical liability insurance.
- Dr. Thomas R. Hurley, neurosurgeon at Silver Cross Hospital in Joliet and member of the Chicago Institute of Neurosurgery and Neuroresearch, said three years ago, the medical liability insurance for the 16 neurosurgeons in his group was $700,000 to provide $1 million of coverage for each neurosurgeon. That same insurance was renewed last year for $3.8 million.
- Dr. Patrick Daly, a 43-year old general surgeon who has practiced in Rockford for 11 years and is past president of the Winnebago County Medical Society, moved to Wisconsin to avoid an expected medical liability insurance premium of $55,000 to $60,000. In Wisconsin, his premium is less than half his Illinois premium and is being paid by his employer. Daly was the sixth surgeon to leave Rockford in the past year.
- Dr. Mark Stephens, a family practice physician who also delivers babies, left Greenville to move to Kansas because his 2-doctor partnership's medical liability insurance costs increased from $80,000 to $188,000 per year. His partner, who remained in Greenville, has a premium of $160,000 for his solo practice.



- Springfield-area physicians, including some at Memorial Medical Center in Springfield, are moving to locations with more favorable medical liability insurance conditions, such as to the Springfield Clinic, which offers a group rate, and the SIU School of Medicine, which is state-affiliated.
- Carbondale neurosurgeons Sumeer Lal, M.D. and Theo Mellion, M.D. closed their 14,000-patient practice last year, due to the escalation of medical liability insurance costs. Dr. Lal's Illinois insurance premium went from $200,000 to $300,000 in a year.

The Medical Liability Crisis Damages Communities

- Like good schools, high quality medical and hospital care are essential to an area's economic health. Reputable health and education services are imperative to industrial and business leaders as they select a community to locate their businesses.
- Good health is key to the productivity of the labor force. Employees also want their families to have readily accessible, high quality care close to where they live and work.
- Loss of physicians, restriction of services, and the steep costs of medical liability insurance lead to inevitable layoffs of hospital and physician employees.

Hospitals Keep Community and State Economies Strong as Engines of Sustained Growth:

- Hospitals are one of the top 3 employers in 48 of Illinois' 102 counties. They employ nearly 240,000 people and pay more than $10 billion a year in salaries and benefits, with a total impact of nearly $50 billion a year on the Illinois economy.
- Illinois hospitals provide more than $1.2 billion every year in uncompensated care – essential health care services for people who have no insurance or are underinsured and are unable to pay for their care.
- Every dollar a hospital spends on salaries and goods and services puts more money into the local and state economies.

The Devastating Impact of the Medical Liability Crisis

- The negative economic impact when a physician leaves Illinois is $1.1 million. The average family physician generates, directly and indirectly, an estimated 50 full-time jobs in the local health care community and beyond.
- When a doctor leaves a community, the impact is not just a medical professional making a personal decision to go elsewhere. The physician's exodus has a profound impact on the local health care community – i.e., lost patient admissions to the local hospital that will affect other professionals such as nurses and hospital support staff. It also affects the entire community, including contractors, service workers, janitors, construction workers and many others whose livelihoods are all connected to the well-being of the local health care system.
- If the current medical liability crisis continues to wreak havoc on the health care sector, Illinois communities will suffer from the erosion of this critical base of their local economies.

The Solutions: Meaningful Medical Liability Reform for Illinois

The Illinois Hospital Association can only support medical liability reform legislation that will:

1. reduce the cost of liability insurance premiums;
2. keep doctors in Illinois; and,
3. promote patient access to health care.

Meaningful Medical Liability Legislation Must Include These Critical Reforms:

1. Reasonable caps on non-economic damages that fairly compensate plaintiffs and allow hospitals and physicians to have the resources to continue serving their patients. Such reasonable caps would not affect the full payment of economic damages to plaintiffs – e.g., hospital bills, future health care needs, and lost wages.
2. Structured awards that will more efficiently and reliably pay for the future medical care of injured patients (e.g., periodic payments such as annuities).
3. Real apparent agency reform that provides for straightforward disclosure processes so that only legitimate agency claims lead to liability (to protect hospitals from liability for harms they did not cause, i.e., harms caused by physicians who are not hospital employees).
4. Protection of all (100%) of a physician's personal assets from paying liability claims if the physician has at least $1 million in coverage.

Additional Medical Liability Reforms Supported by the Illinois Hospital Association

1. Insurance Reform.
   a. The Department of Insurance (DOI) may review rates for adequacy and excessiveness without finding that an area lacks competition.
   b. DOI may hold a hearing on a rate increase for policyholders.
   c. Insurers must file their actuarial data.
   d. Insurers must file their risk management plan with discounts for those implementing a risk management program.
   e. DOI must establish an insurance coverage resource center on the Internet.
   f. Any insurer, risk retention group, charitable risk pooling trust and other entities providing medical liability insurance in Illinois must file all claims and suits filed against their insureds.
   g. Medical liability insurers must also file:
      i. Paid and incurred losses by county for each of the past 10 years;
      ii. Earned exposures by ISO code, policy type, and policy year by county for each of the past 10 years.
   h. All of the information filed with DOI is protected as confidential and violators may be fined $50,000 per disclosure.

A Reasonable Cap on Non-economic Damages

In a medical liability case, a jury may be asked to award both economic and non-economic damages to an injured person (plaintiff).

An economic damage award is the amount of money that a jury gives to cover a plaintiff's medical costs as well as his/her lost wages, past and future. Economic damages can include money for things like remodeling a home or car, if necessary, to enable the person to move about; or hiring a home care worker. In general, economic damages can be objectively quantified or "added up."

A non-economic damage award is an additional amount for a plaintiff's pain and suffering, such as physical impairment or loss of enjoyment of life. Because of their subjective nature, the proper amount to award for non-economic damages is not as clear as with economic damages.

While an individual should be adequately compensated for an injury, excessive awards for non-economic damages are creating danger for all Illinoisans that their access to doctor and hospital care will be significantly reduced.

For this reason, doctors and hospitals are working together to obtain a reasonable limit (cap) on non-economic damages. Twenty-nine states have caps on damages, including Indiana, Missouri and Wisconsin. When surrounding states with caps offer more attractive medical liability climates for doctors, it puts Illinois at a competitive disadvantage.

The Illinois Hospital Association and the Illinois State Medical Society are proposing to cap non-economic damage awards at $500,000 for hospitals and $250,000 for doctors. Economic awards would remain unlimited. Capping non-economic damages is a critical and important reform that will result in more predictable awards and help to safeguard access to health care for all Illinoisans.

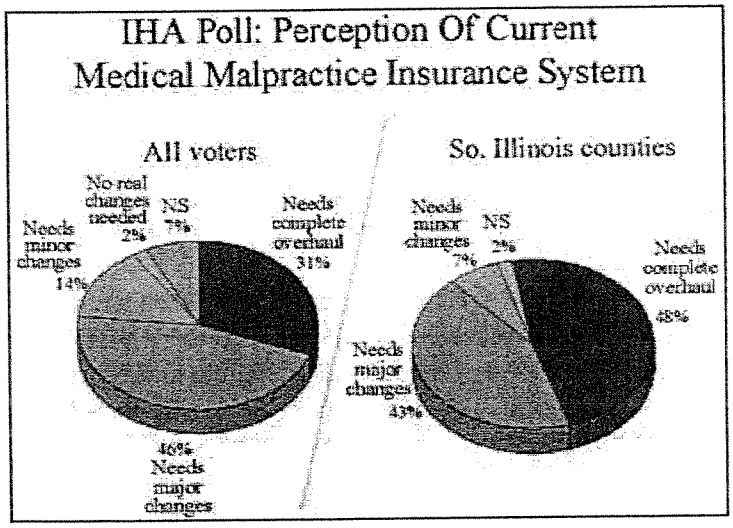
2. Department of Financial and Professional Regulation (DFPR) Reforms:
   a. Double the number of DFPR investigators.
   b. Double the statute of limitations for bringing disciplinary actions from 5 to 10 years.
   c. Give DFPR ability to get medical records without patient consent.
3. Streamline Arbitration Act. Several of the procedural steps to using arbitration agreements with patients should be removed to make the law easier to use.
4. Respondents in Discovery. Expand a plaintiff's ability to use discovery to identify possible defendants before actually naming them in the case.
5. Eliminate Unwarranted Cases (Certificate of Merit Reform). Require the expert reviewer to satisfy expert witness standards for medical liability cases. Require the reviewer to be identified by name, address, phone number and state license number.
6. Jury Instructions. Juries must be instructed on the tax treatment of awards and that punitive damages may not be awarded in any form.
7. Attorney Fee Caps. Reduce the amount plaintiff's attorneys may collect according to the following schedule:
   a. 40% of the first $50,000
   b. 33 1/3% of the next $50,000
   c. 25% of the next $500,000
   d. 15% of any amount recovered over $600,000
8. Apology Protection. Any expression of a provider's apology for a medical outcome is not discoverable or admissible in a trial for medical liability.
9. Expert Witness Standards. Expert witnesses must be board certified or eligible in the same specialty as the physician-defendant and devote most of their time to the type of care at issue in the case.
10. Good Samaritan Act for Emergency Care. Physicians who provide free care in hospital emergency departments would only be liable for willful and wanton misconduct.
11. Good Samaritan Protection for Free Clinics. The Act is expanded to cover home visits and referrals to hospitals.
12. Sorry Works Pilot Program. One hospital in Illinois may agree to be the site for a study of whether "promptly apologizing for mistakes" and "promptly offering fair settlements" reduces its total liability costs. A new state 10-member committee would decide if the hospital's liability costs under the "sorry" program are higher than they would have been without the program. If the costs are higher, the committee shall also decide how much it will pay the hospital to make up for this difference, but the total payment to a hospital in any year may not exceed $2 million. The program may be expanded to include a second hospital. Data from the program would be publicly available.
13. County Insurers. Counties would be authorized to provide medical liability insurance.

Illinoisans Overwhelmingly Support Meaningful Medical Liability Reform, Including a Cap on Non-economic Damages

In poll after poll, an overwhelming majority of Illinoisans recognizes that the state is in a medical liability crisis and wants a major overhaul of the broken medical liability system, including a cap on non-economic damages.

A March 2004 poll of 600 likely voters statewide, conducted for the Illinois Hospital Association found:

- 84 percent characterize the medical liability situation as a crisis or major problem;
- 77 percent say the system needs major changes or a complete overhaul;
- 76 percent say juries awarding excessively high awards are to blame for the crisis;
- 73 percent support capping non-economic damages.



An August 2004 poll of 3,600 Illinois residents, conducted by Provena Health found:

- 91 percent are concerned or very concerned about the rising cost of medical liability insurance for physicians;
- 70 percent favor capping non-economic damages.

A November-December 2004 survey of 1,300 residents statewide, conducted by Northern Illinois University's Center for Governmental Studies found:

- 44 percent of those living in southern Illinois say they have lost a doctor because he or she left a practice or moved out of state to escape high medical liability insurance premiums;
- 34 percent of statewide respondents blame lawyers seeking large settlements in court cases for the rising cost of medical liability insurance;
- 67 percent of statewide respondents favor a limit on the amount of money people can receive from medical liability suits – with the support for such a limit being at least 60 percent in every region of the state.

Myths and Facts: What's Really Behind the Medical Liability Crisis

Insurance Myths

Myth: Isn't the medical liability crisis really caused by insurers raising premiums to make up for investment losses?

Fact: Investment losses affect all insurance companies equally nationwide (i.e., they all have similar investment portfolios), yet insurance premiums vary wildly from state to state, despite the fact that many carriers provide coverage in multiple states.

For example, in Wisconsin, an OB/GYN pays between $23,677 and $36,742 for medical liability insurance, while an OB/GYN in Illinois pays between $74,300 and $230,428. One system with hospitals in both states found its liability costs per patient day in 2003 were 5 times higher in Illinois than Wisconsin. Investment returns and losses offer no explanation for why coverage in Illinois is so much higher than its neighboring states. The differences in the underlying judicial system explain the disparity.

- Declines in the stock market actually had a more limited impact on insurers than on other businesses because insurance companies limit the percentage of assets that they invest in stocks. Equities have made up only about 9 percent of medical liability carriers' portfolios for the last several years. (Source: Brown Brothers Harriman, 1/21/2003)
- Premiums are being increased because insurers are losing money on the doctors that they insure. In 2002, ISMIE had an underwriting loss of 39 cents (38.6 percent) for each dollar of premium that was collected. Six of the top eight insurers in Illinois in that year showed underwriting losses – some much higher than ISMIE's. All of these companies were losing money on their core business – not on investments. (Source: Illinois Department of Insurance, November 10, 2003)

Myth: Aren't the peaks and valleys in medical liability insurance premiums tied to the cyclical profitability of insurers? So isn't legislation to require insurance rate approval the answer to curbing the crisis?

Fact: Unlike the average investor who puts away money for a rainy day, insurers invest the premiums they collect and use the income from those investments to reduce the amount of premium income that would have been required otherwise. Thus, a decrease in investment income means that income from insurance premiums has to cover a larger share of an insurer's loss. In 2002, insurance companies in Illinois paid out $1.59 for every premium dollar they collected. If it weren't for investment income, premiums would be even higher. Medical liability costs are skyrocketing because of unpredictable increases in verdicts and settlements.

Apparent Agency Reform: Protecting Hospitals from Liability for Harms They Did Not Cause

In tort law, an organization is automatically liable for the actions of its employees and agents. The actions of an employee or agent are considered to be the actions of the organization.

However, under the doctrine of apparent agency, the courts will treat a non-employee or non-agent as if the person were an employee or agent if:

- The organization does something to create the impression in the mind of the plaintiff that the individual is an employee or agent of the organization.
- The plaintiff relies on that false impression created by the organization.
- The plaintiff suffers an injury as a result of relying on that false impression.

This is classic apparent agency as applied in all Illinois cases except medical liability. It all depends on what the plaintiff believed about the relationship between the organization and the individual and that the plaintiff relied on that belief.

But this is not how Illinois courts apply apparent agency to hospital cases. In hospital cases, the courts often disregard what the plaintiff actually knew or thought. For example, apparent agency has been applied to hold a hospital liable even when the plaintiff was brought to the hospital unconscious. How could an unconscious patient form an impression about the relationship between the hospital and doctor and then rely on that impression?

The Illinois Hospital Association supports a reform to apply classic apparent agency law to hospitals – to treat hospitals the same as all other defendants. The reform says that apparent agency cannot be applied against a hospital when:

- The plaintiff knew that the doctor was not a hospital employee or agent; OR
- The plaintiff was incapable of forming an impression or relying on an impression because he or she was unconscious.

In tort cases, a defendant should only be liable if it has done something that causes or contributes to the plaintiff's injury. In apparent agency cases, that something is leading the plaintiff to believe that a doctor is the hospital's employee or agent. Under this reform, apparent agency will not apply when the hospital can prove that belief was not present – by either showing that the plaintiff actually knew the true facts or that the plaintiff knew nothing about the hospital-doctor relationship because he or she was unconscious.

The current liability system is broken, and it's running insurance companies out of Illinois because they can't make a profit even at these high rates – Illinois is among the top 3 states in highest medical liability premiums for OB/GYNs, internists and general surgeons (*Medical Liability Monitor,* Oct. 2004).

Legislating insurance company rates will only drive out more insurers from the Illinois market. Several years ago, Illinois had more than 30 medical liability insurers. It now has only five.

Furthermore, if insurance companies are not allowed to react to changes in the market, insurers will be forced to limit the scope of their coverage for high-risk specialists and for volatile territories.

Myth: Aren't insurers overcharging physicians for coverage?

Fact: A free market economy guards against excessive profiteering. If any insurer in Illinois were "gouging" doctors by taking in more than they need to cover them adequately, other carriers would enter the market at lower premiums. Such a competitor would quickly get physicians to leave the so-called "gouging" insurer and the lower premiums would either drive the "gouging" insurer out of business or cause it to lower its premiums. The sad and simple truth is that Illinois is a horrible market for medical liability insurance. Illinois now has only five companies writing medical liability insurance, with one insurer covering 56 percent of all physicians in this state.

In addition, about 70 percent of the hospitals in Illinois are either self-insured or insured by risk pooling trusts that they own and control. Hospitals have become their own insurance companies – many medical centers in Chicago cannot obtain commercial insurance coverage for under $15 million to $20 million per claim.

Insurance companies are not maximizing profits for shareholders or gouging to make up for losses in the stock market, as they have been accused of doing. The premiums in Illinois reflect what it costs to adequately cover physicians given the excesses of the medical liability system.

Myth: Isn't it true that insurers undercharged physicians for coverage in the 1990s, so they are now forced to overcharge them today?

Fact: According to a federal report (GAO, June 2003), the single greatest factor driving up premiums is the cost of claims. The fact that some insurers may have decided to defer collecting enough premium in earlier years does not make the excessive cost of claims any better. Those costs must be paid eventually. The undercharging argument fails to address the root cause of the problem: an out of control liability system.

"There's Nothing Wrong with the Judicial System" Myths

Myth: Isn't medical liability claim severity either flat or consistent with medical and wage inflation (i.e., economic damages)?

Fact: About two-thirds of the money being awarded in medical liability cases comes in the form of non-economic damages. So the big driver of big awards is not medical costs or lost wages. It is the incalculable losses attributed to pain and suffering. As a result, we are seeing awards in excess of $1 million in Illinois increase at an alarming rate.

- Claim severity is not flat. The percentage of medical liability payments over $500,000 has risen by 135 percent in Illinois since 1994. During the same period, medical inflation rose by about 40 percent.
- Approximately 37 percent of all Illinois medical liability payments were over $500,000 in 2004 – but only 18 percent of payments in our border states were this high.

"We Don't Have Any Access Problems" Myths

Myth: The total number of physicians in Illinois is relatively stable, so don't patients still have access to all the care they need?

Fact: The total number of licensed physicians in a state does not measure who is actually in the state and providing care. A large number of physicians in Illinois who are retired or working in academic and administrative settings still have their licenses.

No licensing statistic captures the reluctance of physicians to be "on-call" for emergency deliveries, to do emergency neurosurgery or offer other high-risk specialty services. We know from the very physicians who are withdrawing from the Illinois health care system that liability costs are driving them away.

An Illinois Hospital Association survey found that 64 percent of responding hospitals are finding it difficult – or even impossible – to get physicians to staff neurosurgical Emergency Department calls.

Physician flight is very real, especially in certain areas of the state. Hospitals in Madison and St. Clair counties count more than 160 physicians who have responded to the medical liability crisis by leaving their practices in the past two years.

"Caps Don't Work" Myths

Myth: Won't a cap on non-economic damages only benefit insurers, without controlling insurance premiums?

Fact: A recent empirical analysis of caps found that premiums in states with caps are 17 percent lower than in states without caps. (*Health Affairs*, Jan. 21, 2004)

In addition, a study released in May 2003 by the Joint Economic Committee of the U.S. Congress stated that caps on pain and suffering damages are among the key reforms that have proven successful at producing savings when implemented.

A report by the federal government (GAO) in August 2003 supports this – "From 2001 to 2002, the average rates of increase in the states with non-economic damage caps of $250,000 and $500,000 or less were 10 and 9 percent, respectively, compared to 29 percent in the states with limited reforms."

Twenty-nine states now have a cap on medical liability awards. Caps are one of the few reforms with a real track record and the record shows that they work to make coverage more affordable. The notion that insurers would only pocket the savings from a cap makes no sense. Other insurers would certainly enter a capped market and offer coverage at lower prices to reflect the benefits of the cap.

Myth: Don't caps unfairly hurt the most severely injured patients? Why should they be denied a full recovery in order to preserve access to care for others?

Fact: First, caps on non-economic damages does not in any way limit economic awards for medical care and life care costs or lost wages – recovery of economic damages in medical liability cases remains unlimited.

No one says that medical liability plaintiffs are not entitled to any award for non-economic damages. We support a reasonable amount for such losses. But we are all in this health care system together. We all pay for the right to let one plaintiff recover an unlimited amount of damages in a single case. The price of that right is loss of access to health care. Ironically, as the right to sue without limits continues to erode access, the right to sue will become meaningless. The logical end of this trend is that patients will never become plaintiffs because they never got to a doctor in the first place. Given this dynamic, the need to preserve physician access is more important than the need to preserve an unlimited right to sue for non-economic damages. And a reasonable cap is the correct way to strike the balance between these competing societal concerns.

Myth: In California, wasn't it really the insurance reform law, Proposition 103, that lowered medical liability premiums, not the cap on non-economic damages?

Fact: MICRA (the Medical Injury Compensation Reform Act) – a $250,000 cap on non-economic damages – was enacted in 1976, but the California Supreme Court did not uphold MICRA until 1985. Beginning in 1986, and continuing through 1991, medical liability incurred losses dropped dramatically from about $429 million in 1986 to $216 million in 1990 and to about $49 million in 1991. Proposition 103 was enacted in 1988 and was upheld by the California Supreme Court in late 1989, in the midst of this steep decline in incurred losses. By the time Proposition 103 was upheld, incurred losses had already dropped in California, due to MICRA.

Myth: Aren't caps unconstitutional? They've been twice struck down by the Illinois Supreme Court.

Fact: The cap that we are proposing is unlike any cap considered by the Illinois Supreme Court – and we believe that it is constitutional.

While many people have focused on the two court decisions on caps, there is another very significant Illinois Supreme Court case that is not getting any attention. In the mid-1980s – during a medical liability crisis – the Illinois General Assembly eliminated punitive damages in medical liability cases. An entire category of damages available in other tort cases was totally eliminated. The Illinois Supreme Court upheld that law in the 1987 Bernier decision. Why?

- Because (1) the legislature found that there was a medical liability crisis affecting access to health care by the public and (2) the legislature tailored a solution directed only at medical liability cases. That's what we are proposing – and it's very different from the two cases where the court struck down caps.

In the mid-1970s, the legislature put a cap on all damages – economic and non-economic. No one is suggesting that today. Therefore, the Wright case is really not applicable.

In the mid-1990s the legislature found there was a medical liability crisis, but it placed a cap on non-economic damages in all tort cases – e.g., slips and falls, product liability and car accidents. The solution – caps in all cases – was broader than needed to address the specific problem – the state's medical liability crisis.

The General Assembly does have the authority to limit damages in medical liability cases in order to address a public health crisis caused by the medical liability system.

Payment of Future Medical Expenses Through Periodic Payments (Annuities)

Another method of eliminating excess from the judicial system is to pay the plaintiff's future medical expenses through the use of "periodic payments." Such payments give the plaintiff everything he or she needs, but because of the way they are structured, the cost to the defendant's insurance company is significantly lower. This result can be effective in holding down medical liability insurance costs and preserving patient access to health care.

Today, medical malpractice plaintiffs recover damages for future medical care in a one-time, lump sum payment.

A better approach is the use of a structured award, which sets up periodic payments to the plaintiff. This is done when the defendant purchases an annuity contract from a life insurance company, and the life insurance company then makes payments to the plaintiff for everything he or she needs as determined by the jury at trial.

During the trial, the jury is presented with a "life care plan" that is designed to spell out and add up the cost of any future medical, custodial, or life care required by the plaintiff, including medical equipment, supplies, medication, home nursing care and institutional care. Payments for such care may be monthly, quarterly, annually, or may vary, based on whether the plaintiff requires an immediate up-front payment, for example, to reconfigure his or her home to accommodate a particular physical handicap.

Various studies have found that plaintiffs face a substantial risk of misspending their lump sum awards and then seeking coverage for needed care from publicly funded health care programs such as Medicaid. Researchers have found that many personal injury settlements are used up within five years of the settlement. Periodic payments structured through an annuity guarantee the plaintiff a lifetime of payments for medical care, by legally binding the life insurance company to make the payments for as long as the plaintiff lives.

Providing for periodic payments will help control medical liability costs and will be an important step in preserving access to health care for all Illinoisans.

About the Illinois Hospital Association

The Illinois Hospital Association, with offices in Naperville and Springfield, represents approximately 200 hospitals and health systems and the patients and communities they serve.

Our members range from the teaching hospitals that train tomorrow's doctors and nurses, to community hospitals that transform advances in medicine and technology into better lives for patients, to rural facilities that bring high-quality patient care to the less populated regions of our state, to specialty institutions that care for patients in need of behavioral health, long-term care, or rehabilitation services.

Since IHA was formed in 1923, its mission has been to strengthen and unite hospitals and make high-quality, affordable health care available to all Illinoisans. To make this possible, we work to ensure that adequate resources are available for our state's health care delivery system. With health care delivery going through radical changes, that mission is more important than ever.

For the latest information about Medical Liability see our web sites at:

www.ihatoday.org

www.conditioncritical.org

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