REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

The Liability Insurance Crisis And The Need For Tort Reform

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Report of the
Joint Subcommittee Studying
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To
The Governor and the General Assembly of Virginia
Richmond, Virginia
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To: Honorable Gerald L. Baliles, Governor of Virginia
and
The General Assembly of Virginia

I. INTRODUCTION

During the 1985 Session of the General Assembly, Senator Wiley F. Mitchell, Jr., introduced Senate Bill No. 556 to include localities within the purview of the state Tort Claims Act. Local governments would waive their rights to claim immunity from suits for personal injury, death or property damage caused by the negligent or wrongful act or omission of an employee acting within the scope of his employment. In return, the liability of the localities would be limited to the greater of $25,000 or the maximum limits of their applicable insurance coverage. The localities would not be liable, in any case, for punitive damages or prejudgment interest. The time for filing the required notice of claim with the locality would be extended from six months to within one year of the occurrence on which the claim was based. The plaintiff would then have eighteen months from the date of filing the notice of claim to file suit.

The bill was defeated in the Senate Committee for Courts of Justice. However, at the request of the chief patron, it was agreed that a subcommittee would be appointed during the interim to review the need for and effects of the changes contemplated by S.B. 556. The members of the subcommittee were Senators Parkerson, Mitchell, Babalas, Bird and Goode. In addition, attorneys from across the state were asked to assist the subcommittee.[1]

Senate Bill No. 556 was an attempt to alleviate the problems local governments were experiencing in obtaining reasonably priced and adequate liability insurance coverage. The chief patron believes that the cap on total recovery, coupled with certainty over the extent of exposure, warrants the waiver of the limited immunity now enjoyed by the localities and would ease their insurance problems.

As the interim study progressed, the subcommittee recognized that the scope of the study needed to be expanded. The problems the localities were experiencing in finding adequate, affordable liability coverage were not unique. Similar problems are apparent in virtually every business and profession. The subcommittee agreed that a more in-depth analysis of the problem was necessary.

Senate Joint Resolution No. 22 (Appendix A) was introduced by Senator William F. Parkerson, Jr., of Henrico, during the 1986 Session upon recommendation of the interim subcommittee. The resolution created a joint subcommittee to study "(i) the causes, effects and possible solutions to the problems experienced by political subdivisions, businesses, including day care facilities, and citizens of the Commonwealth in obtaining adequate and affordable liability and related insurance coverage, and (ii) the tort reparations system, including a review of the ability of that system to ensure an equitable method of determining liability and assessing damages, and the impact of that system on the cost and availability of liability insurance."

The membership of the joint subcommittee was appointed in accordance with SJR 22 as follows: from the Senate Committee for Courts of Justice, William F. Parkerson, Jr., of Henrico and Wiley F. Mitchell, Jr., of Alexandria; from the Senate Committee on Commerce and Labor, William E. Fears, of Accomac; from the House Committee for Courts of Justice, C. Hardaway Marks, of Hopewell, Theodore V. Morrison, Jr., of Newport News and Thomas W. Moss, Jr., of Norfolk; and from the House Committee on Corporations, Insurance and Banking, V. Thomas Forehand, Jr., of Chesapeake and Frank D. Hargrove, of Hanover. Senator Parkerson was elected chairman of the joint subcommittee and Mr. Marks was elected vice-chairman.

Five public hearings and three work sessions were held in Richmond. All meetings were well attended by individuals and organizations, representing the diverse interests affected by the liability insurance "crisis".

The joint subcommittee is grateful to all those, too numerous to mention, who participated in the public hearings and provided invaluable information and assistance.

EXECUTIVE SUMMARY

Following a comprehensive evaluation of the process by which liability insurance coverage is made available to the public and the process by which damages for civil wrongs are assessed and paid, a majority of the the joint subcommittee makes the following recommendations:

1. That liability insurers be encouraged to utilize credible loss experience from Virginia in setting premium rates to be charged Virginia insureds to assure that Virginians reap the benefits of our relatively stable loss environment;

2. That commercial liability insurers be required to submit more detailed information on their direct experience in Virginia with respect to identified lines and subclassifications of insurance which have historically experienced availability and/or affordability problems and which it is anticipated will continue to experience such problems to provide additional data to be used in rate making and to better monitor any future problems;

3. That a closed-claim reporting requirement be adopted to facilitate a review of the claims experience of liability insurers and provide more data for policy analysis and decision making;

4. That the general provision which tolls the statute of limitations during the minority of an injured person be modified as it applies to medical malpractice actions brought on behalf of a minor in order to provide more predictability to the loss assessment process, reduce the risks of providing coverage for these losses and, thereby, make the necessary liability insurance coverage more widely available at a more reasonable cost;

5. That emergency obstetrical services be covered under the "Good Samaritan Statute" in order to ensure that such services continue to be available to indigent women.

6. That limitations be placed on the potential liability of corporate officers and directors and members of local governmental boards in order that qualified individuals will continue to serve in such positions;

7. That alternatives to mandatory insurance requirements, whether statutory or regulatory, be provided to alleviate hardships caused where such insurance becomes unavailable or unaffordable;

8. That most exemptions from jury service be eliminated to provide a broader cross-section of persons available for service and thereby improve the quality of justice dispensed;

9. That the courts be granted authority to impose sanctions on a party or counsel, or both, for asserting a frivolous claim or defense in a civil action;

10. That a limitation be placed on the amount of non-economic damages which may be awarded in order to strike a proper balance between affording an injured person his rightful compensation for losses incurred and providing a degree of predictability of loss exposure necessary to a system of compensation such as ours which is largely dependent upon the continued availability of insurance;

11. That payments on awards of future damages exceeding $250,000 be required to be made in installments rather than in a lump sum to provide a significant cost savings to the payor while equitably providing compensation to the injured party; and

12. That the joint subcommittee be continued to allow further consideration of the issues, specifically alternative methods of dispute resolution.

BACKGROUND

In the mid-1970's, state legislatures across the country were called upon to alleviate the "medical malpractice insurance crisis". The problems facing health care providers at that time were similar to those facing governments, businesses, professions and citizens today. In simple terms, the costs of obtaining adequate insurance coverage, essential to provide necessary health care services, had risen dramatically or, in some instances, was unavailable. Many health care providers were faced with

the prospect of conducting their business without insurance coverage, thereby exposing themselves and their families to personal liability. This was clearly risky and unacceptable. The alternative, getting out of the medical profession, was also unacceptable. Insurers and health care providers alike feared what was perceived to be an increasingly litigious society and excessive awards granted by unrestrained judges and juries.

A majority of the states responded by modifying the tort law, both substantively and procedurally, as it applied to medical malpractice cases. Additionally, a number of states made changes in their insurance laws to ease the crisis. Closed-claim reporting requirements were adopted to provide the insurance company regulators with data necessary to monitor the crisis. Insurance pooling arrangements, state-funded insurance pools, insurance reciprocals, joint underwriting associations, limitations on liability, prescreening panels and other procedural reforms were authorized or created in a number of states.

Today, the states and the federal government are being called upon to conduct similar studies and adopt similar changes to ease a broader crisis. In addition to SJR 22, the 1986 Session of the General Assembly approved several measures designed to alleviate the problems created by the current liability insurance "crisis". Localities will be allowed to establish group self-insurance pools (House Bill No. 469, Ch. 520; Senate Bill No. 137, Ch. 556) and reciprocals (Senate Bill No. 337, Ch. 82). Commercial liability insurers will be required to give 45 days' written notice of intent to cancel or refusal to renew a policy and the insured will have the right to request a review of the insurer's action by the State Corporation Commission (House Bill No. 140, Ch. 376). Participation in the state insurance plan will be available for localities and their officers, agents and employees. Additionally, a market assistance plan has been put together by the Bureau of Insurance for the localities. A number of other bills to effect various tort reforms were considered during the 1986 Session but were defeated or carried over to allow further consideration. Many of the bills are specific to medical malpractice or governmental liability cases. (See list, Appendix B).

House Joint Resolution No. 93 was adopted and calls for a study by the State Corporation Commission of the problems experienced by day care centers and family day care homes. The S.C.C. is directed to make recommendations which may result in "assisting insurance companies to make coverage more available and to reduce liability insurance premiums." House Joint Resolution No. 43 created a joint subcommittee to study the insurance rates of taxicab owners. Both study groups are to submit their reports and recommendations for consideration by the 1987 Session of the General Assembly.

The availability and affordability problems today are focused primarily in the medical malpractice and general liability lines. In 1985, medical malpractice premiums accounted for less than 2% of all property and casualty premiums written, while underwriting losses attributable to malpractice coverage accounted for 5.6% of all underwriting losses. General liability premiums accounted for less than 8% of all property/casualty premiums but 18.3% of all underwriting losses were attributable to this line.[2]

The broad availability/affordability crisis experienced nationally is linked to several factors. During the period 1979-1983, the insurance industry experienced an average annual increase of $3 billion in underwriting losses.[3] Increases in investment income resulting from the high interest rates of the late 1970's and early 1980's were initially able to cover the increased underwriting losses. However, as interest rates declined, so too did investment income. The result was reductions in the insurers' surplus. Minimum surplus is required to protect insureds from a company's insolvency. Reductions in surplus restrict the ability of a company to write new business, thereby creating availability problems for insurance consumers.

Conflicting explanations for the increases in underwriting losses, and data to support those explanations, have been proffered. Some point to an "explosion" in the frequency and severity of tort claims, compounded by an inability to accurately predict risk exposure due to judicial activism in expanding traditional doctrines under which liability is imposed. Others suggest that in their rush to attract new premium dollars to invest at the high rates of return, insurers wrote new business at rates below those filed with state regulators and were not as careful as they should have been in picking the risks they would insure. The joint subcommittee found some truth in both positions. All generally agree that the profit/loss experience of the insurance industry is cyclical in nature and that the recent dip in the cycle is perhaps the worst yet experienced by the industry.

It is significant that the joint subcommittee found little empirical data pointing to the tort system in Virginia as the primary contributing factor to the current problems. During the period 1975-1985, health care costs nationally increased 300%, from $132.7 billion to $400 billion. The Consumer Price Index rose from 133.1 to 289.1.[4] A study conducted by Tillinghast, Nelson and Warren, Inc. of Atlanta concluded that the rise of 8.9 times in liability-related costs, after adjustment for inflation, is not out of line with the expansion of other compensation programs such as welfare (9.3 times) or Social Security, Medicaid and Medicare (18.2 times).[5]

Critics of the tort system point to the "explosive" growth in the number and amount of plaintiffs' verdicts. It is impossible to determine whether there has been any increase in the number of tort suits filed in Virginia. Virginia does not keep records breaking down the classification of civil cases. However, during the period 1977 through 1984, the total number of all civil cases commenced (including divorce, property, etc.) increased 19.3% in the circuit courts and 79.4% in the general district courts. During that same period, the population of Virginia increased 8.3%. New civil filings were up 11.6% during the period 1980-84 while the population increased 5.4%.[6]

A recent study by the National Center for State Courts analyzed data from twenty states keeping statistics on tort, contract and real property rights suits. The data revealed a 14% increase in the number of filings during the period 1978-81 and a 4% decrease in 1981-84. The increase in filings for the entire period 1978-84 was 9%. During 1978-84, the population in those states increased by 5%. Thirteen states provided comparable data for tort filings only. The increase in tort filings was

only 2% for 1978-81 and 7% for 1981-84. The population increased by 4% during each period. For the entire period of 1978-84, total tort filings increased 9% while the population increased 8%. The report notes that tort filings were the only types of cases analyzed in the study where the aggregate number of cases increased over each time period evaluated. However, the study concludes that this does not qualify as a "litigation explosion", since the population increased at approximately the same rate as tort filings.[7] The joint subcommittee did not find any circumstantial evidence of an uncontrolled "explosion" in the number of tort filings in Virginia.

Nationally, there have been 1,642 awards of $1 million or more in the past 14 years. In more than 2/3 of those cases, the plaintiffs had suffered permanent paralysis, brain damage, amputations or death.[8] It has been suggested that when these few large awards are excluded from consideration, the rate of increase in the frequency of large damage awards is minimal.[9]

The Circuit Court Report publishes data on jury awards in state courts in the Richmond metropolitan area. An analysis of the 231 jury verdicts returned for plaintiffs during the period 1982-1986 established an average award of $57,400.[10] This figure includes three awards which exceeded $1 million.

The average medical malpractice award nationally increased from $220,000 to $1 million during the period 1975-1985. The average medical malpractice award in the Richmond area during 1982-1985 was $302,000.[11] The average medical malpractice claim paid statewide in 1984 was $17,000.[12] The loss ratio for insurers in Virginia is significantly better than the national average for medical malpractice, and other liability lines (See Appendix C).

Much of the available evidence suggests then that increases in frequency and severity of tort claims nationally and in Virginia are generally in line with increases in the costs of medical care, population and, possibly, increases in the severity of injuries sustained. Yet, notwithstanding the apparently bright picture, the Virginia Insurance Reciprocal which writes insurance only in Virginia, experienced an increase of approximately 500% in actual payments made on medical malpractice claims on behalf of physicians during the period 1981-1984. The average incurred per physician claim almost doubled between 1984 and 1985 and during the period 1982-1985 increased from $15,000 to $62,500.[13] It is difficult to ascertain the reason for this experience.

The joint subcommittee also found it difficult to evaluate the financial condition of the insurance industry. It has been suggested that if adjustments are made for some of the more common and unique accounting practices used by the insurance industry with regard to the treatment of taxes, dividends and the rising value of paper, the industry has made a profit every year. Much of the financial data is based upon the companies' own estimates of future losses (i.e. reserves). Critics of the industry charge that companies can easily hide income and report greater losses by artifically inflating reserves. The companies can then report incurred losses which exceed premium income. The National Insurance Consumer Organization contends that industry profit, after taxes, for 1985 was actually $5 billion.[14]

In testimony before the House Ways and Means Committee, a senior associate director of the U.S. General Accounting Office claimed that during the period 1976 through 1985 the industry had a net gain of $75 billion ($140.2 billion investment gain less $65.2 billion underwriting loss). The investment gain figure used by the GAO includes unrealized capital gains "because it is within a company's control to manage its investment portfolio so as to realize those gains while the investment is profitable." The underwriting loss figure does not include policyholder dividends because "the companies are not required to make these distributions."[15] If the GAO figures are adjusted to exclude unrealized gains and include dividends the industry's net gain is claimed to be $51 billion.

In Virginia, the financial condition of insurance companies and business practices and products of the companies and their agents are regulated by the Bureau of Insurance (State Corporation Commission). There are currently 116 authorized technical/clerical and professional positions within the Bureau. Thirty-five employees are engaged in financial regulation of the insurers, including on-going analysis of the companies' results and their financial condition. Sixty-five employees review the day-to-day business and consumer oriented practices of the companies. There are approximately 608 property and casualty insurers licensed to transact business in Virginia. The records of domestic insurers are examined every three years. However, more frequent on-site examinations may be conducted if a particular problem in a company's financial picture has been identified or until a new company is able to stabilize its business. For foreign insurers, the Bureau relies on examiners from the insurer's home state. On-site zone examinations, requiring participation by regulators of the insurer's domicile and of states in which they do business, are required if the premium volume of the company in the foreign jurisdiction exceeds 20% of the total premiums written or $1 million.

Rates for liability insurance in Virginia are regulated primarily through competition in the industry. Prior approval of rates by the State Corporation Commission (S.C.C.) is not required except as provided in § 38.2-2000, et seq. The major lines requiring prior approval include uninsured motorist coverage, workers compensation, assigned risk automobile coverage and home protection contracts. Proposed rates for medical malpractice insurance and supporting data for the rates must also be filed with the S.C.C. (§ 38.2-1912). Under a competitive market rating system, the rates filed by the insurers with the S.C.C. become effective unless the Commission determines that the rates are excessive, inadequate or unfairly discriminatory. Insurance industry representatives explained that to the extent Virginia data on loss experience is credible, it is used in the rate-making process. As long as there is a reasonable degree of competition in the marketplace, the rates filed cannot be determined to be excessive (§ 38.2-1904).

In general, loss reserves for routine claims are set on a formula basis using average amounts based upon past experience. As more information is gathered on these claims, reserves are adjusted based upon the company's best actuarial estimates of the value of the claim (case basis). The reserves set by the companies are reviewed by the Bureau to ensure that they are not excessive or inadequate to cover claims.

Currently companies being licensed in Virginia are statutorily required to maintain a minimum surplus of $1 million and $1 million in paid-in capital if a stock company or $2 million in surplus for non-assessable mutual companies. The Bureau requires all companies licensed in Virginia to maintain a $300,000 "cushion" in addition to the above requirements. The general rule is that premium volume for a company should not exceed three times the value of the company's "surplus to policyholders." "Surplus to policyholders" means the total capital and surplus for stock companies or total surplus for mutual companies (§ 38.2-100). When following this rule, a company's ability to write new coverage decreases as its surplus to policyholders decreases.

Reserve and surplus requirements provide protection to consumers against insurance company insolvencies. Testimony before the joint subcommittee suggested that the Bureau will tend to err on the side of high reserves in order to protect consumers from the possible insolvency of the company. With the exception of one small insolvency in 1981, there have been no problems with respect to domestic property and casualty insurers in Virginia. In the past two years, however, there has been a rapid increase in the number of insolvencies of foreign companies licensed in Virginia. In mid-1986, eighteen companies were being handled by the Guaranty Fund.

The joint subcommittee believes that, in general, the competitive rating system and the degree of regulation of the industry by the Bureau of Insurance have worked well. However, the joint subcommittee was concerned by the numbers of persons they heard from representing day care centers, bars, restaurants and others, who were experiencing severe problems obtaining adequate and affordable liability coverage although they had never had a claim filed against them. It is apparent that this should not be the case.

FINDINGS AND RECOMMENDATIONS

The joint subcommittee began deliberations by gathering data on the nature and extent of the "liability insurance crisis". While it quickly became apparent that the problems were widespread[16], the specific reasons for the manifestation of the problems have not been so easy to identify. The joint subcommittee recognizes that excesses in the civil justice system exist and that such factors necessarily influence the cost and availability of liability insurance. However, the joint subcommittee found that, on balance, the Virginia civil justice system contributes to a relatively stable loss environment for liability insurers. For example, the joint subcommittee found no evidence that punitive damages were being awarded too frequently or in excessive amounts in Virginia. The standard for an award of such damages is sufficiently high (actual malice or such recklessness or negligence as to show a conscious disregard of the rights of others, Giant of Virginia v. Pigg, 207 Va. 679). The doctrine of joint and several liability, while admittedly creating some risk assessment problems for defendant's insurers, is almost uniquely appropriate in Virginia because of our adherence to the doctrine of contributory negligence as a complete defense.

Nevertheless, the joint subcommittee recognizes that (i) the continued availability of affordable liability insurance coverage is necessary and (ii) insurers are finding it increasingly difficult to provide such coverage given their obligations to their shareholders to make a reasonable profit and their inability to accurately predict their risk exposures due to factors outside of their control and the control of the Virginia General Assembly. A majority of the joint subcommittee therefore recommends the attached legislative proposals as striking the proper balance between the needs of the consumers, injured persons and insurers. (See Appendices F1 through F9.)

A. INSURANCE REGULATORY REFORM

The joint subcommittee found that Virginia occupies a preferred position among the other states with respect to loss experience. In the medical malpractice line, Virginia has the third best loss ratio in the country. The joint subcommittee believes it is critical that Virginia purchasers of liability insurance obtain the benefits of that good loss experience.

In testimony before the joint subcommittee, Attorney General Mary Sue Terry outlined a proposal for modifying the way in which insurance companies are regulated in Virginia. The Attorney General suggested that in order to ensure that Virginia insured's are not subsidizing insured's in other states with bad loss experience, a nexus must be established in the rate making process between Virginia loss experience and premiums charged. She further suggested that this be accomplished by (i) discontinuing the presumption in the rate making process that competition is an effective regulator rates for most liability lines, (ii) requiring more detailed information to be submitted, by line, for each rate filing to be used in making the determination whether competition is an effective regulator of rates and whether the rates are excessive, and (iii) requiring closed claim reporting for commercial liability lines to provide a more detailed data base for rate making and for monitoring any future "crises" which might develop (See Appendix D; Compare Appendix E, proposal submitted by the Bureau of Insurance).

The joint subcommittee found some significant merit to the Attorney General's proposal. However, they noted with concern the objections to specific provisions of the proposal raised by the Bureau of Insurance and industry representatives. It was noted that exclusive reliance on Virginia experience in the rate making process could be harmful to Virginia insureds in some circumstances (e.g., rate filings for products liability or day care centers). Therefore, it was suggested that rather than requiring such reliance in all cases, the Bureau should be allowed to discount aberrational Virginia-specific data.

Additionally, it was suggested that the proposal constituted a rejection of the file and use rate making process and a return to prior approval. The Bureau and the industry question the need for requiring additional hearings in the rate making process in the absence of a showing that competition is not effectively regulating the market. It was noted that such hearings would undoubtedly increase the costs of the rate making process. These costs would certainly be passed on to the consumer. It was also suggested that the further hearing requirements might have a

detrimental effect on competition. Some insurers might stop writing in Virginia and thereby exacerbate the availability crisis.

The Bureau agreed with the Attorney General's recommendation that additional information, broken down by line, should be submitted with the annual report. The Bureau believes this will be helpful to them in the rate making process. (See Appendix D, § 38.2-1301.1 and Appendix E, § 38.2-1301.1.) The Bureau does not believe that similar additional data should be required as a part of each rate filing. (See Appendix D, § 38.2-1906.) The Bureau suggests that it has the inherent authority to require additional data as a part of any rate filing, if necessary.

With respect to the closed claim reporting requirement, the Bureau and the industry raised a number of objections. First, the Bureau argues that the data is not credible for rate making purposes due to the lag time between when the claim was filed and when it was paid. Therefore, the data is of no use to them. Second, based on experience with the closed claim reports in medical malpractice cases, the data is of no use to anyone. According to Bureau representatives, rarely, if ever, are they asked for access to the data collected pursuant to § 38.2-2228. Third, the National Association of Insurance Commissioners is currently working on a uniform reporting form to standardize the collection of such data by the states. The form will minimize the costs to the industry of compliance with state reporting requirements. It is anticipated that a report by the N.A.I.C. will be available after the first of the year.

Recognizing the merits of both positions, the joint subcommittee in mid-October asked representatives of the Attorney General and representatives of the Bureau of Insurance to attempt to work out a compromise proposal. The joint subcommittee believed that these individuals who had developed the interest and expertise in this complex area were in the best position to work out a proper legislative recommendation. The joint subcommittee had hoped for a proposal which would include administratively workable provisions to (i) encourage more detailed oversight of the rate making process when necessary, including enhanced collection of data by line or subclassification, (ii) greater reliance on credible Virginia-specific loss experience data and (iii) some form of closed claim reporting requirement. The joint subcommittee is concerned that any additional regulation of the industry not worsen, in any way, the current availability crisis. Unfortunately, the specific statutory language of such a compromise could not be worked out prior to the last meeting of the joint subcommittee on December 3, 1986. The joint subcommittee was advised that the Attorney General and the State Corporation Commission would continue to meet and were working towards such a compromise. It is sincerely hoped by the joint subcommittee that a proposal will be submitted for consideration by the 1987 Session of the General Assembly.

B. TORT REFORM

The joint subcommittee spent a considerable amount of time addressing the availability problems facing the medical profession, specifically obstetricians. The situation has truly reached a crisis level. PHICO Insurance Company announced that beginning November 1, 1986, it will not renew coverage for the 1,100 physicians they insured who are not employed

by a hospital or who do not practice in a group of 10 or more. St. Paul's and the Virginia Insurance Reciprocal had previously placed a moratorium on new business for obstetricians. Many of those subject to non-renewal by PHICO are obstetricians. Therefore, their access to liability coverage is severely restricted.

In response to PHICO's action, the State Corporation Commission activated the Joint Underwriting Association pursuant to § 38.2-2800 et seq. As of December 3, 1986, the J.U.A. had received seven applications for coverage; only two of the applicants met the criteria for coverage.

Many people question the ability of the J.U.A. to ease the crisis in any meaningful way. The costs of participation are high (premium plus 50% assessment). Additionally, the individuals who will pay those costs and be insured by the J.U.A., will be those who have, for one reason or another, been identified by the commercial insurers as "high risk" insureds.

The joint subcommittee recognizes the obvious need for the continued availability of medical care and further recognizes that this continued availability is severely jeopardized by the unavailability of adequate liability coverage. However, the joint subcommittee also believes that the liability exposure for Virginia insureds is relatively good and that the limitation on recovery in medical malpractice actions (§ 8.01-581.15) is constitutional. Cf., Boyd v. Bulala, Civil Action No. 83-0557-A-C (W.D.Va., Nov. 5, 1986). But health care providers in Virginia who provide services to minors face peculiar problems.

Insurers find it difficult to adequately assess the risk exposure of health care providers who treat minors because of the long tail on the claim. Under Virginia law, a minor has until his twentieth birthday to file a claim (See § 8.01-228). It is extremely difficult to document or prove or disprove events which occurred as long as twenty years ago for birth-related injuries. This problem is compounded by the inherent complexity of medical malpractice cases.

Recognizing (i) the particular and severe insurance availability problems facing physicians, (ii) the need of insurers for predictability of risk exposure and (iii) the effect of the provision tolling the two-year statute of limitations during minority on the ability of insurers to adequately assess their risk of loss, the joint subcommittee recommends that the statute of limitations, as it applies to minors in medical malpractice actions, be modified. Appendix F1. The proposal is based on a similar provision in Indiana law and would require actions by minors who are injured by malpractice while under the age of six to commence the action before reaching age eight. A minor six years of age or older who is injured by medical malpractice would not have the benefit of any tolling provision. The joint subcommittee believes that this proposal will accomplish the goal of relieving the insurance availability crisis while affording reasonable protection to an injured minor. The length of time given a minor under six is sufficient to allow a malpractice injury to manifest. By the time a minor reaches his eighth birthday, he has had several years of formal education and socialization. Latent neurological injuries, for example, will be apparent. Under the proposal, a minor

would be allowed to take advantage of the date of discovery accrual provision in the same manner as an adult in cases involving foreign objects and fraudulent concealment of the injury. See § 8.01-243 C.

The joint subcommittee also heard testimony about another peculiar problem affecting birth-related services. Many obstetricians throughout the state rotate through hospital emergency rooms. While working in the emergency room, they frequently will be faced with an indigent female about to deliver. Because the woman is indigent, she frequently will not have received the best, if any, prenatal care. She is, therefore, considered a "high risk" delivery.

Faced with the existing insurance climate, many obstetricians and many hospitals across the state are limiting their liability exposure by refusing to participate in the delivery of an indigent female. The joint subcommittee recognizes the legitimate concerns of these health care providers, but believes this is an unacceptable alternative. The joint subcommittee recommends that "Good Samaritan" immunity be granted to health care providers who render emergency obstetrical services to a female in active labor without compensation. Appendix F2. It is not intended that the immunity granted under this proposal would attach where the physician waived his right to compensation after a bad result delivery, in order to avoid the imposition of liability.

Other groups testified before the joint subcommittee to outline particular problems being experienced. With respect to day care centers, the joint subcommittee was concerned about the problems raised but agreed to defer to the findings and recommendations of the State Corporation Commission upon completion of their study. (H.J.R. No. 43) As previously indicated, the impetus for this study was the problems municipalities were experiencing in obtaining adequate and affordable coverage. Some relief was provided by the General Assembly in 1986 (See previous discussion). However, the joint subcommittee recognizes the unique nature of the services provided by governmental entities and wants to ensure the continued availability of qualified individuals to serve in necessary positions. Therefore, the joint subcommittee recommends that immunity from liability for simple negligence be granted to members of local governing bodies and boards, commissions, etc., of local governmental entities. Appendix F3. The proposal submitted is drawn from a statute recently enacted in Tennessee. Specific exclusions from the immunity provisions are provided for willful misconduct and knowing violations of criminal law. Additionally, functions of the members involving the appropriation of funds are excluded.

The joint subcommittee also recommends that a limitation be placed on the liability of corporate officers and directors. The joint subcommittee heard testimony about the increasing unavailability of liability coverage for officers and directors. For example, one small manufacturing company advised the joint subcommittee that in 1985 they experienced a 2000% increase in premium, a 400% increase in their deductible and a 67% decrease in coverage. Members of the joint subcommittee were especially concerned about the deterioration in the availability and affordability of this type of coverage in light of the fact that in 1985, the General Assembly effectively immunized officers and directors by adopting a "good faith, business judgment" standard. See §§ 13.1-870 and 13.1-690.

As with municipalities, the joint subcommittee recognized the relative importance to all Virginians of ensuring that qualified individuals continue to serve in such positions. The joint subcommittee believes that it is necessary to provide an outside limit on the liability of such individuals in order to ease the availability/affordability problems in this line of coverage. The proposed legislation is a limited step to this solution. Appendix F4.

Officers and directors of not-for-profit corporations, who serve without compensation, are granted immunity from liability for acts involving simple negligence in any type of civil action arising out of the performance of their duties. The immunity granted and the broad classification of civil actions to which it applies are believed to be justified given the public service nature of the duties these individuals undertake. The immunity does not attach to these officers and directors if they receive compensation for their services. However, in recognition of their public service, these individuals do have limited liability in any civil action arising out of their duties. This liability is limited to the lesser of an amount specified in the articles of incorporation or by laws or the cash compensation received during the prior year.

Different policy considerations were controlling with respect to officers and directors of for-profit corporations. The joint subcommittee does not believe a cloak of immunity is necessary or desirable. The joint subcommittee recommends a limitation on liability equal to the lesser of (i) any amount specified in the articles of incorporation or by-laws or (ii) the greater of $100,000 or the cash compensation received during the prior year. The limitation specified in Subsection (i) was included in order to allow the corporation and shareholders an opportunity to reduce the liability of the officers and directors below the statutory amount specified in Subsection (ii) if they believe the reduction is in their best interests.

For the same reason that the public service aspect of the duties is not primary, the joint subcommittee does not believe that the limitation should apply in all civil actions. Rather, the limitation applies only in derivative and shareholder proceedings. Third-party suits against officers and directors of for-profit corporations will not be subject to the limitation on liability.

The joint subcommittee also heard testimony from pest controllers and holders of permits for solid waste facilities. Each of these groups is required by statute or regulation to maintain minimum assurance of financial stability in the event of a loss. The purpose of these minimum requirements is to provide protection to the public in the event of a potentially catastrophic loss. In the past, commercial liability insurance provided the necessary assurance in most instances. However, the joint subcommittee was advised that adequate coverage for these types of businesses has become unavailable due to the high risk nature of the activities performed. The joint subcommittee believes that these services also are necessary and recommends that pest controllers and solid waste facility permit holders be allowed to satisfy the minimum financial responsibility requirements otherwise than by commercial liability insurance if such insurance is not available. Appendix F5.

The proposals discussed above are addressed to specific problems affecting the availability and affordability of liability insurance coverage. In addition to these proposals, the joint subcommittee recommends four much broader proposals which affect how the determination is made whether a person is entitled to compensation and the ways in which injured persons will be compensated. These final recommendations are intended to ensure the continuation of an equitable system of assessing damages and paying compensation for civil wrongs. Additionally, the proposals affecting the payment of damages will add a greater degree of predictability to the risk assessment process.

The joint subcommittee recommends that most of the exemptions from jury service be eliminated. Appendix F6. Juries perform an important function in our civil justice system, and in our criminal justice system as well. It is the jury which sifts through all the frequently conflicting evidence to determine the facts. It is essential that juries be drawn from a cross section of the population. The joint subcommittee believes that increasing the pool of persons available for jury service will improve the quality of justice for several reasons.

First, the expertise and knowledge brought into jury deliberations by individual jurors will necessarily be broader. Second, increasing the numbers of persons available for service will decrease the number of times an individual is called to serve. Minimizing the inconvenience associated with jury service will improve the attitude of the individual toward jury service. Third, increasing the numbers of persons exposed to the civil justice system will improve the public understanding of the ways in which the system works. The joint subcommittee believes that improved understanding will lead to greater confidence in and respect for the process.

Additionally, the joint subcommittee recognizes the public perception that frivolous suits are clogging the court system. No testimony or other data was presented suggesting this was a significant problem in Virginia. Nonetheless, to ensure that such a problem does not arise and to further improve public confidence in the system, the joint subcommittee recommends that the courts of the Commonwealth be specifically empowered to impose sanctions on parties or their counsel who interpose frivolous claims or defenses. Appendix F7. The proposal is modeled after Rule 11 of the Federal Rules of Civil Procedure.

The proposal expanded Rule 11 to cover the making of oral motions. Unlike federal practice, much of the practice in Virginia courts, especially in the district courts, is based on oral motions. In order to ensure the effectiveness of the sanction proposal in discouraging frivolous and dilatory practices, it was necessary to cover oral motions.

The joint subcommittee discussed at some length whether to delete the provision of Rule 11 allowing the issue of sanctions to be raised by any party or his counsel. Critics of this provision suggest it would contribute to delays in proceedings by encouraging each party in every action to seek sanctions against the other(s). The joint subcommittee concluded that allowing sanctions to be imposed only upon motion of the court would effectively eliminate a significant facet of the proposal. The joint subcommittee believes that detection and punishment of a

violation of the certification requirement should be an obligation of all persons who use the civil justice system. In this way, the efficient operation of the system will be maintained.

There was some disagreement among the members over the remaining legislative proposals.[17] Each proposal affects, in some way, the compensation to be paid an injured person. The issues involved are emotional ones.

The joint subcommittee recognizes that there is an element of unfairness inherent in any statutory limitation on the recovery of damages in a civil action. However, in certain circumstances, such limitations are required for the good of the public as a whole.

Non-economic damages are subjective in nature. Testimony received indicated that it is this element of damages which is most subject to abuse by triers of fact and which accounts for significant escalations in the amounts of total damages awarded. This, in turn, affects the availability and affordability of liability insurance coverage. Our society has become dependant upon commercial liability insurance as the means of spreading the risk of loss. The continued availability of coverage is therefore necessary to the continued functioning of society and the continued availability of necessary goods and services.

A majority of the joint subcommittee believes that the proposed limitation on non-economic damages strikes a proper balance between the rights of injured persons to full and fair compensation and the need to provide a greater degree of predictability to the loss assessment process. This will ensure the continued availability of liability insurance coverage and the continued inability of the tort reparations systems for the benefit of all Virginians. Appendix F8.

With or without a limitation, some people will be overcompensated for their non-economic loss and others will be undercompensated. The proposal does not affect an individual's right to full compensation for his actual, out-of-pocket losses. Additionally, by including the unique provision for recovery of non-economic damages up to three times the economic loss incurred if greater than the dollar limitation of $250,000, the proposal more equitably provides for the most seriously injured individuals. These persons will generally incur higher economic losses (e.g., medical expenses and lost wages). The proposal specifically limits the total of non-economic damages as against all defendants. Additionally, it specifically provides that the limitation on non-economic damages be applied within the $1 million dollar limitation on total recovery in medical malpractice actions. See § 8.01-581.15.

Finally, a majority of the joint subcommittee recommends that awards for future damages be payable in periodic installments to the extent the amount of the award exceeds $250,000. Appendix F9. The proposal is modeled after a recently enacted Florida statute. The majority believes that this proposal will result in a significant cost savings to a defendant or his insurer. Insurers may then pass the savings on to consumers. Additionally, the periodic payment schedule assures the injured party sufficient compensation for expenses to be incurred at the time they are incurred. The joint subcommittee discussed at some length

whether payments for future medical expenses and future non-economic loss should terminate upon the premature death of the injured person. Theoretically, the cost-savings aspect of the periodic payment proposal would be enhanced. However, the joint subcommittee was advised that a scheduled payment package which would give credit to the purchaser in the form of a reduced purchase price or a rebate for such an early reduction provision did not exist. The joint subcommittee recommends then the full amount of the payments continue to be made.

CONCLUSION

The joint subcommittee spent considerable time reviewing the complex issues under study. In general, the joint subcommittee is satisfied that the insurance regulatory system and the civil justice system in the Commonwealth are functioning in an equitable manner. Nonetheless, the joint subcommittee believes there is room for improvement. The proposed legislative package on tort reform and the suggested insurance regulatory reforms represent well-reasoned improvements in those systems. These improvements will ensure that Virginians continue to have access to an equitable system for determining liability and assessing damages, and that the method of payment of those damages, which in most instances involves liability insurance, will be available and affordable.

The joint subcommittee members did not have sufficient time to address several of the charges to them outlined in Senate Joint Resolution No. 22. They believe that an evaluation of alternative methods of dispute resolution as specified in the resolution should be conducted. Therefore, the joint subcommittee also recommends that the study be continued for an additional year to allow a review of the need for and effects of the implementation of the various methods of alternative dispute resolution and also to provide an opportunity for an evaluation of any available data on the effects of the recommendations of the joint subcommittee adopted by the General Assembly.

Respectfully submitted,

William F. Parkerson, Jr., Chairman
C. Hardaway Marks, Vice-Chairman
William E. Fears
Wiley F. Mitchell, Jr.
Thomas W. Moss, Jr.
Theodore V. Morrison, Jr.
V. Thomas Forehand, Jr.
Frank D. Hargrove

FOOTNOTES

[1]These attorneys were: Colin J. S. Thomas, Jr., of Staunton; Thomas E. Albro of Charlottesville; T. S. Ellis, III, of Richmond; Thomas V. Monahan of Winchester; Alexander H. Slaughter of Richmond; C. Flippo Hicks of Gloucester; and Edward W. Taylor of Richmond.

[2]Statement of Johnny C. Finch, General Government Division of the United States General Accounting Office, before the Subcommittee on Oversight of the House Committee on Ways and Means on the Profitability of the Property/Casualty Insurance Industry, Apr. 28, 1986, at p. 9.

[3]The Executive Letter, Special Report, Insurance Information Institute, June 24, 1985.

[4]Don't Punish the Injured, Peter Perlman, ABA Journal, May 1, 1986 at 34.

[5]Those Who Pay Most Lobby to Change Way Suits Are Tried, Damages Awarded, Wall Street Journal, Jan. 21, 1986 p. 31.

[6]Information supplied by Robert N. Baldwin, Executive Secretary, Supreme Court of Virginia and Donald Lillywhite, Department of Planning and Budget.

[7]A Preliminary Examination of Available Civil and Criminal Trend Data in State Trial Courts for 1978, 1971 and 1984, Court Statistics and Information Management Project, National Center for State Courts, April 1986.

[8]The Explosion in Liability Suits Is Nothing But A Myth, Business Week, April 21, 1985.

[9]Id.

[10]Discussion of Verdict Analysis of Richmond Metropolitan Area by Thomas W. Williamson, Esquire of Richmond; submitted to the joint subcommittee July 16, 1986.

[11]Id.

[12]Testimony of Grover C. Czech, American Insurance Association before the Joint Subcommittee Studying Virginia's Medical Malpractice Laws, 1985.

[13]Letter from F. Douglas Wall, Vice-President, Virginia Insurance Reciprocal to Edward C. Minor, Union Camp Corp., dated Aug. 6, 1986.

[14]Sorry, Your Policy is Cancelled, Time, March 24, 1986.

[15]Statement of Johnny C. Finch, supra.

[16]At the public hearing held on August 12, 1986, over 35 persons representing various businesses and professions registered in advance to detail their individual problems and numerous others spoke or submitted written statements.

[17]Mr. Marks and Mr. Morrison do not believe it is necessary or desirable to place a limitation on the recovery of non-economic damages. They note that no evidence was presented to suggest that such a limitation would directly affect the availability or affordability of liability insurance coverage. Additionally, they note that limitations on recovery are the subject of litigation pending before the Virginia Supreme Court and the Fourth Circuit Court of Appeals. Mr. Moss abstained from the vote on this proposal. Mr. Marks and Mr. Morrison also dissent from the recommendation that the periodic payment of damages concept has merit and should be encouraged. However, they do not believe that the method of payment should be mandated.

Dissent-in-Part of Wiley F. Mitchell, Jr.

I find myself in the unusual position of agreeing with the subcommittee's legislative recommendations, but disagreeing with portions of the report on which those recommendations are based. My points of disagreement are as follows:

1. The effort to minimize the significance of the nearly nine-fold increase in liability related costs which occurred between 1975 and 1985 by comparing that increase with similar increases in welfare, social security, and Medicaid costs is bizarre. The simple fact is that liability related costs, most of which are driven up by our current tort system, increased during the 1985-86 period at a pace many times that of the consumer price index. That fact should not be obscured by questionable comparisons to increases in unrelated social welfare programs.

2. Relying primarily on a nationwide study conducted by the National Center for State Courts, the subcommittee report finds no evidence of a litigation explosion in Virginia. In reaching this conclusion, the report ignores uncontroverted evidence that civil litigation filings in Virginia increased at more than twice the rate of population growth during the same eight-year period covered by the National Center for State Courts study.

3. The report attempts to play down the significance of the huge increase in the number of multi-million dollar verdicts by suggesting that these "few large awards" distort the liability picture. In fact, the percentage increase in the number of million dollar plus verdicts during the last five years has been nothing short of phenomenal, and it is no more accurate to disregard the large verdicts at the top of the spectrum than it is to disregard the small verdicts at the bottom. Both contribute to "average" costs. The million dollar verdicts, however, have a grossly disproportionate effect on overall liability costs because of their impact on voluntary settlements. Between 80 and 90 percent of all claims for injury or death are settled short of verdict, and knowledge of the growing exposure to million dollar verdicts exerts enormous pressure to settle at higher and higher levels. In short, million dollar verdicts breed million dollar settlements and it is the cost of these settlements which determines more than three quarters of all claims costs.

4. The reference in the report to profits made by the insurance "industry" is accurate but misleading. Many individual insurance companies, particularly those specializing in high risk segments of the market, have experienced severe losses and have either withdrawn from the market entirely or have gone into receivership. Moreover, almost every insurance company in the business of writing general, commercial, or professional liability coverage has had to rely on investment income, rather than premiums, to balance its books for most of the last

decade. Profits of insurance companies aside, the evidence is uncontroverted, in my judgment, that the overall rise in claims costs during the last decade has considerably exceeded the rate of inflation.

5. The report does not mention the effect of the current tort system on the reinsurance market, much of which is concentrated in London. Major European underwriters have become so concerned over their inability to predict accurately either the nature or the extent of their potential losses that they have either withdrawn from the American market entirely or have severely restricted the coverage they are willing to write. This, in turn, severely limits the capacity of the domestic market and adversely effects most domestic premiums and coverages.

6. The doctrine of joint and several liability is inherently inequitable in that responsibility for paying a loss is determined primarily by the ability to pay, not by the degree of fault. It poses not just a "risk assessment" problem, as the report seems to suggest, but also a problem of fundamental fairness. This doctrine should be abolished.

7. I agree that physicians who render uncompensated emergency care to women who are giving birth should be protected by the good samaritan doctrine, but I fail to see any relevance at all in the question of whether the woman is or is not indigent. The issue should be the emergency nature of the care, not the financial resources of the patient.

8. I do not agree with the report that the primary reason for adopting a rule penalizing the party who institutes a frivolous suit or asserts a frivolous defense is the "impression" that frivolous suits are clogging our courts. In my judgment, both plaintiffs and defendants are frequently subjected to unreasonable delays, expense, and inconvenience because of frivolous claims or frivolous defenses. This is the impetus for the suggestion that Rule 11 of the Federal Rules of Civil Procedure be adopted.

Index to Appendices

APPENDIX A

SENATE JOINT RESOLUTION NO. 22

Requesting creation of a joint subcommittee to study various tort reforms and the means of ensuring the continued availability of affordable liability insurance coverage.

Agreed to by the Senate, March 4, 1986
Agreed to by the House of Delegates, February 28, 1986

WHEREAS, an ad hoc subcommittee of the Senate Courts of Justice Committee was created to examine the nature and extent of the problems local governments were experiencing in obtaining affordable liability insurance; and

WHEREAS, during the course of the study it became apparent that the problems involving the cost and availability of liability insurance were pervasive, affecting most lines of liability coverage including governmental, professional, malpractice, products liability and hazardous and toxic substance liability; and

WHEREAS, the problems experienced nationwide in obtaining liability insurance coverage are having a significant impact in Virginia on the ability of governments, professionals, manufacturers and businesses, including day care facilities, to provide goods and services and, if allowed to continue, may result in a substantial curtailment in the availability of essential governmental services, health care, and other necessary goods and services; and

WHEREAS, the causes for declining availability of and skyrocketing premium increases for liability coverage in Virginia are complex, involving various aspects of the tort reparations system and insurance industry practices; and

WHEREAS, it is not against the public policy of Virginia to insure for punitive damages, and punitive damages are being sought more frequently, and awards for multiple punitive damages awards against the same tort-feasor based upon the same act or course of conduct, regardless of the duration of the tortious conduct or the number of persons claiming to be injured are being allowed; and

WHEREAS, the subcommittee believes that a thorough review of (i) the causes for and extent of the problems regarding the availability and cost of liability and other related insurance coverage, and (ii) the efficiency of the tort reparations system in the Commonwealth is necessary; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee be created to study (i) the causes, effects and possible solutions to the problems experienced by political subdivisions, businesses, including day care facilities, and citizens of the Commonwealth in obtaining adequate and affordable liability and related insurance coverage and (ii) the tort reparations system, including a review of the ability of that system to ensure an equitable method of determining liability and assessing damages, and the impact of that system on the cost and availability of liability insurance, and to make recommendations on methods for improving the liability insurance system and the tort reparations system as they may affect the public interest.

The membership of the joint subcommittee shall be appointed as follows: two members of the Senate Committee for Courts of Justice, and one member of the Senate Committee on Commerce and Labor to be appointed by the Senate Committee on Privileges and Elections; three members of the House Committee for Courts of Justice, and two members of the House Committee on Corporations, Insurance and Banking to be appointed by the Speaker of the House of Delegates.

The joint subcommittee is requested to study the need for and effects of modifications in the laws with respect to procedures governing offers of judgment similar to the provisions of Rule 68 of the Federal Rules of Civil Procedure, procedures for trials limited to damages only in cases where liability is admitted and other alternative methods of dispute resolution, including mediation, arbitration and conciliation, limitations on the amount and payment of noneconomic damages, including punitive damages, limitations on the amount of damages payable, limitations on both plaintiffs and defendants attorneys' fees, application of the Virginia Tort Claims Act to localities and limiting damages recoverable from state and local employees, and the desirability of other reforms. The joint subcommittee is requested to seek the advice and assistance of independent economists and actuaries, the Bureau of Insurance, and representatives of the particular groups most affected by the increasing unavailability and cost of insurance and to monitor the study of similar issues being conducted by the Presidents' Tort Policy Working Group. The joint subcommittee is further requested to complete its work prior to November 15, 1986.

The direct and indirect costs of this study are estimated to be $20,245.

APPENDIX B

1986 Tort Reform Legislation

SB 47	-	Summary Jury Trials
SB 77	-	Jury Exemptions
SB 88	-	Limit on Punitive Damages
SB 90	-	Tort Claims Act; Localities Included
SB 98	-	Limit on Localities' Liability
SB 100	-	Limit on Local Employees Liability
SB 101	-	Limit on Non-Economic Damages; Medical Malpractice
HB 130	-	Waiver of Medical Malpractice Cap; Standard of Care
HB 623	-	Reduction of Medical Malpractice Cap
HB 851	-	Immunity if Free Obstetrical Care Rendered

APPENDIX C

AVERAGE PURE LOSS RATIOS[1] TOP TEN VIRGINIA INSURERS

Commercial Multi-Peril

Year	Virginia Incurred Loss Ratio	Total Incurred Loss Ratio
1983	66.67%	72.12%
1984	78.19	80.74
1985	60.70	76.48
Average	68.52	76.45

Medical Malpractice

Year	Virginia Incurred Loss Ratio	Total Incurred Loss Ratio
1983	66.65%	83.13%
1984	72.60	111.71
1985	72.49[2]	147.01
Average	70.58	113.95

Workers' Compensation

Year	Virginia Incurred Loss Ratio	Total Incurred Loss Ratio
1983	62.59%	72.97%
1984	90.07	71.89
1985	96.78	69.46
Average	81.15	77.44

Other Liability

Year	Virginia Incurred Loss Ratio	Total Incurred Loss Ratio
1983	40.25[3]	57.35%
1984	94.43	88.93
1985	73.80	92.49
Average	69.49	79.59

NOTES: 1. Virginia incurred loss ratios and country wide medical malpractice incurred loss ratio equals the weighted average of losses incurred divided by earned premium for the top ten insurers as determined by earned premiums. All other country wide incurred loss ratios are aritmetic averages.

2. Excludes Federal Insurance Company which reported an incurred loss ratio of 4,821% in 1985.

3. Excludes Aetna Casualty and Surety which reported an incurred loss ratio of negative 2,905% in 1983.

Source: Submitted by Bureau of Insurance

APPENDIX D

OFFICE OF THE ATTORNEY GENERAL

LIABILITY INSURANCE REGULATORY REFORM

September 8, 1986

OVERVIEW

I. PREMISE

A. Everyone seems to agree that a "crisis" exists in the availability and affordability of liability insurance.

B. The issue is what is the "cause" of that crisis.

C. Most of the emphasis so far has been on tort reform--i.e., that the cause of the crisis is our civil justice system and the best solution is tort reform.

1. We agree that there are problems with the civil justice system and some tort reform probably makes sense.

2. But tort reform is only part of the solution; the other major part is "regulatory reform" of the insurance industry.

D. Premise of our proposals:

1. The key to rates is losses.

2. Tort reform is aimed at reducing losses, and therefore reducing rates.

* 3. However, when you are dealing with national insurance companies which do business in many states, it does not make sense to talk about tort reform in Virginia unless you have state-based ratemaking.

[Ex.1.]

a. Why? = in order to achieve the major goal of tort reform, which is lower rates for consumers, we have to ensure that Virginia's good "loss record" is in fact fully credited to Virginians -- i.e., state-based ratemaking ensures that Virginians realize the full benefit of their better loss record and that we do not subsidize other states by paying for their poorer loss records or their tort system problems.

b. Tort reform alone will not guarantee:

(1) That liability insurance will be more available or affordable, or

(2) That Virginians will share in any savings to insurance companies.

II. PROPOSAL

Thus, we are proposing regulatory reform which builds upon the current system of insurance regulation but ensures that:

1. Competition does, in fact, exist;

2. Insurance companies are following reasonable loss reserve practices; and

3. More specific data on each insurance company's (1) loss experience in Virginia and (2) loss experience and rates in other states is available to the Bureau of Insurance as it reviews the "reasonableness" of rates.

OFFICE OF THE ATTORNEY GENERAL

LIABILITY INSURANCE REGULATORY REFORM

September 8, 1986

DETAILED OUTLINE

I. **"LIABILITY INSURANCE CRISIS" IS MULTIFACETED**

A. Primarily viewed in terms of:

1. Affordability (today's focus), and

2. Availability.

B. This outline addresses primarily the issue of affordability, while recognizing the problem of insurance availability.

II. **COMPETITION IS PREFERRED REGULATOR OF RATES**

A. Virginia, like many other states, has relied upon competition to regulate rates effectively.

B. Competition is preferred in our economic system.

C. Where competition is absent, a method of regulating rates must take its place.

III. **EXISTENCE AND RECOGNIZED CAUSES OF LIABILITY INSURANCE CRISIS**

A. Existence of an "Insurance Crisis"--All seem to agree that a "crisis" exists in liability insurance availability and affordability. Parameters of crisis depend on perspective:

1. Ratepayers--No doubt.

a. Soaring premiums.

b. Reductions in coverage.

c. Cancellation and nonrenewal of coverage.

d. Difficulty in finding adequate coverage at a reasonable price.

2. Insurers--"Crisis" is viewed from different perspective; but claim seems to be inconsistent with profits.

   a. View crisis as one of how to **insure profitability**.

      (1) Profitability viewed in terms of:

         (a) **Underwriting** profit, and

         (b) **Investment** profit.

      (2) "Reasonable" premiums set primarily in terms of **underwriting profit**.

   b. Claim of crisis by insurers seems inconsistent with profits:

      (1) Wall Street Journal (Aug. 1, 1986)--reported estimates of insurance industry pretax operating profits of $3.8 billion in 1986.

      (2) Wall Street Journal (Aug. 28, 1986) reported:

         (a) Net income up 600% in 1st half of 1986 compared to 1st half of 1985.

         (b) Net income $5.7 billion, including pretax profit of $1.97 billion from operations.

3. The Virginia crisis:

   a. Virginia insurance ratepayers have had better loss experience than their counterparts in many other states, yet Virginia ratepayers have experienced same problems as elsewhere.

      (1) Businesses, individuals and the economy of Virginia depend on affordable and adequate insurance.

   b. Last Subcommittee meeting heard from ratepayers from many segments of our society:

      (1) Pest control companies--required by law to have general liability; only 3 carriers writing new business; reported 1000% increase in rates in less than 4 years after 19 years without claim.

(2) Directors & Officers--

(a) Large and small companies

(b) Charitable organizations

United Way agencies
Richmond Renaissance

(3) Day care centers--

(a) William Byrd Community House--

Increase from $870 to $6,300 in 1986

(b) Friends Association (child welfare agency)--

Cancelled after 25 years; new premium increased 500%.

(4) Franklin Equipment Co.--family-run business with annual profits of $1 million.

Premiums-1982	$17,400
1985	$40,000
1986	$715,000

(5) Architects & Engineers--

Only 3 companies provide professional liability.

c. Must establish adequate controls in order to assure fairness in the rates used by insurers.

B. Causes of the "Crisis"--Most observers attribute crisis, in varying proportions, to both insurance industry's "business cycle," and long-term surge in civil liability costs.

1. Business Cycle:

a. Cannot deny it exists; its course is well-documented over time.

b. Exists because insurance companies are really in two (2) businesses--insurance and investment.

c. Cycle is driven by insurance company's ability to generate and desire for investment income.

2. Surge in Costs:

   a. Some attribute this second factor to a nationwide "litigation explosion."

   b. There is considerable doubt, however, that there has been a sudden increase in both the number and expense of civil lawsuits, especially here in Virginia.

C. The Cry for Tort Reform:

1. Both insurance companies and insurance ratepayers, looking for a quick solution to crisis conditions, have pointed accusing fingers at the civil justice system and demanded tort reform.

2. Some reform may be appropriate but will not, in and of itself, cure the problems of insurance unavailability and unaffordability.

3. Tort reform may result in insurance companies paying less in claims; but it does not guarantee that insurance companies will allow policyholders in Virginia to share in their savings or that rates charged will reflect the actual loss experience ir Virginia.

   a. Virginia ratepayers should pay only for their losses and not be called upon by insurers to subsidize losses in other states.

D. The Need for Regulatory Reform:

1. Need for Reform:

   a. Insurers do business in many states.

   b. Loss experience varies (variations in civil justice system of other states is one factor that may account for this).

   c. Virginia loss experience is generally better than nationwide.

   d. Must look at Virginia's good loss experience in setting rates for Virginia's ratepayers.

2. We will not be able to evaluate what effect tort reforms in Virginia might have unless we also provide a better insurance monitoring mechanism.

3. Proposed regulatory reform intended to:

a. Ensure that Virginia insurance ratepayers pay fair share in relation to their loss experience rather than to the losses in other states.

b. Assure that Virginia's good loss experience results in savings in premiums.

IV. PRESENT REGULATORY STRUCTURE FOR LIABILITY INSURANCE RATEMAKING IN VIRGINIA

A. Three Procedures:

1. **Prior Approval** (§§ 38.2-2000 to 38.2-2027):

a. Lines specified by statute (§38.2-2001)--workers' compensation insurance, the Virginia Automobile Insurance Plan (assigned risk plan), the Property Insurance Residual Market/Joint Underwriting Association (JUA), uninsured motorist coverage, and home protection contracts.

b. Commission approval of rates is prerequisite to use. § 38.2-2006

[EX.2.] 2. File and Use (§ 38.2-1906):

a. Rates filed on or before effective date.

b. Is basic insurance rate filing and approval procedure in Virginia.

c. Applies to most lines of liability insurance (§ 38.2-1906).

d. Commission may investigate and determine whether rate meets statutory standard (§ 38.2-1910).

3. "30-Day Pre-Filing" (§ 38.2-1912):

a. Implemented as to a given line (e.g., general liability), subline (e.g., lawyers professional liability) or rating class (e.g., lawyers, law clerks, paralegals) if:

(1) Bureau examines competition and files an ex parte proceeding before the SCC, and

(2) SCC finds that for any class, line, rating class, subdivision, or territory that:

(a) **Competition is not an effective regulator of rates,** or

(b) Insurers are competing irresponsibly, or

(c) There are widespread code violations.

b. The 30-day waiting period permits actuarial analysis of proposed rates.

c. Method used since 1975 in medical malpractice ratemaking.

B. Statutory Standard for Rates: "Rates . . . shall not be excessive, inadequate, or unfairly discriminatory." §§ 38.2-1904(A)

[EX.3.]

C. Examination of Whether Rate is Excessive:

1. Basic tenet: Rate not excessive unless:

a. "Unreasonably high" and

b. "A reasonable degree of competition does not exist in the area with respect to the classification to which the rate applies." § 38.2-1904(A)(1).

2. Examination of whether there is a "reasonable degree" of competition:

a. Not one of Insurance Bureau's regular watchdog functions.

(1) Not routinely done.

(2) Not mandated.

b. Examined only in extraordinary circumstances, i.e., widespread complaint.

c. Medical Malpractice--Currently only insurance line routinely examined and for which competition is considered not to be an effective regulator of rates.

(1) Beginning in 1975, complaints about the declining number of carriers offering medical malpractice coverage triggered examination of competition. SCC issued rule 8/15/75 (first time rule issued; has been issued annually since 1975) requiring filing of rates 30 days in advance of intended use.

(a) Competition re-examined annually.

(2) Competition held not effective regulator because of **small number of carriers actually offering coverage** to physicians.

(3) Medical malpractice rate filings have been subject, not to file and use procedure, but to 30-day pre-filing procedure since 1975. § 38.2-1912(A).

(a) Proposed rates subject to actuarial analysis. See § 38.2-1912(B).

d. **Bureau Lacks Information Needed**--If Bureau wanted to examine competitive "behavior" among insurers in some of the troubled liability insurance lines, sublines or rating classes, it would not have sufficient information to do so.

[EX.4.]

(1) Only data available currently is on Annual Statement.

(2) "PAGE 14" data--data taken from page 14 of insurance company Annual Statement:

(a) Annual exhibit of **Virginia** premiums and losses broken out by lines of insurance business. Provides limited information.

(b) Currently relied upon by Bureau only for medical malpractice:

(i) Medical malpractice information provided as separate line on Page 14.

(ii) Used to assess:

(a) Who actually writes medical malpractice coverage, and

(b) Market share of premiums written and earned for each medical malpractice carrier. See Line 11 of Page 14.

e. Bureau acknowledges:

(1) In prior testimony before Subcommittee, Bureau indicated liability lines are "structurally" competitive, but not "behaviorally" competitive.

(a) Bureau appears to assume that the ability of many carriers to write liability insurance in any given line (i.e., they are licensed to write a particular line of liability insurance) establishes that competition exists in that line.

(b) Many licensed insurers do not, in fact, write liability insurance in many of the sublines or classes for which there are problems of availability or affordability.

(2) Existence of many "problem" lines:

[EX.5.]

(a) Bureau responded to Nat'l Assoc. of Insurance Commissioners survey, dated May 23, 1986, and identified 17 areas in which there were availability problems:

(i) Day care
(ii) Exterminators
(iii) Pesticide application
(iv) Restaurants
(v) Liquor liability
(vi) Governmental entities
(vii) Directors and officers
(viii) Asbestos removal
(ix) Hazardous waste disposal
(x) Landfills (environmental liability)
(xi) Landfills (governmental liability)
(xii) Pollution liability
(xiii) Medical malpractice (General)
(xiv) OB/GYN
(xv) Nurse midwives

(xvi) Truckers auto liability
(xvii) Hazardous waste haulers

(b) Many were the same lines and classes of insurance about which Subcommittee has heard testimony.

(c) Affordability problems have just as great an impact as availibility problems.

f. Speakers at past Subcommittee hearings:

(1) Several testified about having only 2-3 carriers willing to write needed insurance coverage (e.g., pest control companies, electrical contractors, architects).

(2) Nearly every speaker spoke of soaring premium costs, seemingly unrelated to their loss experiences.

g. Bureau has not examined degree to which competition is an effective regulator of rates and insurance markets in any of these problem areas.

(1) Only recently, Bureau has begun looking at competition among legal malpractice carriers. (Note that legal malpractice was not viewed as one of the problem lines by the Bureau in the May 1986 National Association of Commissioners survey.)

h. Most types of insurance coverage sought by businesses and professionals who testified at last Subcommittee hearing are all grouped together on Page 14 of Annual Statement under "Other liability." See Line 17.

(1) Grouping of these lines and classes makes it impossible to identify which of the approximately 450 to 500 general liability carriers are actually writing certain lines or classes of insurance.

3. Examination of whether rate is "unreasonably high":

Factors currently considered--By statute (§ 38.2-1904(B)) "due consideration" is to be given to:

(1) Past and prospective loss experience in Virginia and outside Virginia.

(2) Conflagration or catastrophe hazards.

(3) A reasonable margin for underwriting profit and contingencies.

(4) Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders.

(5) Past and prospective expenses both countrywide and those specially applicable to Virginia.

(6) Investment income earned or realized from unearned premium and loss reserve funds.

(7) All relevant factors within and outside Virginia.

D. **Rates are presumed not to be excessive without examination of either competition or filed rates.**

1. A reasonable degree of competition is assumed unless (a) the Bureau examines competition and (b) the SCC determines that competition is not an effective regulator of rates.

2. Competition within specific lines, sublines or rating classes, other than medical malpractice, has not been examined by Bureau.

3. **Rates filed under the "file and use" system are, therefore, treated as per se not excessive** because competition is assumed.

4. "File and use" rates are:

a. Not subject to actuarial analysis, and

b. In nearly all cases, are approved as filed.

5. In fact, lower rates may appropriate. That can only be determined upon greater scrutiny of the rate filings.

V. **PROPOSAL: PRE-DETERMINATION OF COMPETITION**

A. Eliminate assumption that competition exists and require predetermination of competition--Amend §§ 38.2-1902, 38.2-1906 & 38.2-1912 to:

I. Allow file and use only for lines, sublines and rating classes for which Insurance Bureau has made an annual determination that:

[Ex.7.]

a. Competition does exist, and

b. Such competition effectively regulates rates.

2. Require the Insurance Bureau to determine lines, sublines or rating classes of insurance for which insurers will be required to provide specific information in their Annual Statements.

[EX.8.]

a. I.e., divide the "Other liability" category (on page 14 of the Annual Statement) into separate lines, sublines and rating classes.

b. Bureau already has authority to require submission of additional information. §§ 38.2-1300(C) & 38.2-1301.

c. Required information should include, but not be limtied to:

(1) Written and earned premium volume and changes over the years.

(2) Number of units of exposure (insureds).

(3) Number of new units of exposure over previous year.

(4) Number of cancellations and non-renewals both at companys' and at insured's initiative.

(5) Extent to which new business is sought.

(6) Whether insurer establishes rates through a rating service organization.

(a) Rating service organizations compile information from member insurance companies, analyze the data, and recommend or, in some cases, file the rates for their member companies.

3. Identify factors relevant to the assessment of competition as an effective regulator:

a. Whether current rates of the line, subline or

rating class designated by the Bureau generally are "unreasonably high." (First year only, to adjust for past failure to assess competition.)

b. Number of insurers actually writing the line or subline of insurance.

c. Nature of rate differentials within line or subline.

d. Respective market share of the companies writing line and changes in market share over the years.

e. Ease of entry by insurer into line or subline not now being written by insurer.

f. Degree to which rates within the line, subline or rating class are established by rating service organization.

B. Proposed procedure--If Bureau finds within the designated line, subline or rating class that:

[EX.9.]

1. Competition does not exist or is not an effective regulator of rates:

   a. Rates must be filed under the "30-Day Pre-Filing" procedure.

2. Competition exists and is an effective regulator of rates:

   a. Rates may be filed under "File and Use" procedure.

   b. **EXCEPT**, where proposed rate exceeds a prescribed percentage (e.g. 10%, 15% or 25%) increase over the existing rates of the insurer, then:

      (1) Rates subject to "30-Day Pre-Filing".

      (2) "Triggering" percentage may be prescribed by statute or by Commission regulation.

VI. PROPOSAL ("30-DAY PRE-FILING" PROCEDURE): MORE DETAILED EXAMINATION OF LOSS RESERVE ASSOCIATED PRACTICES

A. Premise -- Loss reserves and expenses require closer scrutiny.

[EX.10]

B. **RATE = (Number of future claims) x (Cost per future Claim) + (Company overhead) - (Return on Investments)**

C. Recommendation -- Examine Loss Reserve Practices:

1. Loss reserves are primary factor in determining premium rate.

a. Insurer's "underwriting profit" consists of:

(1) Earned premium

(2) Minus "losses."

b. If losses high, then insurer needs to offset it by increased premium.

2. Losses consist of 3 components:

[Ex.11]

a. "**Paid losses**" and paid loss expenses:

(1) Claims reported, adjusted, paid and closed.

(2) Involves actual reduction of company's assets.

b. "**Incurred and reported losses**" and expenses:

(1) Claims reported, but open and unpaid.

(2) "Loss" is purely a predicted "paper loss" except to extent company has paid expenses associated with loss adjustment.

3) Amount of loss is merely estimate of what might be paid out on claims reported.

c. "**Incurred But Not Reported Losses**" and expenses:

(1) Prediction of claims not yet reported, not open.

(2) Loss is purely a "paper loss." Nothing paid out.

(3) Actuarial estimate presumably based on historical trends to predict the number and amount of future loss payouts attributable to premiums earned in a

given year.

3. "Losses" are not necessarily actual payments. Important to note that both Incurred and Incurred But Not Reported losses do not involve any actual payment by the company, nor do they create any liquidated liability.

   a. Company has full use of these loss reserves until a claim is settled or finally adjudicated.

   b. Company makes significant profits (investment income) from loss reserves.

4. Reserves may be unrealistically high. Suggested by many that incurred loss reserves are set unrealistically high.

[EX.12.]

   a. Many reasons why insurance companies might over-reserve:

      (1) Tax advantages--Loss reserves treated as a present loss for tax purposes, thereby reducing company's taxable income.

         (a) Loss reserves are not discounted to present value.

         (b) Note: Company still has use of money for investment.

      (2) Tort system--Fears that tort law system is out of control.

         (a) Alleged increase in number of claims.

         (b) Alleged increase in size of awards.

         (c) New causes of action--claims for injuries for which underwriters presumed company would have no liability; these cases cause companies to reserve additional funds for same types of cases that may arise in future.

      (3) Build investment base:

         (a) During late 1970s and early 1980s, high yielding investments resulted in high investment profits.

Insurers used loss reserves and unearned premium reserves for investment and realized profits on the investment of those reserves.

(i) High investment yields lead to price cutting to compete for premium/investment dollars.

(b) Mid-1980s--low interest rates resulted in reduced investment income.

(c) Therefore, insurers increased loss reserves to justify need for higher premiums which broadened investment portfolio. Result is increased investment profit.

5. **Reserving practices should be examined**. Regardless of reason, Insurance Bureau must step up effort to monitor insurance company reserves.

[EX.13.]

a. **Disclose reserving standards and policies**. Companies should be required to document precisely their reserve policies and standards with full disclosure to Insurance Bureau.

b. **Closed claim reporting**. Would permit comparison of amounts reserved to final payments.

(1) Only required now for Medical Malpractice claims. § 38.2-2228. (Note: current statute does not require reporting of loss reserve history.)

(2) Should be required in all liability lines.

(3) Would permit Insurance Bureau to monitor incurred loss reserving practices.

c. Bureau now has authority to require disclosure of standards. § 38.2-1301.

VII. PROPOSAL ("30-DAY PRE-FILING" PROCEDURE): REQUIRE INFORMATION ON AND EXAMINE RATES CHARGED IN OTHER STATES

A. Present Procedures:

1. Rates not to be excessive, inadequate or unfairly discriminatory. How is this standard to be measured?

2. Code does not specify weight to be attributed to Virginia-specific data, although it is to be considered.

   a. In most lines, Virginia enjoys a more favorable loss ratio than exists nationwide.

   b. Yet, no information provided to the Insurance Bureau sets forth how Virginia rates compare to rates in other states or nationwide.

B. **Recommendation:**

[EX.14.]

1. Insurer to disclose rates. Insurers proposing rate increases should be required to disclose their rates in other states, together with loss experience data, for the line of insurance and rate classification for which the rate increase is proposed.

2. Compare proposed rate to rate in other states. In setting rates, proposed Virginia rates should be compared with like rate filings by the particular company in all other states where the company writes business within the insurance classification in question, giving due consideration to the respective loss experience in the various states.

3. Insurer to justify differences in rates. Where proposed Virginia rates are disproportionately high, insurers should be required to explain and document a sound actuarial basis for such differences.

4. Greater emphasis on Virginia loss experience in setting Virginia rates ensures that our citizens do not subsidize the uncontrolled civil justice systems of other states.

VIII. SUMMARY

[Ex.15.]
[Ex.16.]

Mary Sue Terry
Attorney General

H. Lane Kneedler
Chief Deputy Attorney General

COMMONWEALTH of VIRGINIA

Office of the Attorney General

R. Claire Guthrie
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Deputy Attorney General
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Stephen D. Rosenthal
Deputy Attorney General
Criminal Law Enforcement Division

Deborah Love-Bryant
Executive Assistant

MEMORANDUM

TO: The Honorable William F. Parkerson, Jr.
Chairman, Joint Subcommittee Studying
Liability Insurance and Tort Reform

FROM: H. Lane Kneedler
Chief Deputy Attorney General Lane Kneedler

DATE: November 28, 1986

RE: Attorney General's Insurance Regulatory
Reform Proposals

Attached is a copy of the November 11, 1986, working draft of Attorney General Terry's proposed insurance regulatory reform legislation, which we distributed to the Joint Subcommittee at its meeting on November 18, and a copy of the covering memorandum which accompanied that working draft and which summarizes how the November 11 working draft differs from earlier working drafts.

We were very pleased that, at the October 10 working session, members of the Joint Subcommittee supported in principle the approach taken in the working draft. That approach is the same approach outlined by the Attorney General in her presentation to the Joint Subcommittee at its September 8 meeting.

We are continuing to refine the November 11 working draft to ensure that it is administratively workable. We would appreciate any comments or suggestions members of the Joint Subcommittee or other persons to whom you have distributed our materials might have. We also greatly appreciate the time the Joint Subcommittee has taken to review our proposal and would be pleased to have the Joint Subcommittee adopt in principle the Attorney General's proposed approach as we continue to work on the specific language.

If you or other members of the Joint Subcommittee have any questions on the Attorney General's proposed approach in general, or on the November 11 working draft in particular, we would be pleased to meet with you at your convenience.

HLK/ed

cc: Members, Joint Subcommittee Studying
Liability Insurance and Tort Reform

Mary Sue Terry
Attorney General

H. Lane Kneedler
Chief Deputy Attorney General

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Deborah Love-Bryant
Executive Assistant

MEMORANDUM

TO: The Honorable William F. Parkerson, Jr.
Chairman, Joint Subcommittee Studying
Liability Insurance and Tort Reform

FROM: H. Lane Kneedler
Chief Deputy Attorney General

DATE: November 18, 1986

RE: Attorney General's Insurance
Regulatory Reform Proposals

Attorney General Terry has asked me to provide to you the attached copy of the latest working draft of her insurance regulatory reform proposals. I have also included copies of two memoranda which summarize the proposed legislation and the main areas of disagreement between our proposals and those submitted by the Bureau of Insurance.

The enclosed draft differs from the proposals offered to the Subcommittee at its October 10, 1986 working session. The modifications represent, in large measure, our effort to incorporate suggestions provided to us by the Bureau. The attached draft also differs in two respects from that provided to the Bureau and to the Subcommittee's counsel, Mary Devine, on October 31. The first substantive change appears in proposed § 38.2-231 and provides for notice of increases in premiums of greater than 25%. An additional change appears in proposed § 38.2-1912 and eliminates non-existence of competition as a factor, which, alone, could trigger the pre-filing procedures. Several minor modifications have been made as well, merely as corrections or for clarification.

We look forward to sharing with the Subcommittee as soon as possible proposals which, hopefully, will represent a consensus between the State Corporation Commission and the Attorney General's Office.

HLK/ed

cc: Members, Joint Subcommittee Studying Liability Insurance and Tort Reform

DRAFT

THE HONORABLE MARY SUE TERRY

ATTORNEY GENERAL OF VIRGINIA

PROPOSED INSURANCE REFORM LEGISLATION

November 11, 1986

DRAFT

A BILL to amend and reenact §§ 38.2-231, 38.2-1904, 38.2-1906, 38.2-1908, 38.2-1909, 38.2-1910, 38.2-1912, 38.2-2003, 38.2-2005, and 38.2-2006 of the Code of Virginia and to amend the Code of Virginia by adding in Title 38.2 sections numbered 38.2-1301.1, 38.2-1905.1 and 38.2-2228.1, relating to liability insurance companies; cancellation, nonrenewal and reduction in coverage; ratemaking.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-231, 38.2-1904, 38.2-1906, 38.2-1908, 38.2-1909, 38.2-1910, 38.2-1912, 38.2-2003, 38.2-2005, and 38.2-2006 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 38.2 sections numbered 38.2-1301.1, 38.2-1905.1 and 38.2-2228.1 as follows:

§ 38.2-231. Notice of cancellation, ~~of or~~ refusal to renew, reduction in coverage or increase in premium of certain ~~commercial~~ liability insurance policies.--A. No ~~notice of~~ cancellation or refusal to renew by an insurer of a policy of insurance as defined in § 38.2-117 or § 38.2-118 insuring a business entity shall be effective unless the insurer shall deliver or mail to the named insured at the address shown on the policy a written notice of cancellation or refusal to renew. Such notice shall:

1. ~~Be approved as to form by the Commissioner of Insurance prior to its use;~~ Be in a type size authorized under § 38.2-311;

2. State the date, which shall not be less than forty-five days after the delivery or mailing of the notice of cancellation or refusal to renew, on which such cancellation or refusal to renew shall become effective, except that such effective date may not be less than fifteen days from the date of mailing or de-

livery when the policy is being cancelled or not renewed for failure of the insured to discharge when due any of his obligations in connection with the payment of premium for the policy;

~~3. Be mailed or delivered to any lien holder if the terms of the policy require the giving of such notice;~~

~~4.~~3. State the specific reason or reasons of the insurer for cancellation or refusal to renew; and

~~5.~~4. Advise the insured of its right to request in writing, within fifteen days of the receipt of the notice, that the Commissioner of Insurance review the action of the insurer.

B. No written notice of cancellation or refusal to renew that is mailed by an insurer to an insured in accordance with this section shall be effective unless:

1. a. It is sent by registered or certified mail, or

b. At the time of mailing the insurer obtains a written receipt from the United States Postal Service showing the name and address of the insured stated in the policy;

2. The insurer retains a duplicate copy of the notice of cancellation or refusal to renew; and

3. At the time of mailing the insurer endorses upon the duplicate copy of the notice a certificate showing that the duplicate is a copy of the notice that was sent to the insured (i) by registered or certified mail, or (ii) by regular mail for which the postal receipt was obtained.

C. No reduction in coverage and no increase in premium greater than 25% by an insurer of a policy of insurance defined in §§ 38.2-117 or 38.2-118 shall be effective unless the insurer

shall deliver or mail to the named insured at the address shown on the policy a written notice of such reduction in coverage or premium increase not later than forty-five days prior to the effective date of same. Such notice shall state the manner in which coverage under an existing policy will be reduced or the amount of such premium increase, as the case may be, and shall advise the insured of its right to request in writing, within fifteen days of receipt of the notice, that the Commissioner of Insurance review the action of the insurer.

~~C.~~ D. Nothing in this section shall prohibit any insurer or agent from including in ~~the~~ a notice of cancellation, ~~or~~ refusal to renew, reduction in coverage or premium increase any additional disclosure statements required by state or federal laws.

~~D.~~ E. For the purpose of this section (1) the term "business entity" shall mean an entity as defined by § 13.1-603 or § 13.1-803 and shall include an individual, a county, city, town, or an authority, board, commission, sanitation, soil and water, planning or other district, public service corporation owned, operated or controlled by a locality or other local governmental authority~~.~~ , and (2) the term "reduction in coverage" shall mean, but not be limited to, any diminution in scope of coverage, decrease in limits of liability, addition of exclusions, increase in deductibles, or reduction in the policy term or duration.

F. Within fifteen days of receipt of the notice of cancellation, refusal to renew, reduction in coverage or increase in premium, the insured shall be entitled to request in writing to the Commissioner that he review the action of the insurer. Upon

receipt of the request, the Commissioner shall promptly begin a review to determine whether the insurer's notice of cancellation, refusal to renew, reduction in coverage or premium increase complies with the requirements of this section. Where the Commissioner finds from the review that the notice of cancellation, refusal to renew, reduction in coverage or premium increase does not comply with the requirements of this section, he shall immediately notify the insurer, the insured and any other person to whom such notice was required to be given by the terms of the policy that such notice is not effective. Nothing in this section authorizes the Commissioner to substitute his judgment as to underwriting for that of the insurer.

G. Every insurer shall maintain for at least one year records of cancellations, refusals to renew, reductions in coverage and premium increases and copies of every notice or statement referred to in subsections A, B, and C of this section that it sends to any of its insureds.

~~E.~~ H. There shall be no liability on the part of and no cause of action of any nature shall arise against (i) the Commissioner of Insurance or his subordinates, (ii) any insurer, its authorized representative, its agents, its employees, or (iii) any firm, person or corporation furnishing to the insurer information as to reasons for cancellation, ~~or~~ refusal to renew, reduction in coverage or premium increase for any statement made by any of them in complying with this section or for providing information pertaining thereto.

§38.2-1301.1. Supplemental report; required for certain

lines or subclassifications of liability insurance.--A. All insurers licensed to write the classes of insurance defined in §§ 38.2-117 and 38.2-118 shall file a report in conjunction with the annual statement showing their direct experience in the Commonwealth attributable to all lines or subclassifications of general liability insurance designated by the Commission in accordance with § 38.2-1905.1~~(A)~~.

B. This supplemental report shall be on a form prescribed by the Commission and shall include the following information for the previous year ending on the 31st of December:

1. Number of exposures;

2. Direct premiums written;

3. Direct premiums earned;

4. Direct losses paid;

5. Number of claims paid;

6. Direct losses incurred;

7. Direct losses unpaid;

8. Number of claims unpaid;

9. Direct losses incurred but not reported;

10. Increase or decrease in the number of units of exposure as compared with the number reported or existing in the preceeding year;

11. Whether the insurer's rates for the line or subclassification are filed by a rate service organization;

12. Such other relevant information as may be required by the Commission.

C. The supplemental report shall include information on the

following lines or subclassifications of liability insurance listed below unless the Commission has exempted such classification upon a finding, pursuant to § 38.2-1905.1(B), that competition is an effective regulator of rates for that line or subclassification:

1. Day Care;

2. Exterminators;

3. Asbestos removal;

4. Pesticide application (crop spraying);

5. Pollution and hazardous waste disposal;

6. Governmental;

7. Architects and Engineers professional;

8. Directors and Officers professional;

9. Lawyers professional;

10. Insurance agents professional;

11. Commercial umbrella or excess;

12. Liquor;

13. Products liability; and

14. Medical malpractice.

D. The first supplemental report required by this section for the lines or subclassifications enumerated in paragraphs 1 through 12 of subsection C shall be filed with the annual statement due in 1987 for calendar year 1986.

§ 38.2-1904. Rate standards.--A. Rates for the classes of insurance to which this chapter applies shall not be excessive, inadequate or unfairly discriminatory. All rates and all changes and amendments to rates to which this chapter applies for use in

this Commonwealth shall be based on loss experience and other factors within Virginia if relevant and actuarily sound; provided, however, other data, including countrywide, regional or other state data, may be considered where the Commission finds that such data is relevant and that a sound actuarial basis exists for considering data other than Virginia-specific data.

1. No rate shall be held to be excessive unless it is unreasonably high for the insurance provided and ~~(i)~~ a reasonable degree of competition does not exist in the area with respect to the classification to which the rate applies~~,~~ or ~~(ii)~~ the rate ~~will have the effect of destroying competition or creating a monopoly~~.

2. No rate shall be held inadequate unless it is unreasonably low for the insurance provided and (i) continued use of it would endanger solvency of the insurer, or (ii) the rate is unreasonably low for the insurance provided and use of the rate by the insurer has or, if continued, will have the effect of destroying competition or creating a monopoly.

3. No rate shall be unfairly discriminatory if a different rate is charged for the same coverage and (i) the rate differential is based on sound actuarial principles or (ii) is related to actual or reasonably anticipated experience.

B. 1. In determining whether rates comply with the standards of subsection A of this section, due separate consideration shall be given to (i) past ~~and prospective~~ loss experience within ~~and outside~~ this Commonwealth, (ii) past loss experience outside the Commonwealth, (iii) prospective loss experience within the

Commonwealth, (iv) prospective loss experience outside the Commonwealth, (v) conflagration or catastrophe hazards, ~~(iii)~~ (vi) a reasonable margin for underwriting profit and contingencies, ~~(iv)~~ (vii) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, ~~(v)~~ (viii) past and prospective expenses both countrywide and those ~~specially~~ specifically applicable to this Commonwealth, ~~(vi)~~ (ix) past expenses, countrywide, (x) prospective expenses specifically applicable to this Commonwealth, (xi) prospective expenses, countrywide, (xii) investment income earned or realized by insurers both from their unearned premium and loss reserve funds, (xiii) the loss reserving practices, standards and procedures utilized by the insurer, and ~~(vii)~~ (xiv) all relevant factors within and outside this Commonwealth.

2. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which such experience is available.

C. For the classes of insurance to which this chapter applies, including insurance against contingent, consequential and indirect losses as defined in § 38.2-133, (i) the systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group for any class of insurance, or with respect to any subdivision or combination of insurance for which separate expense provisions are applicable, and (ii)

risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards, expense provisions, or both. The standards may measure any difference between risks that can be demonstrated to have a probable effect upon losses or expenses.

D. No insurer shall use any information pertaining to any motor vehicle conviction or accident to produce increased or surcharged rates above their filed manual rates for individual risks for a period longer than thirty-six months. This period shall begin no later than twelve months after the date of the conviction or accident.

§ 38.2-1905.1. Annual report on level of competition.--A. The Commission shall submit an annual report on the level of competition in the Virginia property and casualty insurance industry to the General Assembly on or before November 15 of each year. In addition to the industry in the aggregate, the Commission's report shall designate all insurance lines, sublines, or rating classifications for which insurance coverage is not reasonably available or not reasonably affordable. A copy of the annual report and designations shall be sent by the Commission to the Division of Consumer Counsel of the Office of the Attorney General.

B. Those lines or subclassifications set forth in § 38.2-1301.1(C) and such lines or subclassifications as may be designated under subsection A above shall thereafter be subject to

review by the Commission for a determination of whether competition is an effective regulator of rates for such designated lines or subclassifications. The Commission shall hold a hearing at which it shall hear evidence offered by any interested party.

C. In determining whether competition is an effecive regulator of rates for each designated line or subclassification, the Commission shall consider the following factors:

1. The number of insurers actually writing insurance within the line or subclassification.

2. The extent and nature of rate differentials among insurers within the line or subclassification.

3. The respective market share of insurers actually writing insurance within the line or subclassification, and changes in market share compared with previous years.

4. The ease of entry into the line or subclassification by insurers not currently writing such line or subclassification.

5. The degree to which rates within the line or subclassification are established by rating service organizations.

6. The extent to which insurers licensed to write the line or subclassification have sought to write or obtain new business within the line or subclassification within the past year.

7. Whether current rates within the line or subclassification are unreasonably high.

8. Such other factors as the Commission deems relevant to the determination of whether competition is an effective regulator of rates within the line or subclassification.

D. Notwithstanding any designation made by the Commission pursuant to subsection A, the Commission may, upon petition of any interested party, hold a hearing to determine whether, under the factors set forth in subsection C, competition is not an effective regulator of rates for lines or subclassifications not so designated. If the Commission finds that competition is not an effective regulator of rates for a line or subclassification not so designated, then rates for that line or subclassification shall be filed in accordance with § 38.2-1906(A)(2).

§ 38.2-1906. Filing and use of rates.--A. Each authorized insurer subject to the provisions of this chapter and each rate service organization licensed under § 38.2-1914 that has been designated by any insurer for the filing of rates under § 38.2-1908 shall file with the Commission all rates and supplementary rate information and all changes and amendments to the rates and supplementary rate information made by it for use in this Commonwealth ~~on or before the date they become effective~~: as follows:

1. In cases where the Commission has made a determination under the provisions of § 38.2-1905.1(B) that competition is an effective regulator of rates within the lines or subclassifications designated by the Commission, or in the case of all other lines or subclassifications not designated under § 38.2-1301.1(A), such rates, supplementary rate information, changes and amendments to rates and supplementary rate information shall be filed with the Commission on or before the date they become effective.

2. Where, pursuant to § 38.2-1905.1(B), the Commission has

either (a) not made a determination with respect to a line or subclassification designated by the Commission or (b) has made a determination that competition is not an effective regulator of rates for a line or subclassification so designated, such rates, supplementary rate information, changes and amendments to rates and supplementary rate information for that line or subclassification shall be filed in accordance with and shall be subject to the provisions of § 38.2-1912.

3. Those lines or subclassifications set forth in § 38.2-1301.1(C) shall be subject to § 38.2-1912, unless the Commission finds pursuant to a hearing under § 38.2-1905.1(B) that competition is an effective regulator of rates within a line or subclassification enumerated.

B. Each insurer shall submit with each rate filing the following information:

1. Historical financial experience by line, subline or rating classification, as appropriate, and by year for the preceding three years for which data is available, including:

a. Premiums written;

b. Premiums earned;

c. Losses paid;

d. Losses incurred;

e. Expenses paid;

f. Expenses incurred;

g. Investment income on reserves; and

h. Total return on net worth.

The information submitted pursuant to subparagraphs (e) through

(h) shall be estimates if actual experience is not available.

2. A rate history for the preceding three years.

3. Statewide rate information presented separately for both Virginia and each state wherein the insurer writes the line, subline or rating classification for which the rate filing is made, including:

a. The number of exposures;

b. The premium at present rates;

c. Adjustments to premium, if any;

d. The number of claims;

e. Losses incurred;

f. Loss adjustment expenses incurred;

g. The loss development factor used;

h. The trend factor used;

i. Other expenses incurred, separately by category of expense;

j. The expense trend factor.

4. Detailed supporting information for the factors applied in the filing, including:

a. The loss development factor;

b. The loss trend factor;

c. Adjustments to premium;

d. The expense trend factor.

5. Detailed supporting information for the expected loss ratio, including:

a. Commissions;

b. General expenses;

c. Taxes, licenses and fees;

d. Other acquisition expenses;

e. The profit factor.

6. Any other information determined by the Commission to be useful or necessary for the review of any filing.

B. C. No insurer shall make or issue an insurance contract or policy of a class to which this chapter applies, except in accordance with the rate and supplementary rate information filings that are in effect for the insurer.

D. The Commission shall develop a uniform statement or format for requesting the information specified in this section. Such statement or format shall be utilized by all insurers for all rate filings.

38.2-1908. Delegation of rate making and rate-filing obligation.--A. An insurer or rate service organization shall may establish rates and supplementary rate information for any market segment based on the factors in § 38.2-1904 or it may use rates and supplementary rate information prepared by a rate service organization, with average loss factors or expense factors determined by the rate service organization or with modification for its own expense and loss experience as the credibility of that experience allows.

B. An insurer may discharge its obligations under subsection (A)(1) of § 38.2-1906 by giving notice to the Commission that it uses rates and supplementary rate information prepared and filed with the Commission by a designated rate service organization of which it is a member or subscriber. Any information about modifi-

cations to the rate service organization's filing that is necessary to fully inform the Commission of the insurer's rates shall be filed with the Commission. The insurer's rates and supplementary rate information shall be those filed from time to time by the rate service organization, including any amendments to the rates and supplementary rate information, subject to modifications filed by the insurer.

§ 38.2-1909. Review of rates by Commission.--The Commission may investigate and determine, (i) upon its own motion, (ii) at the request of any citizen of or any interested party in this Commonwealth, or (iii) at the request of any insurer subject to this chapter, whether rates in this Commonwealth for the classes of insurance to which this chapter applies are excessive, inadequate or unfairly discriminatory or whether loss experience and other factors within the Commonwealth are being properly used to determine the rates. In any such investigation and determination the Commission shall give due separate consideration to those factors specified in § 38.2-1904.

§38.2-1910. Disapproval of rates.--A. If the Commission finds, after providing notice and opportunity to be heard, that a rate is not in compliance with § 38.2-1904, or is in violation of § 38.2-1916, the Commission shall order that use of the rate be discontinued for any policy issued or renewed after a date specified in the order. The order may provide for rate modifications. The order may also provide for refund of the excessive portion of premiums collected during a period not exceeding one year prior to the date of the order. Except as provided in subsection B of

this section, the order shall be issued within thirty days after the close of the hearing or within another reasonable time extension fixed by the Commission.

B. Pending a hearing, the Commission may order the suspension prospectively of a rate filed by an insurer and reimpose the last previous rate in effect if the Commission has reasonable cause to believe that ~~either~~: (i) a reasonable degree of competition does not exist in the area with respect to the classification to which the rate applies, (ii) competition does not effectively regulate rates; ~~(ii)~~ (iii) the filed rate will have the effect of destroying competition or creating a monopoly, ~~or~~ ~~(iii)~~(iv) use of the rate will endanger the solvency of the insurer, or (v) Virginia loss experience and other factors specifically applicable to the Commonwealth have not been properly used to determine the rates. If the Commission suspends a rate under this provision, it shall hold a hearing within fifteen business days after issuing the order suspending the rate unless the right to a hearing is waived by the insurer. In addition, the Commission shall make its determination and issue its order as to whether the rate shall be disapproved within fifteen business days after the close of the hearing.

C. At any hearing held under the provisions of subsection A or B of this section, the insurer shall have the burden of justifying the rate in question. All determinations of the Commission shall be on the basis of findings of fact and conclusions of law. If the Commission disapproves a rate, the disapproval shall take effect not less than fifteen days after its order and the

last previous rate in effect for the insurer shall be reimposed for a period of one year unless the Commission approves a substitute or interim rate under the provisions of subsection D or E of this section.

D. For one year after the effective date of a disapproval order, no rate promulgated to replace a rate disapproved under the order may be used until it has been filed with the Commission and not disapproved within ~~thirty~~ sixty days after filing.

E. Whenever an insurer has no legally effective rates as a result of the Commission's disapproval of rates or other act, the Commission shall, on the insurer's request, specify interim rates for the insurer that are high enough to protect the interests of all parties. The Commission may order that a specified portion of the premiums be placed in an escrow account approved by it. When new rates become legally effective, the Commission shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis shall not be required.

§ 38.2-1912. Delayed effect of rates.--A. 1. If the Commission finds in any class, line, or subdivision of insurance, or in any rating class or rating territory that (i) competition is not an effective regulator of the rates charged, (ii) rates are, or could be expected to be, unreasonably high for the insurance provided, (iii) Virginia loss experience and other factors specifically applicable to the Commonwealth have not been properly used to determine the rate, (iv) a substantial number of insurers are competing irresponsibly through the rates charged, or ~~(iii)~~

(v) there are widespread violations of this chapter, it may shall promulgate a rule requiring that any subsequent changes in the rates or supplementary rate information for that class, line, subdivision, rating class or rating territory shall be filed with the Commission at least ~~thirty~~ sixty days before they become effective. The Commission may extend the waiting period for thirty additional days by written notice to the filer before the first ~~thirty-day~~ sixty-day period expires. Upon filing any rate to which this section is applicable, the insurer shall give notice to the Division of Consumer Counsel of the Office of the Attorney General that such rate has been filed with the Commission and such insurer shall so certify to the Commission in its rate filing.

2. The provisions of this section shall also be applicable to (i) any line or subclassification designated by the Commission in accordance with the provisions of § 38.2-1905.1(A) for which the Commission has not made a determination that competition is an effective regulator of rates and (ii) to those subclassifications listed in § 38.2-1301.1(C) unless otherwise excluded from the operation of this section.

B. By this rule the Commission may require the filing of supporting data for any classes, lines or subdivisions of insurance, or classes of risks or combinations thereof it deems necessary for the proper functioning of the rate monitoring and regulating process.

C. A rule promulgated under this section shall expire no later than one year after issue. The Commission may renew the

rule after a hearing and appropriate findings under this section.

D. If a filing is not accompanied by the information the Commission has required under subsection B of this section, the Commission shall within thirty days of the initial filing inform the insurer that the filing is not complete, and the filing shall be deemed to be made when the information is furnished.

§ 38.2-2003. Rate filings by insurer; supporting information.--A. Each insurer writing in this Commonwealth a class of insurance to which this chapter applies shall file with the Commission every manual of classifications, minimum rate, class rate, rating schedule, rating plan, rating rule, and every modification of any of the foregoing that it proposes to use. Every filing shall indicate the character and extent of coverage contemplated. When a filing is not accompanied by the information upon which the insurer supports the filing, and the Commission does not have sufficient information to determine whether the filing meets the requirements of this chapter, the Commission may require the insurer to furnish the information upon which it supports the filing. A filing and any supporting information shall be a public record. Upon filing any rate to which this chapter is applicable, the insurer shall give notice to the Division of Consumer Counsel of the Office of the Attorney General that such rate has been filed with the Commission and such insurer shall so certify to the Commission in its rate filing. For the purposes of this section, a group or fleet of insurers operating under the same general management may be considered an insurer.

B. Each insurer shall submit with each rate filing the fol-

lowing information:

1. Historical financial experience by line, subline or rating classification, as appropriate, and by year for the preceding three years for which data is available, including:

a. Premiums written;

b. Premiums earned;

c. Losses paid;

d. Losses incurred;

e. Expenses paid;

f. Expenses incurred;

g. Investment income on reserves; and

h. Total return on net worth.

The information submitted pursuant to subparagraphs (e) through (h) shall be estimates if actual experience is not available.

2. A rate history for the preceding three years.

3. Statewide rate information presented separately for both Virginia and each state wherein the insurer writes the class of insurance for which the rate filing is made, including:

a. The number of exposures;

b. The premium at present rates;

c. Adjustments to premium, if any;

d. The number of claims;

e. Losses incurred;

f. Loss adjustment expenses incurred;

g. The loss development factor used;

h. The trend factor used;

i. Other expenses incurred, separately by category of ex-

pense;

j. The expense trend factor.

4. Detailed supporting information for the factors applied in the filing, including:

a. The loss development factor;

b. The loss trend factor;

c. Adjustments to premium;

d. The expense trend factor.

5. Detailed supporting information for the expected loss ratio, including:

a. Commissions;

b. General expenses;

c. Taxes, licenses and fees;

d. Other acquisition expenses;

e. The profit factor.

6. Any other information determined by the Commission to be useful or necessary for the review of any filing.

C. The Commission shall develop a uniform statement or format specifying the information categories specified in this section. Such statement or format shall be utilized by all insurers in all rate filings.

§ 38.2-2005. Provisions governing making of rates.--A. Rates for the classes of insurance to which this chapter applies shall not be excessive, inadequate or unfairly discriminatory. All rates and all changes and amendments to rates to which this chapter applies for use in this Commonwealth shall be based on loss experience and other factors within Virginia if relevant and

actuarily sound; provided, however, other data, including countrywide, regional or other state data, may be considered where the Commission finds that such data is relevant and that a sound actuarial basis exists for considering data other than Virginia-specific data.

B. 1. In making rates for the classes of insurance to which this chapter applies, ~~due~~ separate consideration shall be given to (i) past ~~and prospective~~ loss experience within ~~and outside~~ this Commonwealth, (ii) past loss experience outside the Commonwealth, (iii) prospective loss experience within the Commonwealth, (iv) prospective loss experience outside the Commonwealth, (v) conflagration or catastrophe hazards, ~~(iii)~~ (vi) a reasonable margin for underwriting profit and contingencies, ~~(iv)~~ (vii) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, ~~(v)~~ (viii) past ~~and prospective~~ expenses ~~both countrywide and those specially~~ specifically applicable to this Commonwealth, ~~(vi)~~ (ix) past expenses, countrywide, (x) prospective expenses specifically applicable to this Commonwealth, (xi) prospective expenses, countrywide, (xii) investment income earned or realized by insurers both from their unearned premium and loss reserve funds, (xiii) the loss reserving practices, standards and procedures utilized by the insurer, and ~~(vii)~~ (xiv) all relevant factors within and outside this Commonwealth.

2. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period fo

which such experience is available.

3. In the case of uninsured motorist coverage required by subsection A of § 38.2-2206, consideration shall be given to all sums distributed by the Commission from the Uninsured Motorists Fund in accordance with the provisions of Chapter 30 (§ 38.2-3000 et seq.) of this title.

C. For the classes of insurance to which this chapter applies (i) the systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group for any class of insurance, or for any subdivision or combination of insurance for which separate expense provisions apply, and (ii) risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards, expense provisions, or both. The standards may measure any difference among risks that can be demonstrated to have a probable effect upon losses or expenses.

D. All rates, rating schedules or rating plans and every manual of classifications, rules and rates, including every modification thereof, approved by the Commission under this chapter, shall be used until a change is approved by the Commission.

§ 38.2-2006. Approval by Commission prerequisite to use of filing.--A. Except as provided in § 38.2-2010, no filing shall become effective, be applied, or be used in this Commonwealth

until it has been approved by the Commission. However, a rate produced in accordance with a rating schedule or rating plan, previously approved by the Commission, may be used pending the approval.

B. A filing shall be deemed to meet the requirements of this chapter and to become effective unless disapproved by the Commission within ~~thirty~~ sixty days of the time that the filing was made. However, the Commission may extend the waiting period for thirty additional days by written notice to the filer before the ~~first thirty-day~~ sixty-day period expires.

C. If a filing is not accompanied by the information necessary for the Commission to determine if the requirements of § 38.2-2005 are satisfied, the Commission shall so inform the filer within ~~thirty~~ sixty days of the initial filing. The filing shall be deemed to be made when the necessary information is furnished.

D. The provisions of subsection B of this section shall be suspended when the Commission has ordered a hearing to be held under the provisions of § 38.2-2007.

§ 38.2-2228.1 Certain liability claims to be reported to Commissioner; duty of Commissioner; annual report; statistical summary.--All claims covered under policies described in §§ 38.2-117 or 38.2-118 settled or adjudicated to final judgment against a person, corporation, firm, or other entity and any such claim closed without payment during each calendar year shall be reported annually to the Commissioner by the insurer. The reports shall not identify the parties. The report to the Commissioner

shall state the following in a format prescribed by him:

1. Nature of the claim and damages asserted;

2. The amount of all reserves established in connection with the claim and all adjustments thereto, including the dates on which such reserves were established or the adjustments thereto were made;

3. Attorney's fees and expenses paid by the insurer in connection with the claim or defense to the extent these amounts are known;

4. The amount paid by the insurer in satisfaction of the settlement or judgment;

5. Whether either a structured settlement or periodic payment of the judgment was utilized and, if so, the amount of immediate payment and the projected total future payment; and

6. Any other pertinent and relevant information which the Commissioner may require as is consistent with the provisions of this section.

The report shall include a statistical summary of the information collected in addition to an individual report on each claim. Each annual report shall be a matter of public record.

APPENDIX E

REPORT
INSURANCE REFORM PROPOSALS

Senate Joint Resolution 22 passed by the General Assembly in the 1986 Session provided for a study of Tort Reform and its affect on insurance availability and affordability. In keeping with the mandate of this study, meetings have been held to receive public testimony beginning in May and have been held almost monthly since.

On September 8, 1986, the Attorney General testified before the Tort Reform Study Committee that little tort reform was needed and much insurance reform was needed. See Exhibit 1. She outlined proposals which included a closer rate review, including Virginia based data, as well as increased reporting requirements both by the industry and the Bureau of Insurance, and closed claim reporting by the industry including a history of case reserves.

Subsequent to this, the Bureau was contacted by the Senators on the SJR 22 Study Committee and a meeting with Bureau staff was held. As a result of this meeting, a draft of some proposed changes to Chapter 19, the competitive rating statute, and Chapter 28, the JUA statute, was prepared by Mary Devine of Legislative Services. This draft was sent to the Bureau for review on September 24, 1986 with instruction to make suggested changes in preparation for a discussion at a working session of the study committee to be held on October 10, 1986. This draft called for standby authority for the Commission to institute Joint Underwriting Associations for all lines of insurance, and required rate data to be based primarily on Virginia data. It required no closed claim reporting, and did not require prior approval of rates, nor did it require increased reporting by either the companies or the Commission. See Exhibit 2.

After reviewing the committee draft, the Bureau suggested several amendments which were agreed to by Ms. Devine in discussions with the Bureau. Her draft was amended accordingly and was forwarded to the study committee to be discussed at the working session scheduled for October 10, 1986. See Exhibit 3.

The Bureau's suggested changes were in keeping with the intent of the study by limiting the standby Joint Underwriting Association authority to the commercial general liability lines where residual markets do not currently exist. We also

suggested some clean up wording but no substantive changes were made to the intent of the first Committee draft.

At the October 10 meeting, before the committee draft was discussed, representatives from the Attorney General's office presented to the Committee proposed insurance reform legislation. See Exhibit 4.

The Committee, instead of discussing the amended committee draft, instructed the Bureau to meet with the Attorney General during the working session to see what compromises could be reached. During the meeting, the Bureau indicated that they had had no opportunity to discuss this with the Attorney General's office or the Commission. Having immediately noticed several major problems with the proposal, it was decided to hold a working meeting with the Attorney General's staff and the Bureau staff at a later date.

The major proposals in the legislation from the Attorney General were as follows:

1. An amendment to the recently enacted commercial liability termination law.

2. A requirement of additional reporting by companies with their annual statement of ten different statistics on any line of insurance where the Commission has determined that insurance is not reasonably available or affordable.

3. A requirement that only Virginia loss and expense experience be used in ratemaking unless sound actuarial reasons exist for using countrywide data.

4. A requirement that in every line of insurance subject to Chapter 19 all rate filings must be reviewed by the Bureau of Insurance to determine whether Virginia based data has been used properly as well as a requirement that every rate filing, whether file and use or 30 day prior filing (60 day prior

filing proposed by the Attorney General), contain information on written and earned premium, paid and incurred losses, paid and incurred expenses, investment income and total return on net worth as well as twenty-one separate statistics for each rate filing.

5. A requirement that each rate filing contain information on the company's loss reserves and reserving practices for that line.

6. A requirement that the Commission annually determine those lines, sublines, or rating classifications where insurance is not reasonably available or reasonably affordable. Additionally, there is a requirement that a hearing be held on those lines where such a determination has been made in order to determine whether competition is an effective regulator of rates. Until the hearing has been held, the rates must be filed 60 days prior to use.

7. A requirement that the same detail of reporting statistics be used in Chapter 20 prior approval of rate filings.

8. A requirement that companies file individual and summary reports on all closed claims for all liability lines of insurance.

A meeting with the Attorney General's staff was held shortly thereafter and the Bureau suggested several modifications to the Attorney General's proposal which would make the overall proposal acceptable to the Bureau. See Exhibit 5. The Bureau's proposal agreed to the amendment suggested by the Attorney General to the commercial liability termination statute, but amended the rest of the Attorney General's proposal as follows:

1. A supplemental report would be required of each company for designated lines or subclassifications of commercial liability insurance, using the reporting requirements currently used on medical malpractice and product liability supplemental reports. These lines include all the lines included in

the Attorney General's September 8 report as well as others added by the Bureau. In order to allow sufficient time for the companies to program their data processing equipment, and assuming the effective date of the law will be July 1, 1987, our proposal requires that the first supplemental report be filed with the annual statement due in 1989 for calendar year 1988.

2. A requirement in Chapter 19 similar to our requirement in Exhibit 3 (the committee draft) concerning the primary use of Virginia based ratemaking data.

3. A requirement that an annual report regarding the level of competition in the Virginia property and casualty industry and market segments within the industry as deemed appropriate be submitted by the Commission to the General Assembly by November 15 of each year.

4. For those lines of insurance indicated in the Commission's report where there is insufficient competition, a survey of the industry and an actuarial and economic review of rates of the leading writers of business in that line would be conducted. If the survey indicated that competition is insufficient and the rates are excessive, a hearing would be held to determine whether this line should be subject to 60 day prior filing.

5. Chapter 20 would be amended to require the same data as required for Chapter 19 lines of business (See point number 2 above).

The Bureau proposal does not contain any closed claim reporting requirement as this is not in any way helpful in the ratemaking process. Further, the rate review portion refers only to excessive rates, and does not require a determination as to whether or not rates are reasonably affordable.

On October 31, 1986, the Attorney General's staff delivered a revised Attorney General proposal, which included some revision to the termination statute as suggested by the Bureau staff at the earlier staff meeting. However, the Attorney General's proposal totally rejected any of the compromises suggested by the Bureau. See Exhibit 6. A detailed analysis of the Attorney General's proposal follows:

The amendment to the termination statute provides for an expansion to include reduction in coverage in the 45 day notice of termination provision that was enacted during the 1986 Session of the General Assembly. Additional clarifying amendments relating to the Commissioner's review of cancellations have also been added at the Bureau's suggestion. However, the Attorney General inadvertently omitted the clairifying changes relating to package policies and the mailing requirements. The Bureau is not opposed to the changes proposed in the commercial liability termination statute, but we do believe that the additional technical changes should be included.

The proposal includes a requirement for an annual report to the General Assembly and to the Attorney General's office by the Commission of all lines, sublines, or rate classifications for which insurance is not reasonably available or not reasonably affordable. For those lines, sublines, and rating classifications so designated, rates would immediately go to a 60 day prior filing requirement, pending a hearing by the Commission to determine whether competition is an effective regulator of rates.

The report which the Bureau has suggested be filed identifies only those lines where competition may be insufficient and where rates may be excessive. The Bureau strongly opposes making a determination of what is "reasonably affordable" because that will vary from one insured to another based upon their financial circumstances. The requirement to determine what is "not reasonably available" causes similar concerns. Further, it appears to be inappropriate, based upon the Bureau's subjective finding, to automatically place the line of insurance under 60 day prior filing when the hearing has not yet been held and the industry has not been given an opportunity to be heard. Further, the proposal is not clear as to when the 60 day filing requirement is effective. Is it 12:01 a.m. after we submit the report? Is it January 1st of the yea

following the report, is it after approval by the General Assembly, or when? Further, should our actuarial review under the 60 day prior filing indicate that the rate is not excessive, then the rate would be approved even though it may not be "reasonably affordable". Further, it appears that the use of the word "thereafter" in Section 38.2-1905.1 (B) on page 9, would require that a hearing be held every year on designated lines even if in the prior year it was determined that competition was an effective regulator of rates. It is not clear whether one hearing is required or whether separate hearings are required for each specific line, subline, or subclassification. Additionally, any interested party, including the Attorney General, who petitions the Commission could force the Commission to hold a hearing.

The Attorney General's proposal requires a supplemental annual report on those lines of liability insurance designated in the Commission's annual report as not being reasonably available or reasonably affordable. However, some 14 designated lines or subclassifications need not be reported on if the Commission has had a hearing and found that competition is an effective regulator of rates for those lines. This report would be required to be filed for the calendar year 1986 with the annual statement due March 1, 1987 which would be before this proposed law would go into effect. The Bureau finds this reporting requirement inconsistent and confusing and instead supports the requirement of supplemental reports as spelled out in the Bureau's proposal. See Exhibit 7. This will also allow the Bureau to add or subtract those lines of insurance which must be reported on the supplemental report as conditions warrant.

The Attorney General's proposal requires that <u>every</u> rate filing, whether subject to file and use, 60 day prior filing, or prior approval contain all of the statistical elements (more than 30 separate statistics) required in her original proposal, although under the file and use law the absence of this data would not enable us to disapprove the rate filing. In addition, the Virginia specific data must be used if relevant or actuarially sound. However, if there is a sound actuarial basis for using other than Virginia data, that appears to be permitted. Each rate filing still must contain information on the insurer's loss reserving practices for that line, regardless of whether this is a file and use, 60 day prior filing or prior approval line of business. The

Bureau strongly opposes this rate filing modification, primarily since it will not be in the consumer's interest. In some lines of insurance, state-based information is irrelevant. For example, products manufactured in Virginia are sold countrywide and the laws of the state in which the product causes injury governs the claims payment. Therefore, countrywide rates are used for products liability insurance and not state rates. Further, even when Virginia data can be determined, in many cases, the use of Virginia-only data will result in higher rates than if countrywide rates were used. Day-care centers, for example, would be charged a much higher rate than they are now because Virginia data is worse than the national average. In any event, use of Virginia-only data in lines of insurance with relatively small exposures would result in widely fluctuating rates from year to year since one medium size claim would affect everyones rates. The Bureau's proposal does encourage consideration of Virginia data, but allows flexibility to use all data where appropriate to produce a more equitable and predictable result. Further, the Attorney General's requirement of reviewing the loss reserving practices of the company for each rate filing is unnecessary and redundant. In prior approval rate filings, this is accomplished in the actuarial review of loss development factors, and on an overall basis, by the home state of the insurer examining reserves at least every three to five years. Most of the informational requirements proposed by the Attorney General are simply not useful for rate analysis purposes. Some of the required information could only be very rough estimates because of the rather arbitrary allocation decisions that are necessary. In any case, the Commission already has the authority to require the information it needs to analyze proposed revisions.

The Attorney General's proposal further states that on the effective date of the bill, presumably July 1, 1987, all lines designated in the bill as being subject to the Commission's review (the 14 lines in Section 38.2-1301.1 (C)) will automatically be 60 day prior filing, even though no hearing has been held, and no determination would have been made by the Commission as to whether or not insurance was reasonably available or reasonably affordable. The Bureau strongly opposes this provision since the net result will be further dessication of the limited market which already exists.

As the Commission knows, certain lines of business must be individually rated, due to widely varying characteristics of individual risks within the classification and the need for underwriting judgment to properly price the risk. Several of these lines of insurance have been exempted from rate filing pursuant to the provisions of Section 38.2-1903. Examples include directors and officers liability coverage, commercial umbrella or excess coverage, environmental (pollution) liability, municipal liability, liquor law liability, architects errors and omissions, and others. If companies are now required to file rates under the 60 day prior filing requirements, then this would eliminate exemptions already granted and, in our opinion, companies will no longer write this business in Virginia as licensed insurers. Instead, the business will be driven to surplus lines companies where rates and forms are not controlled and where no Guaranty Fund protection exists for the consumer.

In the delayed effect of rates section, the Bureau had proposed to delete "competition is not an effective regulator of rates charged" in favor of "a reasonable degree of competition does not exist and the rate is, or could be expected to be, unreasonably high for the insurance provided". However, the Attorney General amended our proposal by retaining the criterion of competition not being an effective regulator of rates and then separated the Bureau's no competition and excessive rate criterion into two separate criteria. Therefore, even if a line of business was being written at rates which were not excessive, under the Attorney General's proposal, there would be a hearing if there were too few companies competing for the business. The Bureau's position is that the whole purpose of this legislation is to see that insurance is available and rates are not excessive. If rates are not excessive, the number of companies writing the line of business seems to be irrelevant, and any push to prior approval will only serve to dry up an already limited market.

Finally, the Attorney General's proposal contains the same requirement for individual and summary closed claim reports for all liability lines as was contained in her earlier draft. The Bureau opposes this requirement, since it is not used for rate-making purposes and imposes a heavy administrative load on Bureau personnel for no useful purpose. The data is necessarily old and stale when received, arising from

policies which were written four or five years or longer prior to the claim payment. This proposal requires a breakout of expense allocations which will do nothing to improve ratemaking data and omits the expenses connected with claims still open or withdrawn prior to settlement. We have been collecting similar data for medical malpractice for the past year and no use has been made of this data by anyone to date. If it is deemed necessary by the Attorney General, the Bureau suggests that the closed claim reports be collected by the Attorney General's office. (The current Attorney General proposal already requires that they be notified of all rate filings made under the 60 day prior approval requirement.) The Bureau of Insurance has no use for this closed claim data.

In summary, for the reasons listed above, the Bureau is stongly opposed to the Attorney General's legislative proposal and feels that the existing law serves well in the regulation of rates. Clearly, the very competitive pricing practices of the early 1980's indicated how well the competitive rating law has worked, and it is only when the rates are raised under the competitive rating statute that individuals seem to complain about the rating law. In actual fact, for many lines of insurance, the rates being charged are less now than they were in 1979 even with the huge increases which have taken place in the last year to year and a half. This is due to the severe price cuts which took place in the early 1980's. This is how the competitive rating law was designed to work.

However, in recognition of the needs of various individuals for additional information to make decisions concerning appropriate tort reform, we are agreeable to proposing certain changes in the manner in which this information is gathered and we have so proposed this in our Exhibit 7. We feel that our proposal is preferable to that of the Attorney General since it will provide additional information but will not have the effect of drying up the voluntary market for the general liability line of business.

The Attorney General's proposal would require huge additional monetary expenditures for actuarial services, as well as increased expenditures for additional professional and clerical employees to handle the exponential increase in rate filing

material. Further, additional storage space and office work stations would be required in an office environment in which we currently do not have sufficient space for our existing employees and those additional positions which have already been authorized but cannot be filled due to lack of office space.

It is the position of the Bureau of Insurance that the net result of the Attorney General's proposal would be a severe restriction of availablity of insurance in Virginia and a severe deterioration in the current comparatively favorable insurance environment in Virginia when compared to other states.

§ 38.2-231. Notice of cancellation of or refusal to renew certain ~~commercial~~ liability insurance policies; notice of reduction in coverage. — A. No notice of cancellation or refusal to renew by an insurer of a policy of insurance as defined in § 38.2-117 or § 38.2-118 insuring a business entity shall be effective unless the insurer shall deliver or mail a written notice of cancellation or refusal to renew. Such notice shall:

1. Be approved as to form by the Commissioner of Insurance prior to its use;

2. State the date, which shall not be less than forty-five days after the delivery or mailing of the notice of cancellation or refusal to renew, on which such cancellation or refusal to renew shall become effective, except that such effective date may not be less than fifteen days from the date of mailing or delivery when the policy is being cancelled or not renewed for failure of the insured to discharge when due any of his obligations in connection with the payment of premium for the policy;

3. Be mailed or delivered to any lien holder if the terms of the policy require the giving of such notice.

4. State the specific reason or reasons of the insurer for cancellation or refusal to renew; and

5. Advise the insured of its right to request in writing, within fifteen days of the receipt of the notice, that the Commissioner of Insurance review the action of the insurer.

B. No written notice of cancellation or refusal to renew that is mailed by an insurer to an insured in accordance with this section shall be effective unless:

1. a. It is sent by registered or certified mail, or

b. At the time of mailing the insurer obtains a written receipt from the United States Postal Service showing the name and address of the insured stated in the policy;

2. The insurer retains a duplicate copy of the notice of cancellation or refusal to renew; and

3. At the time of mailing the insurer endorses upon the duplicate copy of the notice a certificate showing that the duplicate is a copy of the notice that was sent to the

insured (i) by registered or certified mail, or (ii) by regular mail for which the postal receipt was obtained.

C. No reduction in coverage by an insurer of a policy of insurance defined in §§ 38.2-117 or 38.2-118 shall be effective unless the insurer shall deliver or mail a written notice of such reduction in coverage to the insured not later than forty-five days prior to the effective date of same. Such notice shall state the manner in which coverage under an existing policy will be reduced upon renewal.

~~C.~~ D. Nothing in this section shall prohibit any insurer or agent from including in the notice of cancellation or refusal to renew any additional disclosure statements required by state or federal laws.

~~D.~~ E. For the purposes of this section (i) the term "business entity" shall mean an entity as defined by § 13.1-603 or § 13.1-803 and shall include an individual, a county, city, town, or an authority, board, commission, sanitation, soil and water, planning or other district, public service corporation owned, operated or controlled by a locality or other local governmental authority, and (ii) the term "reduction in coverage" shall mean, but not be limited to, any diminution in scope of coverage, decrease in limits of liability, addition of exclusions, increase in deductibles, or reduction in the policy term or duration.

~~E.~~ F. There shall be no liability on the part of and no cause of action of any nature shall arise against (i) the Commissioner of Insurance or his subordinates, (ii) any insurer, its authorized representative, its agents, its employees, or (iii) any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or refusal to renew, or for reduction in coverage, for any statement made by any of them in complying with this section or for providing information pertaining thereto.

§ 38.2-1301.1. Supplemental report required for certain subclassifications of liability insurance. — A. All insurers licensed to write the classes of insurance defined in §§ 38.2-117 and 38.2-118 shall file a supplemental report in conjunction with the annual

statement showing its direct experience in this Commonwealth attributable to any subclassification of general liability insurance designated by the Commission. Provid however, no such report shall be required of an insurer if that insurer has no written or earned premium directly attributable to the designated subclassifications in this Commonwealth.

B. This supplemental report shall be on a form prescribed by the Commission and shall include the following information for the previous year ending on the 31st of December:

1. Number of exposures;

2. Direct premiums written;

3. Direct premiums earned;

4. Direct losses paid;

5. Number of claims paid;

6. Direct losses incurred;

7. Direct losses unpaid; and

8. Number of claims unpaid;

9. Direct losses incurred but not reported; and

10. Such other relevant information as may be required by the Commission.

C. Unless the Commission finds that the continued collection of additional information is no longer necessary for one or more of the following subclassifications, the supplemental report shall include information on the following subclassifications of liability insurance:

1. Day care:

2. Exterminators;

3. Asbestos removal;

4. Pesticide application (crop spraying);

5. Pollution and hazardous waste disposal;

6. Governmental;

7. Architects and Engineers professional;

8. Directors and Officers professional;

9. Lawyers professional;

10. Insurance agents professional;

11. Commercial umbrella or excess;

12. Liquor;

13. Products; and

14. Medical malpractice.

D. The first supplemental report required by this section for items 1 through 12 of subsection C shall be filed with the annual statement due in 1989 for calendar year 1988.

§ 38.2-1904. Rate standards. — A. Rates for the classes of insurance to which this chapter applies shall not be excessive, inadequate or unfairly discriminatory. Rates shall be based primarily on loss experience within the Commonwealth and other relevant factors existing within the Commonwealth unless it is found that such experience ~~and~~/or factors are not relevant to the particular line or subline of insurance to which the rate applies or such experience and/or factors are not actuarially sound.

1. No rate shall be held to be excessive unless it is unreasonably high for the insurance provided and ~~(i)~~ a reasonable degree of competition does not exist in the area with respect to the classification to which the rate applies~~, or (ii) the rate will have the effect of destroying competition or creating a monopoly~~.

2. No rate shall be held inadequate unless it is unreasonably low for the insurance provided and (i) continued use of it would endanger solvency of the insurer, or (ii) the rate is unreasonably low for the insurance provided and use of the rate by the insurer has or, if continued, will have the effect of destroying competition or creating a monopoly.

3. No rate shall be unfairly discriminatory if a different rate is charged for the same coverage and (i) the rate differential is based on sound actuarial principles or (ii) is related to actual or reasonably anticipated experience.

B. 1. In determining whether rates comply with the standards of subsection A of this section, ~~due~~ separate consideration shall be given to (i) past ~~and prospective~~ loss experience within ~~and outside~~ this Commonwealth, (ii) past loss experience outside the Commonwealth, (iii) prospective loss experience within the Commonwealth, (iv) prospective loss experience outside the Commonwealth, (v) conflagration or catastrophe hazards, ~~(iii)~~ (vi) a reasonable margin for underwriting profit and contingencies, ~~(iv)~~ (vii) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, ~~(v)~~ (viii) past ~~and prospective~~ expenses ~~both countrywide and those specially~~ specifically applicable to this Commonwealth, ~~(vi)~~ (ix) past expenses, countrywide, (x) prospective expenses specifically applicable to this Commonwealth, (xi) prospective expenses, countrywide, (xii) investment income earned or realized by insurers both from their unearned premium and loss reserve funds, and ~~(vii)~~ (xiii) all relevant factors within and outside this Commonwealth.

2. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which such experience is available

C. For the classes of insurance to which this chapter applies, including insurance against contingent, consequential and indirect losses as defined in § 38.2-133, (i) the systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group for any class of insurance, or with respect to any subdivision or combination of insurance for which separate expense provisions are applicable, and (ii) risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual

risks in accordance with rating plans that establish standards for measuring variations in hazards, expense provisions, or both. The standards may measure any difference between risks that can be demonstrated to have a probable effect upon losses or expenses.

D. No insurer shall use any information pertaining to any motor vehicle conviction or accident to produce increased or surcharged rates above their filed manual rates for individual risks for a period longer than thirty-six months. This period shall begin no later than twelve months after the date of the conviction or accident.

§38.2-1905.1. Annual report on level of competition. — The Commission shall submit an annual report on the level of competition in the Virginia property and casualty insurance industry to the General Assembly on or before November 15 of each year. In addition to the industry in the aggregate, the Commission's report may give specific consideration to any market segment where the Commission has reason to believe such specific consideration is appropriate.

§ 38.2-1908. Delegation of rate making and rate filing obligation. — A. An insurer may establish rates and supplementary rate information for any market segment based on the factors in § 38.2-1904 or it may use rates and supplementary rate information prepared by a rate service organization, with average loss factors or expense factors determined by the rate service organization or with modification for its own expense and loss experience as the credibility of that experience allows, provided due consideration is given to experience and factors within the Commonwealth.

B. An insurer may discharge its obligations under subsection A of § 38.2-1906 by giving notice to the Commission that it uses rates and supplementary rate infor tion prepared and filed with the Commission by a designated rate service organization of which it is a member or subscriber. Any information about modifications to the rate service organization's filing that is necessary to fully inform the Commission of the insurer's rates

shall be filed with the Commission. The insurer's rates and supplementary rate information shall be those filed from time to time by the rate service organization, including any amendments to the rates and supplementary rate information, subject to modifications file by the insurer.

§ 38.2-1909. Review of rates by Commission. — The Commission may investigate and determine, (i) upon its own motion, (ii) at the request of any citizen of this Commonwealth, or (iii) at the request of any insurer subject to this chapter, whether rates in this Commonwealth for the classes of insurance to which this chapter applies are excessive, inadequate or unfairly discriminatory or whether loss experience and other factors within the Commonwealth are being properly used to determine the rates. In any such investigation and determination the Commission shall give due consideration to those factors specified in § 38.2-1904.

§ 38.2-1910. Disapproval of rates. — A. If the Commission finds, after providir notice and opportunity to be heard, that a rate is not in compliance with § 38.2-1904, or is in violation of § 38.2-1916, the Commission shall order that use of the rate be discontinued for any policy issued or renewed after a date specified in the order. The order may provide for rate modifications. The order may also provide for refund of the excessive portion of premiums collected during a period not exceeding one year prior to the date of the order. Except as provided in subsection B of this section, the order shall be issued within thirty days after the close of the hearing or within another reasonable time extension fixed by the Commission.

B. Pending a hearing, the Commission may order the suspension prospectively of a rate filed by an insurer and reimpose the last previous rate in effect if the Commission has reasonable cause to believe that either: (i) a reasonable degree of competition does not exist in the area with respect to the classification to which the rate applies, (ii) the filed rate will

have the effect of destroying competition or creating a monopoly, or (iii) use of the rate will endanger the solvency of the insurer, or (iv) Virginia loss experience and other factors specifically applicable to the Commonwealth have not been properly used to determine the rates. If the Commission suspends a rate under this provision, it shall hold a hearing within fifteen business days after issuing the order suspending the rate unless the right to a hearing is waived by the insurer. In addition, the Commission shall make its determination and issue its order as to whether the rate shall be disapproved within fifteen business days after the close of the hearing.

C. At any hearing held under the provisions of subsections A or B of this section, the insurer shall have the burden of justifying the rate in question. All determinations of the Commission shall be on the basis of findings of fact and conclusions of law. If the Commission disapproves a rate, the disapproval shall take effect not less than fifteen days after its order and the last previous rate in effect for the insurer shall be reimposed for a period of one year unless the Commission approves a substitute or interim rate under the provisions of subsections D or E of this section.

D. For one year after the effective date of a disapproval order, no rate promulgated to replace a rate disapproved under the order may be used until it has been filed with the Commission and not disapproved within thirty days after filing.

E. Whenever an insurer has no legally effective rates as a result of the Commission's disapproval of rates or other act, the Commission shall, on the insurer's request, specify interim rates for the insurer that are high enough to protect the interests of all parties. The Commission may order that a specified portion of the premiums be placed in an escrow account approved by it. When new rates become legally effective, the Commission shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis shall not be required.

§ 38.2-1912. Delayed effect of rates. — A. If the Commission finds in any class, line, or subdivision of insurance, or in any rating class or rating territory that (i) ~~is not an effective regulator of the rates charged~~ a reasonable degree of competition does not ex and the rate is, or could be expected to be, unreasonably high for the insurance provided (ii) a substantial number of insurers are competing irresponsibly through the rates charged, or (iii) there are widespread violations of this chapter, or (iv) Virginia loss experience and other factors specifically applicable to the Commonwealth have not been properly used to determine the rates, it may promulgate a rule requiring that any subsequent changes in the rates or supplementary rate information for that class, line, subdivision, rating class or rating territory shall be filed with the Commission at least ~~thirty~~ sixty days before they become effective. The Commission may extend the waiting period for thirty additional days by written notice to the filer before the ~~first thirty-day~~ sixty-day period expires.

B. By this rule the Commission may require the filing of supporting data for any classes, lines or subdivisions of insurance, or classes of risks or combinations thereof it deems necessary for the proper functioning of the rate monitoring and regulating process.

C. A rule promulgated under this section shall expire no later than one ye... after issue. The Commission may renew the rule after a hearing and appropriate findings under this section.

D. If a filing is not accompanied by the information the Commission has required under subsection B of this section, the Commission shall within ~~thirty~~ sixty days of the initial filing inform the insurer that the filing is not complete, and the filing shall be deemed to be made when the information is furnished.

§ 38.2-2005. Provisions governing making of rates. — A. Rates for the classes of insurance to which this chapter applies shall not be excessive, inadequate or unfairly discriminatory. Rates shall be based primarily on loss experience within the Commonwealth

and other relevant factors existing within the Commonwealth unless it is found that such experience and/or factors are not relevant to the particular line or subline of insurance to which the rate applies or such experience and/or factors are not actuarially sound.

B. 1. In making rates for the classes of insurance to which this chapter applies, due separate consideration shall be given to (i) past and ~~prospective~~ loss experience within and ~~outside~~ this Commonwealth, (ii) past loss experience outside the Commonwealth, (iii) prospective loss experience within the Commonwealth, (iv) prospective loss experience outside the Commonwealth, (v) conflagration or catastrophe hazards, ~~(iii)~~ (vi) a reasonable margin for underwriting profit and contingencies, ~~(iv)~~ (vii) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, ~~(v)~~ (viii) past and ~~prospective~~ expenses ~~both countrywide and those specially~~ specifically applicable to this Commonwealth, (ix) past experience countrywide, (x) prospective expenses specifically applicable to this Commonwealth, (xi) prospective expenses countrywide, ~~(vi)~~ (xii) investment income earned or realized by insurers from their unearned premium and loss reserve funds, and ~~(vii)~~ (xiii) all relevant factors within and outside this Commonwealth.

2. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which such experience is available.

3. In the case of uninsured motorist coverage required by subsection A of § 38.2-2206, consideration shall be given to all sums distributed by the Commission from the Uninsured Motorists Fund in accordance with the provisions of Chapter 30 (§ 38.2-3000 et seq.) of this title.

C. For the classes of insurance to which this chapter applies (i) the systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group for any class of insurance, or for any

subdivision or combination of insurance for which separate expense provisions apply, and (ii) risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks ... accordance with rating plans that establish standards for measuring variations in hazards, expense provisions, or both. The standards may measure any difference among risks that can be demonstrated to have a probable effect upon losses or expenses.

D. All rates, rating schedules or rating plans and every manual of classifications, rules and rates, including every modification thereof, approved by the Commission under this chapter, shall be used until a change is approved by the Commission.

§ 38.2-2006. Approval by Commission prerequisite to use of filing. — A. Except as provided in § 38.2-2010, no filing shall become effective, be applied, or be used in this Commonwealth until it has been approved by the Commission. However, a rate produced in accordance with a rating schedule or rating plan, previously approved by the Commission, may be used pending the approval.

B. A filing shall be deemed to meet the requirements of this chapter and to become effective unless disapproved by the Commission within ~~thirty~~ sixty days of the time that the filing was made. However, the Commission may extend the waiting period for thirty additional days by written notice to the filer before the ~~first thirty-day~~ sixty-day period expires.

C. If a filing is not accompanied by the information necessary for the Commission to determine if the requirements of § 38.2-2005 are satisfied, the Commission shall so inform the filer within ~~thirty~~ sixty days of the initial filing. The filing shall be deemed to be made when the necessary information is furnished.

D. The provisions of subsection B of this section shall be suspended when the Commission has ordered a hearing to be held under the provisions of § 38.2-2007.

D 9/30/86 Devine T 10/1/86 smw

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend and reenact §§ 8.01-229 and 8.01-243 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 8.01-243.1, relating to statute of limitations in medical malpractice actions; minors.

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-229 and 8.01-243 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 8.01-243.1 as follows:

§ 8.01-229. Suspension or tolling of statute of limitations; effect of disabilities; death; injunction; prevention of service by defendant; dismissal, nonsuit or abatement; devise for payment of debts; new promises; debts proved in creditors' suits.--A. Disabilities which toll the statute of limitations. - Except as otherwise specifically provided in §§ 8.01-237, 8.01-241, 8.01-242 , 8.01-243, 8.01-243.1 and other provisions of this Code,

1. If a person entitled to bring any action is at the time the cause of action accrues an infant, except if such infant has been emancipated pursuant to Article 15 (§ 16.1-331 et seq.) of Chapter 11 of Title 16.1, or of unsound mind, such person may bring it within the prescribed limitation period after such disability is removed; or

2. After a cause of action accrues,

a. If an infant becomes entitled to bring such action, the time during which he is within the age of minority shall not be counted as any part of the period within which the action must be brought except as to any such period during which the infant has been judicially declared emancipated; or

b. If a person entitled to bring such action becomes of unsound mind, the time during which he is of unsound mind shall not be computed as any part of the period within which the action must be brought, except where a guardian or committee is appointed for such person in which case an action may be commenced by such committee or guardian before the expiration of the applicable period of limitation or within one year after his qualification as such, whichever occurs later.

For the purposes of subdivisions 1 and 2 of this subsection, a person shall be deemed of unsound mind if he is adjudged insane by a court of competent jurisdiction to be mentally incapable of rationally conducting his own affairs, or if it shall otherwise appear to the court or jury determining the issue that such person is or was so mentally incapable of rationally conducting his own affairs within the prescribed limitation period.

3. If a convict is or becomes entitled to bring an action against his committee, the time during which he is incarcerated shall not be counted as any part of the period within which the action must be brought.

B. Effect of death of a party. - The death of a person

entitled to bring an action or of a person against whom an action may be brought shall toll the statute of limitations as follows:

1. Death of person entitled to bring a personal action. - If a person entitled to bring a personal action dies with no such action pending before the expiration of the limitation period for commencement thereof, then an action may be commenced by the decedent's personal representative before the expiration of the limitation period or within one year after his qualification as personal representative, whichever occurs later.

2. Death of person against whom personal action may be brought. - If a person against whom a personal action may be brought dies before the commencement of such action and before the expiration of the limitation period for commencement thereof then a claim may be filed against the decedent's estate or an action may be commenced against the decedent's personal representative before the expiration of the applicable limitation period or within one year after the qualification of such personal representative, whichever occurs later.

3. Effect of death on actions for recovery of realty, or a proceeding for enforcement of certain liens relating to realty. - Upon the death of any person in whose favor or against whom an action for recovery of realty, or a proceeding for enforcement of certain liens relating to realty, may be brought, such right of action shall accrue to or against his successors in interest as provided in Article

2 (§ 8.01-236 et seq.) of this chapter.

4. Accrual of a personal cause of action against the estate of any person subsequent to such person's death. - If a personal cause of action has not accrued against a decedent before his death, an action may be brought against the decedent's personal representative or a claim thereon may be filed against the estate of such decedent before the expiration of the applicable limitation period or within two years after the qualification of the decedent's personal representative, whichever occurs later.

5. Accrual of a personal cause of action in favor of decedent. - If a person dies before a personal cause of action which survives would have accrued to him, if he had continued to live, then an action may be commenced by such decedent's personal representative before the expiration of the applicable limitation period or within one year after the qualification of such personal representative, whichever occurs later.

6. Delayed qualification of personal representative. If there is an interval of more than one year between the death of any person in whose favor or against whom a cause of action has accrued or shall subsequently accrue and the qualification of such person's personal representative, such personal representative shall, for the purposes of this chapter, be deemed to have qualified on the last day of such period of one year.

C. Suspension during injunctions. - When the commencement of any action is stayed by injunction, the time

of the continuance of the injunction shall not be computed as any part of the period within which the action must be brought.

D. Prevention of service by defendant. - When an action has been commenced and service of process upon a defendant is prevented by such defendant's:

1. Departing from the Commonwealth; or

2. Absconding or concealing himself; or

3. Filing a petition in bankruptcy or filing a petition for an extension or arrangement under the United States Bankruptcy Act; or

4. Using any other direct or indirect means to obstruct the prosecution of such cause of action; then the time that such prevention has continued shall not be counted as any part of the period within which the action must be brought.

E. Dismissal, abatement, or nonsuit.

1. Except as provided in subdivision 3 of this subsection, if any action is commenced within the prescribed limitation period and for any cause abates or is dismissed without determining the merits, the time such action is pending shall not be computed as part of the period within which such action may be brought, and another action may be brought within the remaining period.

2. If a judgment or decree is rendered for the plaintiff in any action commenced within the prescribed limitation period and such judgment or decree is arrested or reversed upon a ground which does not preclude a new action for the same cause, or if there is occasion to bring a new

action by reason of the loss or destruction of any of the papers or records in a former action which was commenced within the prescribed limitation period, then a new action may be brought within one year after such arrest or reversal or such loss or destruction, but not after.

3. If a plaintiff suffers a voluntary nonsuit as prescribed in § 8.01-380, the statute of limitations with respect to such action shall be tolled by the commencement of the nonsuited action, and the plaintiff may recommence his action within six months from the date he suffers such nonsuit, or within the original period of limitation, whichever period is longer. This tolling provision shall apply irrespective of whether the action is originally filed in a federal or a state court and recommenced in any other court.

F. Effect of devise for payment of debts. - No provision in the will of any testator devising his real estate, or any part thereof, subject to the payment of his debts or charging the same therewith, or containing any other provision for the payment of debts, shall prevent this chapter from operating against such debts, unless it plainly appears to be the testator's intent that it shall not so operate.

G. Effect of new promise in writing.

1. If any person against whom a right of action has accrued on any contract, other than a judgment or recognizance, promises, by writing signed by him or his agent, payment of money on such contract, the person to whom

the right has accrued may maintain an action for the money so promised, within such number of years after such promise as it might be maintained if such promise were the original cause of action. An acknowledgment in writing, from which a promise of payment may be implied, shall be deemed to be such promise within the meaning of this subsection.

2. The plaintiff may sue on the new promise described in subdivision 1 of this subsection or on the original cause of action, except that when the new promise is of such a nature as to merge the original cause of action then the action shall be only on the new promise.

H. Suspension of limitations in creditors' suits. When an action is commenced as a general creditors' action, or as a general lien creditors' action, or as an action to enforce a mechanics' lien, the running of the statute of limitations shall be suspended as to debts provable in such action from the commencement of the action, provided they are brought in before the commissioner in chancery under the first reference for an account of debts; but as to claims not so brought in the statute shall continue to run, without interruption by reason either of the commencement of the action or of the order for an account, until a later order for an account, under which they do come in, or they are asserted by petition or independent action.

In actions not instituted originally either as general creditors' actions, or as general lien creditors' actions, but which become such by subsequent proceedings, the statute of limitations shall be suspended by an order of reference

for an account of debts or of liens only as to those creditors who come in and prove their claims under the order. As to creditors who come in afterwards by petition or under an order of recommittal, or a later order of reference for an account, the statute shall continue to run without interruption by reason of previous orders until filing of the petition, or until the date of the reference under which they prove their claims, as the case may be.

I. When an action is commenced within a period of thirty days prior to the expiration of the limitation period for commencement thereof and the defending party or parties desire to institute an action as third-party plaintiff against one or more persons not party to the original action, the running of the period of limitation against such action shall be suspended as to such new party for a period of sixty days from the expiration of the applicable limitation period.

§ 8.01-243. Personal action for injury to person or property generally; extension in actions for malpractice against health care provider.--A. Unless otherwise provided in this section or by other statute, every action for personal injuries, whatever the theory of recovery, shall be brought within two years after the cause of action accrues.

B. Every action for injury to property, including actions by a parent or guardian of an infant against a tort-feasor for expenses of curing or attempting to cure such infant from the result of a personal injury or loss of services of such infant, shall be brought within five years

after the cause of action accrues.

C. The two-year limitations period specified in subsection A shall be extended in actions for malpractice against a health care provider as follows:

1. In cases arising out of a foreign object having no therapeutic or diagnostic effect being left in a patient's body, for a period of one year from the date the object is discovered or reasonably should have been discovered; and

2. In cases in which fraud, concealment or intentional misrepresentation prevented discovery of the injury within the two-year period, for one year from the date the injury is discovered or, by the exercise of due diligence, reasonably should have been discovered.

However, the provisions of this subsection shall not apply to extend the limitations period beyond ten years from the date the cause of action accrues, except that the provisions of § 8.01-229 A 2 shall apply to toll the statute of limitations in actions brought by or on behalf of a ~~minor or other~~ person under a disability .

§ 8.01-243.1. Actions for medical malpractice; minors.--Notwithstanding the provisions of § 8.01-229A and except as provided in subsection C of § 8.01-243, an action on behalf of a person who was a minor at the time the cause of action accrued for personal injury or death against a health care provider pursuant to Chapter 21.1 (§ 8.01-581.1 et seq.) shall be commenced within two years of the date of the last act or omission giving rise to the cause of action except that if the minor was less than six years of age at

the time of the occurrence of the malpractice, he shall have until his eighth birthday to commence an action.

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D 12/4/86 Devine T 12/5/86 owj

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend and reenact § 8.01-225 of the Code of Virginia, relating to persons rendering obstetrical care without compensation; exemption from civil liability.

Be it enacted by the General Assembly of Virginia:

1. That § 8.01-225 of the Code of Virginia is amended and reenacted as follows:

§ 8.01-225. Persons rendering emergency care, obstetrical services without compensation exempt from liability.--Any person who, in good faith, (i) renders emergency care or assistance, without compensation, to any injured person at the scene of an accident, fire, or any life-threatening emergency, or en route therefrom to any hospital, medical clinic or doctor's office, or (ii) renders emergency obstetrical care or assistance, without compensation, to a female in active labor shall not be liable for any civil damages for acts or omissions resulting from the rendering of such care or assistance.

Any person who, in good faith and without compensation, administers epinephrine to an individual for whom an insect sting treatment kit has been prescribed shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment if he has reason to believe that the individual receiving the

injection is suffering or is about to suffer a life-threatening anaphylactic reaction.

Any person who provides assistance upon request of any police agency, fire department, rescue or emergency squad, or any governmental agency in the event of an accident or other emergency involving the use, handling, transportation, transmission or storage of liquefied petroleum gas or liquefied natural gas shall not be liable for any civil damages resulting from any act of commission or omission on his part in the course of his rendering such assistance in good faith.

Any emergency medical care attendant or technician possessing a valid certificate issued by authority of the State Board of Health who in good faith renders emergency care or assistance whether in person or by telephone or other means of communication, without compensation, to any injured or ill person, whether at the scene of an accident, fire or any other place, or while transporting such injured or ill person to, from or between any hospital, medical facility, medical clinic, doctor's office or other similar or related medical facility, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care, treatment or assistance, including but in no way limited to acts or omissions which involve violations of State Department of Health regulations or any other state regulations in the rendering of such emergency care or assistance.

Any person having attended and successfully completed a

course in cardiopulmonary resuscitation, which has been approved by the State Board of Health, who in good faith and without compensation renders or administers emergency cardiopulmonary resuscitation, cardiac defibrillation or other emergency life-sustaining or resuscitative treatments or procedures which have been approved by the State Board of Health to any sick or injured person, whether at the scene of a fire, an accident or any other place, or while transporting such person to or from any hospital, clinic, doctor's office or other medical facility, shall be deemed qualified to administer such emergency treatments and procedures; and such individual shall not be liable for acts or omissions resulting from the rendering of such emergency resuscitative treatments or procedures.

Nothing contained in this section shall be construed to provide immunity from liability arising out of the operation of a motor vehicle.

For the purposes of this section, the term "compensation" shall not be construed to include (i) the salaries of police, fire or other public officials or emergency service personnel who render such emergency assistance, ~~nor~~ (ii) the salaries or wages of employees of a coal producer engaging in emergency medical technician service or first aid service pursuant to the provisions of § 45.1-101.1 or § 45.1-101.2 or (iii) the salary of any staff health care provider paid by a hospital or other health care facility .

Any licensed physician who directs the provision of

emergency medical services, as authorized by the State Board of Health, through a communications device shall not be liable for any civil damages for any act or omission resulting from the rendering of such emergency medical services unless such act or omission was the result of such physician's gross negligence or willful misconduct.

For the purposes of this section, an emergency medical care attendant or technician shall be deemed to include a person licensed or certified as such or its equivalent by any other state when he is performing services which he is licensed or certified to perform by such other state in caring for a patient in transit in this Commonwealth, which care originated in such other state.

Any volunteer engaging in rescue or recovery work at a mine or any mine operator voluntarily providing personnel to engage in rescue or recovery work at a mine not owned or operated by such operator, shall not be liable for civil damages for acts or omissions resulting from the rendering of such rescue or recovery work in good faith unless such act or omission was the result of gross negligence or willful misconduct.

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D 11/19/86 Devine C 12/08/86 jds

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend the Code of Virginia by adding a section numbered 15.1-7.01, relating to immunity of members of local governmental entities; exception.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 15.1-7.01 as follows:

§ 15.1-7.01. Immunity for members of local governmental entities; exception.--The members of the governing bodies of any county, city, town or political subdivision and the members of boards, commissions, agencies and authorities thereof and other governing bodies of any local governmental entity created by public or private act, whether compensated or not, shall be immune from suit arising from the conduct of the affairs of the governing body, board, commission, agency or authority which do not involve the appropriation of funds. However, the immunity granted by this section shall not apply to conduct constituting intentional or willful misconduct or gross negligence.

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D 9/21/86 Devine C 12/5/86 jrt

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend and reenact §§ 13.1-704 and 13.1-883 of the Code of Virginia, to amend the Code of Virginia by adding sections numbered 13.1-692.1, 13.1-700.1, 13.1-870.1 and 13.1-879.1, and to repeal §§ 13.1-700 and 13.1-879 of the Code of Virginia, all relating to limitations on liability of corporate officers and directors; exceptions; entitlement to and procedure for advances, reimbursement and indemnification.

Be it enacted by the General Assembly of Virginia:

1. That §§ 13.1-704 and 13.1-883 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 13.1-692.1, 13.1-700.1, 13.1-870.1 and 13.1-879.1 as follows:

§ 13.1-692.1. Limitation on liability of officers and directors; exception.--In any proceeding brought by a shareholder in the right of a foreign or domestic corporation or brought by or on behalf of shareholders of the corporation, the damages assessed against an officer or director arising out of a single transaction, occurence or course of conduct shall not exceed the lesser of:

1. The monetary amount specified in the articles of incorporation or, if approved by the shareholders, in the bylaws as a limitation on the liability of the officer or director; or

2. The greater of (i) $100,000 or (ii) the amount of cash compensation received by the officer or director from

the corporation during the twelve months immediately preceding the act or omission for which liability was imposed.

The liability of an officer or director shall not be limited as provided in this section if the officer or director engaged in willful misconduct or a knowing violation of the criminal law.

§ 13.1-700.1. Court orders for advances, reimbursement or indemnification.--An individual who is made a party to a proceeding because he is or was a director of a corporation may apply to a court for an order directing the corporation to make advances or reimbursement for expenses or to provide indemnification. Such application may be made to the court conducting the proceeding or to another court of competent jurisdiction.

The court shall order the corporation to make advances and/or reimbursement for expenses or to provide indemnification if it determines that the director is entitled to such advances, reimbursement or indemnification and shall also order the corporation to pay the director's reasonable expenses incurred to obtain the order.

With respect to a proceeding by or in the right of the corporation, the court may (i) order indemnification of the director to the extent of his reasonable expenses if it determines that, considering all the relevant circumstances, the director is entitled to indemnification even though he was adjudged liable to the corporation and (ii) also order the corporation to pay the director's reasonable expenses

incurred to obtain the order of indemnification.

Neither (i) the failure of the corporation, including its board of directors, its independent legal counsel and its shareholders, to have made an independent determination prior to the commencement of any action permitted by this section that the applying director is entitled to receive advances and/or reimbursement nor (ii) the determination by the corporation, including its board of directors, its independent legal counsel and its shareholders, that the applying director is not entitled to receive advances and/or reimbursement or indemnification shall create a presumption to that effect or otherwise of itself be a defense to that director's application for advances for expenses, reimbursement or indemnification.

§ 13.1-704. Application of article.--A. Unless the articles of incorporation or bylaws expressly provide otherwise, any authorization of indemnification in the articles of incorporation or bylaws shall not be deemed to prevent the corporation from providing the indemnity permitted or mandated by this article.

B. Any corporation shall have power to make any further indemnity, including ~~advance~~ indemnity with respect to a proceeding by or in the right of the corporation, and to make additional provision for advances and reimbursement of expenses, to any director, officer, employee or agent that may be authorized by the articles of incorporation or any bylaw made by the shareholders or any resolution adopted, before or after the event, by the shareholders,

except an indemnity against (i) his ~~gross negligence or~~ willful misconduct , or (ii) a knowing violation of the criminal law . Unless the articles of incorporation, or any such bylaw or resolution expressly provide otherwise, any determination as to the right to any further indemnity shall be made in accordance with ~~subsection B of~~ § 13.1-701 B . Each such indemnity may continue as to a person who has ceased to have the capacity referred to above and may inure to the benefit of the heirs, executors and administrators of such a person.

§ 13.1-870.1. Limitation on liability of officers and directors; exception.--In any proceeding against an officer or director who receives compensation from the corporation for his services as such, the damages assessed arising out of a single transaction, occurence or course of conduct shall not exceed the lesser of (i) the amount of compensation received by the officer or director from the corporation during the twelve months immediately preceeding the act or omission for which liability was imposed or (ii) the monetary amount specified in the articles of incorporation or, if approved by the members, in the bylaws, as a limitation on the liability of the officer or director. An officer or director who serves without compensation for his services shall not be liable for damages in any such proceeding.

The liability of an officer or director shall not be limited as provided in this section if the officer or director engaged in willful misconduct or a knowing

violation of the criminal law.

§ 13.1-879.1. Court orders for advances, reimbursement or indemnification.--An individual who is made a party to a proceeding because he is or was a director of a corporation may apply to a court for an order directing the corporation to make advances or reimbursement for expenses, or to provide indemnification. Such application may be made to the court conducting the proceeding or to another court of competent jurisdiction.

The court shall order the corporation to make advances and/or reimbursement for expenses or to provide indemnification if it determines that the director is entitled to such advances, reimbursement or indemnification and shall also order the corporation to pay the director's reasonable expenses incurred to obtain the order.

With respect to a proceeding by or in the right of the corporation, the court may (i) order indemnification of the director to the extent of his reasonable expenses if it determines that, considering all the relevant circumstances, the director is entitled to indemnification even though he was adjudged liable to the corporation and (ii) also order the corporation to pay the director's reasonable expenses incurred to obtain the order of indemnification.

Neither (i) the failure of the corporation, including its board of directors, its independent legal counsel and its shareholders, to have made an independent determination prior to the commencement of any action permitted by this section that the applying director is entitled to receive

advances and/or reimbursement or indemnification nor (ii) the determination by the corporation, including its board of directors, its independent legal counsel and its shareholders, that the applying director is not entitled to receive advances and/or reimbursement or indemnification shall create a presumption to that effect or otherwise of itself be a defense to that director's application for advances for expenses, reimbursement or indemnification.

§ 13.1-883. Application of article.--A. Unless the articles of incorporation or bylaws expressly provide otherwise, any authorization of indemnification in the articles of incorporation or bylaws shall not be deemed to prevent the corporation from providing the indemnity permitted or mandated by this article.

B. Any corporation shall have power to make any further indemnity, including ~~advance~~ indemnity with respect to a proceeding by or in the right of the corporation, and to make additional provision for advances and reimbursement of expenses, to any director, officer, employer or agent that may be authorized by the articles of incorporation or any bylaw made by the members or any resolution adopted, before or after the event, by the members, except an indemnity against (i) his ~~gross negligence or~~ willful misconduct or (ii) a knowing violation of the criminal law. Unless the articles of incorporation, or any such bylaw or resolution expressly provides otherwise, any determination as to the right to any further indemnity shall be made in accordance with ~~subsection~~ B ~~of~~ § 13.1-880 B. Each such

indemnity may continue as to a person who has ceased to have the capacity referred to above and may inure to the benefit of the heirs, executors and administrators of such a person.

2. That §§ 13.1-700 and 13.1-879 of the Code of Virginia are repealed.

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D 9/20/86 Devine C 9/22/86 jrt

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend and reenact §§ 3.1-249.9 and 10-273 of the Code of Virginia, relating to finanicial responsibility requirements pest control; solid waste facilities.

Be it enacted by the General Assembly of Virginia:

1. That §§ 3.1-249.9 and 10-273 of the Code of Virginia are amended and reenacted as follows:

§ 3.1-249.9. Evidence of financial responsibility required of licensed applicator.--A. The Commissioner shall not issue a commercial applicator's license until the individual applicant or his employer has furnished evidence of financial responsibility with the Commissioner, consisting either of a surety bond to the Commissioner of Agriculture and Consumer Services from a person authorized to do business in Virginia or a liability insurance policy from a person authorized to do business in Virginia or a certification thereof, protecting persons who may suffer legal damages as a result of the use of any pesticides classified for restricted use by the applicant. Such act of financial responsibility need not apply to damages or injury to agricultural crops, plants or property being worked upon by the applicant. In the event the Commissioner determines that due to circumstances beyond his control, the applicant is unable to obtain or maintain a sufficient surety bond

from or insurance policy issued by another in the voluntary market, the Commissioner may permit the applicant to post a personal bond or furnish other surety sufficient to provide the protection required by this section.

B. The amount of such financial responsibility as provided for in this section shall be established by the Board, but shall not be required to exceed $200,000 for property damage, subject to a $1,000 deductible provision and shall not be required to exceed $200,000 for personal injury. Such financial responsibility shall be maintained at not less than such amount at all times during the licensed period. The Commissioner shall be notified ten days prior to any reduction at the request of the applicant or cancellation of such financial responsibility by the surety or insurer.

C. Should the evidence of financial responsibility furnished become unsatisfactory, the applicant shall upon notice immediately provide a new surety bond or insurance policy. Should he fail to do so, or should he fail to pay any damages for which he has been adjudged to be legally liable and which arise out of the use by the applicant of any pesticide classified for restricted use, the Commissioner shall cancel his license and give him notice of that fact. It shall be unlawful thereafter for that person to apply restricted use pesticides until the bond or insurance policy is brought into compliance with the requirements of this section, any such damages are paid in full, and his license is reinstated by the Commissioner.

§ 10-273. Financial responsibility for abandoned facilities.--A. The Board shall promulgate regulations which ensure that, in the event that a facility for the disposal or treatment of solid waste is abandoned, the costs associated with protecting the public health and safety from the consequences of such abandonment may be recovered from the person abandoning the facility.

B. The regulations may include bonding requirements, the creation of a trust fund to be maintained within the Department, self-insurance, other forms of commercial insurance, or such other mechanism as the Department may deem appropriate. Regulations governing the amount thereof shall take into consideration the potential for contamination and injury by the solid waste, the cost of disposal of the solid waste and the cost of restoring the facility to a safe condition. Any bonding requirements shall include a provision authorizing the use of personal bonds or other similar surety deemed sufficient to provide the protections specified in subsection A upon a finding by the Director that commercial insurance or surety bond cannot be obtained in the voluntary market due to circumstances beyond the control of the permit holder.

C. No state, local or other governmental agency shall be required to comply with such regulations.

D. Forfeiture of any financial obligation imposed pursuant to this section shall not relieve any holder of a permit issued pursuant to the provisions of this article of any other legal obligations for the consequences of

abandonment of any facility.

E. Any funds forfeited pursuant to this section and the regulations of the Department shall be paid over to the county, city or town in which the abandoned facility is located. The county, city or town in which the facility is located shall expend such forfeited funds as necessary to restore and maintain such facility in a safe condition.

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D 10/23/86 Devine C 12/5/86 jds

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend and reenact §§ 8.01-341 and 8.01-341.1 of the Code of Virginia, relating to exemptions from jury service.

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-341 and 8.01-341.1 of the Code of Virginia are amended and reenacted as follows:

§ 8.01-341. Who are exempt from jury service.--The following shall be exempt from serving on juries in civil and criminal cases:

1. The President and Vice-President of the United States,

2. The Governor ~~and~~ , Lieutenant Governor and Attorney General of the Commonwealth,

3. The members of both houses of Congress,

4. The members of the General Assembly, while in session or during a period when the member would be entitled to a legislative continuance as a matter of right under § 30-5 ,

~~5. Licensed practicing attorneys,~~

~~6. Licensed practicing physicians,~~

7. [Repealed.]

~~8. Licensed practicing dentists,~~

~~9. Officers of any court, provided such officers are in~~

actual service as such and receive compensation therefor;

10-14. [Repealed.]

15. The judge of any court and , members of the State Corporation Commission, and members of the Industrial Commission of Virginia.

16. [Repealed.]

17. Sheriffs, deputy sheriffs, state police, and police and magistrates in counties, cities and towns;

18-20. [Repealed.]

21. The superintendent of the penitentiary and his assistants and the persons composing the guard;

22-24. [Repealed.]

25. Persons on active duty with the armed forces of the United States or the Commonwealth;

26-31. [Repealed.]

32. Fire fighters who are full-time, paid members of any fire company or department in the Commonwealth.

The citizens of Tangier Island in Accomack County shall be exempt from jury service, except service on grand juries.

§ 8.01-341.1. Who may claim exemptions from jury service.--The following may claim exemptions from serving on juries in civil and criminal cases:

1. Train dispatchers and trainmen employed in train service;

2. Maritime and commercial airline pilots licensed under the laws of the United States or this State;

3. Customhouse officers;

4. Mariners actually employed in maritime service;

~~5. All persons while actually engaged in harvesting or securing grain, fruit, potatoes or hay or in harvesting or securing tobacco, and, during the tobacco marketing season at any tobacco warehouse, warehousemen and persons employed at such warehouse or engaged in purchasing or handling of tobacco thereat,~~

~~6. All professors, tutors and pupils of public or private institutions of learning, while such institutions are actually in session,~~

~~7. Ferrymen actually employed in that capacity,~~

8. A person who has legal custody of and is necessarily and personally responsible for a child or children sixteen years of age or younger requiring continuous care by him during normal court hours,

9. A person who is necessarily and personally responsible for a person having a physical or mental impairment requiring continuous care by him during normal court hours,

10. Any person over seventy years of age,

11. Any person whose spouse is summoned to serve on the same jury panel.

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D 09/17/86 Devine C 10/17/86 owj

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend the Code of Virginia by adding a section numbered 8.01-271.1, relating to certification of merits of pleadings, etc., by attorney or party; sanction.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 8.01-271.1 as follows:

§ 8.01-271.1. Signing of pleadings, motions, and other papers; sanctions.--Every pleading, written motion, and other paper of a party represented by an attorney shall be signed by at least one attorney of record in his individual name, and the attorney's address shall be stated. A party who is not represented by an attorney shall sign his pleading, motion, or other paper and state his address.

The signature of an attorney or party constitutes a certificate by him that (i) he has read the pleading motion, or other paper, (ii) to the best of his knowledge, information and belief, formed after reasonable inquiry, it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and (iii) it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation. If a pleading, written motion, or other paper

is not signed, it shall be stricken unless it is signed promptly after the omission is called to the attention of the pleader or movant.

An oral motion made by an attorney or party in any court of the Commonwealth constitutes a representation by him that (i) to the best of his knowledge, information and belief formed after reasonable inquiry it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification or reversal of existing law, and (ii) it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.

If a pleading, motion, or other paper is signed or made in violation of this rule, the court, upon motion or upon its own initiative, shall impose upon the person who signed the paper or made the motion, a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion, or other paper or making of the motion, including a reasonable attorney's fee.

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D 9/18/86 Devine C 11/19/86 jrt

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend the Code of Virginia by adding a section numbered 8.01-38.1, relating to personal injury actions; monetary limitation on the amount of noneconomic damages recoverable.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 8.01-38.1 as follows:

§ 8.01-38.1. Limitation on recovery of noneconomic damages.--In any action accruing on or after July 1, 1987, for personal injury or death, including an action for medical malpractice under Chapter 21.1 (§ 8.01-581.1 et seq.), the total amount awarded for noneconomic damages against all defendants found to be liable shall not exceed the greater of three times the amount of damages awarded for economic losses or $250,000. As a part of any verdict in such an action the trier of fact shall itemize the award to reflect the monetary amount intended for past medical expenses, future medical expenses, past lost earnings, future lost earnings and lessening of earning capacity, other economic expenses or loss resulting from the injury or death, punitive damages and noneconomic damages.

As used in this section, "noneconomic damages" means damages for pain, suffering, mental anguish, inconvenience, loss of consortium, disfigurement or deformity and

associated humiliation or embarrassment and other nonpecuniary injuries. The term does not include punitive damages.

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D 11/12/86 Devine T 10/12/86 jds

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend the Code of Virginia by adding in Article 1 of Chapter 17 of Title 8.01 sections numbered 8.01-430.1, 8.01-430.2, 8.01-430.3 and 8.01-430.4, relating to when itemized verdict required; periodic payment of award for future damages.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 1 of Chapter 17 of Title 8.01 sections numbered 8.01-430.1, 8.01-430.2, 8.01-430.3 and 8.01-430.4 as follows:

§ 8.01-430.1. When itemized verdict required; periodic payments for certain awards for future damages; bond.--In any action for personal injury or death, accruing on or after July 1, 1987, the trier of fact shall itemize any monetary amount awarded for past medical expenses, future medical expenses, past loss of earnings, future loss of earnings, past noneconomic damages, future noneconomic damages, punitive damages and other damages. If the award includes an amount for future damages the trier of fact shall also determine the probable life expectancy of the party entitled to future damages or other period of time over which such damages will be payable.

As used in this section "noneconomic damages" means damages for pain, suffering, mental anguish, inconvenience,

loss of consortium, disfigurement or deformity and associated humiliation or embarrassment, and other nonpecuniary injury. The term does not include punitive damages.

Subject to applicable rules of law governing setoff, credits, additur and remittitur, the court shall enter judgment in a lump sum for (i) all past damages, (ii) all punitive and other damages and (iii) future damages awarded up to an aggregate of $250,000. Unless the court determines that manifest injustice would result to any party, the court shall enter judgment ordering all future damages that in the aggregate exceed $250,000 to be paid in whole or in part in periodic payments. The court may order that periodic payments made pursuant to this section be equal or vary in amount, depending upon the needs of the claimant and may provide for annualized adjustments to the amount of the payments based upon changes in the consumer price index.

In ordering periodic payments of future damages, the court shall require the defendant to post a bond or security or to purchase an annuity or otherwise to assure full payment of these damages awarded by the judgment. A bond is not adequate unless it is written by a company authorized to do business in this State and is rated A+ by Best's. An annuity is not sufficient unless written by a company rated A+ by Best's. If the defendant is unable to adequately assure full payment of the damages, the court shall order that all damages be paid to the claimant in a lump sum after reduction of the future damages portion to present value.

No bond may be canceled or be subject to cancellation unless at least sixty days' advance written notice is filed with the court and the judgment creditor. Upon termination of periodic payments, the court shall order the return of the security, or so much as remains, to the judgment debtor.

The total dollar amount of the periodic payments for future damages in excess of $250,000 in the aggregate shall equal the dollar amount of all such future damages awarded without reduction to present value, less any attorney's fees payable from future damages as provided in § 8.01-430.3. Notwithstanding the provisions of this section, the court shall reduce to present value that portion of the future damages awarded which does not exceed $250,000 in the aggregate.

The period of time over which the periodic payments shall be made is the injured person's probable life expectancy or other period of time over which the damages will be incurred as determined by the trier of fact. If the claimant has been awarded damages to be discharged by periodic payments and the injured person dies prior to the expiration of the period during which periodic payments are to be made, the unpaid balance of the award for shall, at the election of the plaintiff's representative (i) continue to be paid periodically or (ii) after reduction to present value, be paid in lump sum to the estate of the claimant.

The judgment providing for payment of future damages by periodic payments shall specify the dollar amounts of the payments, the interval between payments, the number of

payments or the period of time over which payments shall be made and, in actions for wrongful death, the amounts and beneficiaries specified in §§ 8.01-52, 8.01-53 and 8.01-54. Periodic payments shall be subject to modification only as specified in this section.

§ 8.01-430.2. Failure or inability to make periodic payments.--Upon petition of a person entitled to periodic payments, if the court finds that the judgment debtor has exhibited a continuing pattern of failing to timely make the required payments, the court shall:

1. Modify the judgment to one for a lump sum amount equal to the unpaid balance reduced to present value;

2. Order that, in addition to the required periodic payments, the judgment debtor pay the claimant all damages caused by the failure to timely make periodic payments, including court costs and attorney's fees; or

3. Enter other orders as appropriate to protect the judgment creditor.

If it appears that the judgment debtor may be insolvent or that there is a substantial risk that the judgment debtor may not have the financial responsibility to pay all amounts due and owing the judgment creditor, the court may:

1. Order additional security;

2. Order that the balance of payments due be placed in trust for the benefit of the claimant;

3. Modify the judgment to one for a lump sum amount equal to the unpaid balance reduced to present value; or

4. Order such other protection as may be necessary to

assure the payment of the remaining balance of the judgment.

§ 8.01-430.3. Periodic payment of judgment; attorney's fee.--The claimant's attorney's fee, if payable from the judgment ordering periodic payments, shall be based upon the total judgment, adding all amounts awarded for past, future, punitive and other damages. The attorney's fee shall be paid from past, future, punitive and other damages in the same proportion. If a claimant has agreed to pay his attorney's fees on a contingency fee basis, the claimant shall be responsible for paying the agreed percentage calculated solely on the basis of that portion of the award not subject to periodic payments. The remaining unpaid portion of the attorney's fees shall be paid in a lump sum by the defendant, who shall receive credit against future payments for this amount. However, the credit against each future payment is limited to an amount equal to the contingency fee percentage of each periodic payment. Any provision of this section may be modified by the agreement of all interested parties.

§ 8.01-430.4. Finality of judgment.--Notwithstanding the provisions of §§ 8.01-430.1 and 8.01-430.2 authorizing the trial court to modify a judgment for periodic payments to one for a lump sum, a judgment for periodic payments entered pursuant to this chapter is a final judgment subject to appeal. Rights of execution and enforcement are not applicable to judgments for periodic payments unless or until the judgment is modified to one for a lump sum.

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D 12/12/86 Devine C 12/16/86 jrt

SENATE JOINT RESOLUTION NO.....

Continuing the joint subcommittee studying the liability insurance crisis and the need for tort reform.

WHEREAS, the 1986 Session of the General Assembly created a joint subcommittee to study the availability and affordability problems affecting liability insurance coverage and to examine the tort reparations system and its impact, if any, on those problems; and

WHEREAS, the joint subcommittee made considerable progress in its study and recommended to the 1987 Session of the General Assembly a number of legislative changes; and

WHEREAS, due to the complexity of the issues under study and the time constraints under which the joint subcommittee was operating, its members were unable to address several of the charges to the joint subcommittee contained in Senate Joint Resolution No. 22; and

WHEREAS, the joint subcommittee believes that an evaluation of the need for and effects of the implementation of various forms of alternative dispute resolution is desirable; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the joint subcommittee studying the liability insurance crisis and the need for tort reform is continued. The membership of the joint subcommittee will

remain the same, with any vacancy being filled in the same manner as the original appointment. The joint subcommittee shall complete its study and submit its recommendations, if any, to the 1988 Session of the General Assembly.

The indirect costs of this study are estimated to be $10,650; the direct costs of this study shall not exceed $5,760.

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