FINAL 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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Final 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
Richmond, Virginia
January, 1987

To: Honorable Gerald L. Baliles, Governor of Virginia,
and
The General Assembly of Virginia

AUTHORITY FOR STUDY

This study was a continuation of the study commenced in 1986 pursuant to Senate Joint Resolution No. 22. In its interim report of 1987, the joint subcommittee recommended that the study be continued to (i) review the need for and effects of implementation of various methods of alternative dispute resolution and (ii) evaluate available data on the effects of the recommendations of the joint subcommittee enacted by the 1987 Session of the General Assembly (see Senate Document No. 11, 1987). Senate Joint Resolution No. 109 and House Joint Resolution No. 221 were passed and the study was continued (see Appendix A). The membership remained the same; Senator William F. Parkerson, Jr., remained Chairman and Delegate C. Hardaway Marks remained Vice-Chairman.

BACKGROUND

Eight "tort reform" measures were introduced during the 1987 Session upon recommendation of the majority of joint subcommittee. Each bill was introduced in identical form in both the House and the Senate. The bill to require installment payments for the portion of an award attributable to future damages exceeding $250,000 was the only proposal which failed in each house (House Bill No. 1099; Senate Bill No. 411). It was argued that the option of a periodic payment schedule is currently available. Additionally, there was concern that the bill did not adequately provide for increases in the cost of living over the term of the payment.

The most controversial bill in the joint subcommittee's package would have imposed a limitation ("cap") on the total amount of non-economic damages recoverable in actions for personal injury or death. (House Bill No. 1085; Senate Bill No. 402). The House Bill was referred to the House Committee for Courts of Justice where it was argued that the cap would have the most adverse impact on those persons who suffer the most severe injuries, e.g., burn victims. Although all caps on recovery are necessarily unfair, the General Assembly has previously approved caps where the unfairness can be minimized and where, on balance, the benefit to the

public may be substantial (see e.g., § 8.01-581.15, medical malpractice cap). A majority on the House Committee did not believe there was sufficient data to suggest that adoption of the non-economic damages cap would favorably affect the cost and availability of liability insurance. The bill failed.

At the same time, the Senate Committee for Courts of Justice recommended and the Senate approved Senate Bill No. 402. The Senate Committee amended the bill to provide for a total cap of $350,000 and to specify that the jury was not to be told of the cap. The latter provision was included to alleviate the fear of some that if jury members were told they could award no more than $350,000 for non-economic damage, they might simply respond by awarding that amount or an amount close to that figure.

Upon considerable deliberation, the Senate bill was amended in the House Committee for Courts of Justice to create a $350,000 cap on punitive damages. Unlike non-economic damages, punitive damages are not compensatory in nature. Punitive damages are awarded to punish a defendant for his wrongful conduct and deter him and others from similar wrongful conduct. Therefore, as finally enacted, Senate Bill No. 402 enables the injured party to be fully compensated for all aspects of his injury, including not only out-of-pocket losses for medical expenses, lost wages, etc. but also damages incurred for pain, suffering, anguish and embarrassment.

The cap on punitive damages will provide a greater degree of predictability to defendants and their insurers in determining the extent of their liability exposure. It was noted that demands for punitive damages are becoming commonplace in civil actions, especially actions against commercial entities. Governor Baliles had previously indicated his support for a cap on punitive damages.

Two other recommendations of the joint subcommittee will greatly affect the conduct of civil actions generally. Senate Bill No. 403 and House Bill No. 1086 as originally introduced would have eliminated many of the exemptions from jury service. The joint subcommittee believed that making more people available for jury service would minimize the inconvenience, improve the knowledge and expertise brought into jury deliberations and ultimately improve the quality of justice and the degree of public confidence in the system.

The House Bill was killed in committee. The Senate Bill was sent to the House on a unanimous vote. After amendments which reinstated the more controversial exemptions, the bill was sent to the House floor on a unanimous vote from the Courts of Justice Committee.

As finally adopted in the House and agreed to by the Senate, attorneys, law enforcement officers, corrections officers and the citizens of Tangier Island would remain exempt from jury service. It was argued that attorneys could wield far too much persuasive power in the jury room. For that reason, they would normally be struck by one of the parties. It was also agreed that law enforcement and corrections officers remain exempt because of the appearance of a built-in bias in criminal cases and because of the inconvenience and possible disruption of their public service

function if required to serve in civil cases. Noting that the residents of Tangier Island suffer a peculiar inconvenience when called to jury service, it was agreed that their exemption should be retained.

The list of persons who may claim an exemption from jury service was also reduced. Trainmen, maritime and commercial airline pilots, customhouse officers, certain farmers and tobacco growers, harvesters and warehouse employees, teachers and ferryman will now be available for jury service as ordinary citizens. At the insistence of the House, mariners actually employed in maritime service may continue to claim an exemption.

Senate Bill No. 407 and House Bill No. 1083 granted statutory authority for a judge to impose sanctions upon a party, his attorney or both for filing a paper or making a motion in bad faith or for an improper purpose. The bill was based on a similar provision in the Federal Rules of Civil Procedure. The bill is broader than the federal rule in that it applies to oral motions as well. This was intended to ensure application of the statute to less formalized proceedings in the district courts. The bill responded to the public perception that the number of frivolous legal claims and defenses is growing.

The remaining recommendations of the joint subcommittee modified the law governing the liability of the health care providers, specifically obstetricians, corporate officers and directors and members of local governmental entities. According to testimony before the joint subcommittee, these groups were experiencing particular problems obtaining adequate, affordable liability coverage.

Senate Bill No. 405 and House Bill No. 1094 dealt with the peculiar problems of medical malpractice claims involving injuries to minors. Many obstetricians in the state are faced with skyrocketing premium costs or the unavailability of insurance at any price. The insurance companies have indicated that much of the problem involves their inability to predict with any degree of certainty the types and amount of claims involving minors and the difficulties they encounter when trying to defend such claims years after the event, when evidence is gone and memories have faded.

The general law applicable to civil claims for injuries allows a minor who is injured to bring an action up until the time of his 20th birthday, without regard to when the injury was incurred. That is, the two-year statute of limitations on such a claim does not begin to run until an injured minor reaches the age of majority (18). These bills provided that as to injuries incurred by a minor after July 1, 1987, an action for medical malpractice must be commenced within the two-year statute of limitations. However, recognizing that injuries to small children, particularly birth-related injuries, are not always readily apparent, the law provides that if the minor was less than eight years old at the time of the injury, an action may be commenced anytime before his tenth birthday. Older minors are placed on par with adults who are injured by alleged medical malpractice. With respect to younger children it was generally agreed that evidence of a latent injury would manifest itself by the time the child was ten years of age and had several years of socialization and schooling. As originally introduced, the bills would have given minors under six until their eighth birthday. The House and Senate finally agreed

that the "tenth birthday" limitation was preferable to allow more time for discovery of a latent injury by the minor, his parents or trained school and medical professionals with whom the child would have frequent contact. House Bill No. 1094 was adopted on a unanimous vote; Senate Bill No. 405 received a similarly favorable vote.

Senate Bill No. 408 granted immunity to a person who provides emergency obstetrical care to a female in active labor whose medical records are not available, provided (i) the person rendering the care or a professional associate has not previously cared for the woman during the pregnancy and (ii) there is no gross negligence involved in the treatment. House Bill 1089 was identical as introduced but failed in the House Committee for Courts of Justice. Initially, the bill required that the care be provided without compensation and did not refer to an absence of gross negligence. On reflection, however, it became apparent that the bill would have had an adverse and possibly discriminating impact on women who were unable to pay for obstetrical care. With clarifying amendments, the intent of the bill was achieved. The law protects from suit physicians who provide emergency obstetrical to women they have never seen and who may not have received proper prenatal care. Many obstetricians believe these types of births pose the greatest risks for them and, as such, most directly affect their liability insurance. The General Assembly agreed that protection from suit was necessary to ensure the continued availability of emergency obstetrical services.

Senate Bill No. 404 and House Bill No. 1088 were legislative responses to growing concern over the liability situation in the business world. Many businesses were finding it difficult to attract qualified individuals to act as officers or to sit on the board of directors because the individuals feared the imposition of personal liability for actions taken in those positions. The joint subcommittee heard testimony that insurance for officers and directors was increasingly becoming unavailable. A reasonable limitation on the liability of such persons for acts or omissions in their official capacity was believed necessary.

Officers and directors of non-stock, tax exempt corporations who receive no compensation are immune from liability in any suit brought against them in their official capacity. These are officers and directors of charitable, quasi-public purpose corporations. The liability of paid officers and directors of tax-exempt, non-stock corporations in any suit is limited to the cash compensation received during the twelve months preceding the wrong.

Officers and directors of stock corporations and paid officers and directors of non-stock corporations which are not tax-exempt are treated the same under the new law. Their liability is limited only in suits by or in the right of the corporation or the shareholders or members and may be reduced in the articles of incorporation or by the shareholders or members in the bylaws. The maximum liability specified in the new law, is the greater of $100,000 or the amount of cash compensation they received in the twelve months preceding their wrongful act.

None of the limitations on liability apply to actions of an officer or director constituting willful misconduct or a criminal violation. An

additional exception is included for officers and directors of stock corporations whose actions violate state or federal securities laws.

Members of local governmental boards and entities perform important public service functions. They too have been faced with the unavailability or high cost of liability insurance. In an effort to secure the continued availability of qualified persons to perform their services, Senate Bill No. 409 and House Bill No. 1084 provided immunity to members of local governing bodies and local governmental boards, commissions, agencies and authorities for acts involving their governmental or discretionary, except for acts involving the appropriation or misappropriation of funds, in the absence of intentional or willful misconduct or gross negligence. These measures were also approved on nearly unanimous votes.

The joint subcommittee found it difficult to determine the actual causes of the availability/ affordability problems. It is apparent that there are inequities in the tort system which make it increasingly difficult for insurance companies to assess their risk of loss and make a reasonable profit. However, it is also true that recent business practices of the companies have contributed to the problem.

The Attorney General suggested to the joint subcommittee that insureds in Virginia were paying the price of excesses and abuses of the reparations system in other states. The joint subcommittee agreed. The joint subcommittee, therefore, encouraged the Attorney General and the State Corporation Commission (S.C.C.) to develop a workable legislative package which would (i) give priority to favorable Virginia loss experience in the rate-making process and (ii) provide more detailed information on an insurer's loss experience to improve the regulatory process. House Bills Nos. 1234 and 1235 encompass a stronger, more consumer-oriented insurance industry regulatory process.

House Bill No. 1234 requires commercial liability insurers to provide more detailed closed-claim reports and authorizes the S.C.C. to require additional information on individual claims. In the long run, this will help the S.C.C. evaluate each company's reserving practices. The bill passed each house unanimously. House Bill No. 1235 modifies rate-making procedures to require closer scrutiny by the S.C.C., and authorizes the Attorney General to play a greater role. The bill requires insurers to give greater consideration to Virginia-specific data in setting rates. It is anticipated that the use of credible loss data from Virginia will result in lower rates or, at least, smaller increases in rates. The bill also specifies the data the S.C.C. is to look at in determining whether rates are competitive. In addition to loss-reserving practices, the S.C.C. is to look at income from the investment of surplus monies. Again, it is hoped that this will result in lower rates for Virginia insureds. Although this bill was strongly opposed by industry representatives, it passed the Senate unanimously and only one negative vote was cast in the House.

The last of the joint subcommittee recommendations affected the insurance situation for a small number of Virginians. Statutes and regulations currently require licensed pest control applicators and holders of permits for solid waste facilities to meet minimum financial responsibility requirements. These requirements are intended to assure

adequate protection for the public in the event of an accident or, in the case of solid waste facilities, abandonment of the site. Historically, the applicators and permit holders met these requirements through commercial liability insurance. As this insurance became unavailable, they were unable to meet their statutory duty. Senate Bill No. 406 and House Bill No. 1087 authorized the State Board of Agriculture and Consumer Services to specify by regulations the acceptable methods of meeting the minimum financial responsibility requirements, including maximum deductibles, in lieu of a surety bond or commercial liability insurance. The Director of the Department of Waste Management is authorized to accept a personal bond or similar surety from a solid waste facility permit holder upon a finding (i) that commercial liability insurance is unavailable and (ii) the unavailability is not due to actions of the permit holder. These bills also passed unanimously.

In addition to the bills recommended by the joint subcommittee, a number of other measures designed to relieve the "insurance crises" were considered. The most significant of these include (i) creation of a no-fault compensation program for infants suffering certain severe, birth-related injuries, House Bill No. 1216; (ii) immunity for persons who administer vaccines which cause injury, provided the federal compensation program for vaccine-related injuries is implemented, Senate Bill No. 665; (iii) immunity and limitations on liability for officers and directors of business entities, other than corporations, which are exempt from federal income taxation, House Bill No. 1394; and (iv) authority for local governments to extend liability coverage to local boards and commissions, House Bill No. 1315. These measures complement the joint subcommittee recommendations as adopted by the General Assembly.

Many of the individuals and groups who participated in the deliberations of the joint subcommittee last year expressed appreciation for and confidence in the enacted reforms. The joint subcommittee believes that the 1987 General Assembly took well-reasoned action in response to the liability insurance crisis and enacted measures designed to restore public confidence in the civil justice system.

CONSIDERATIONS AND FINDINGS

1. Alternative Dispute Resolution

The joint subcommittee held three public hearings in Richmond. As requested by the resolutions continuing the study, the joint subcommittee focused on an evaluation of the need for and effects of implementation of various alternative dispute resolution techniques. Representatives of the special joint committee of the Virginia State Bar and the Virginia Bar Association on Dispute Resolution participated in the deliberations of the joint subcommittee. Upon recommendation of the special committee and with assistance from the Better Business Bureau and the Virginia Law Foundation, the Richmond Dispute Resolution Center opened in July, 1987. By December, 1987, the Center was handling 40-50 cases per month. Additionally, an alternative dispute resolution center opened in Charlottesville to coordinate and encourage the use of arbitration and mediation statewide.

Mediation

The joint subcommittee noted that arbitration and mediation are being used as alternatives to the traditional tort system more frequently. Arbitration is a formalized process, currently subject to various statutory provisions. See Chapter 21 of Title 8.01, §§ 8.01-577 et seq. Mediation is a less formalized process through which an intermediary assists the parties in working toward a mutually agreeable resolution of the controversy between them. Mediation has been utilized most often in domestic relations controversies and similar cases where the parties anticipate a continued relationship. House Joint Resolution No. 246, (1987) created a study of mediation as a tool in resolving child custody, visitation and support cases. The joint subcommittee was interested in the use of mediation in other civil cases.

The joint subcommittee recognizes that mediation is being used more frequently, albeit informally, in diverse types of cases throughout the Commonwealth. In 1987, the General Assembly amended § 16.1-69.35 to authorize the chief judge of a general district court to establish a voluntary civil mediation program. It is apparent that the General Assembly encourages the use of mediation.

The joint subcommittee likewise believes mediation is an appropriate alternative to the traditional court system. The mediation process is quicker and less costly; its use frees the courts to concentrate on more complex cases. The joint subcommittee believes mediation is a less costly mechanism for resolving "small claims" than creation of another level of the courts system as has been recommended in the past (see e.g., House Bill No. 1614, 1987).

It was noted in testimony before the joint subcommittee that based upon experience in North Carolina, the parties to mediation finally resolve their dispute in over 80% of the cases.[1] The joint subcommittee recommends that mediation be considered by the courts and parties to a controversy and its use encouraged. Creation of the dispute resolution centers in Charlottesville and Richmond will help develop greater awareness among the public and the judiciary of the availability of mediation as an alternative.

During the course of discussions regarding mediation, it became apparent that statutory guidelines would be necessary to facilitate the process. The primary areas of concern were (i) the need to protect the confidentiality of the mediation process and (ii) the need to protect mediators from civil liability for good faith actions taken by them in assisting the parties. Protecting the mediation process from disclosure ensures that the parties will honestly and openly work toward a resolution of their conflict. The parties should not fear future disclosure of information exchanged during the mediation process. Confidentiality will protect the credibility of the process. Immunity is believed necessary to ensure that qualified individuals continue to be available to serve as mediators. It was noted that mediators working through the Richmond ADR Center serve without compensation.

Conceptual proposals to ensure confidentiality and grant immunity were unanimously endorsed by the Boyd-Graves Conference in November, 1987. It was noted that many states have recently enacted statutes or rules to provide confidentiality and immunity. Representatives of the Richmond ADR Center submitted statutory language and the joint subcommittee recommends that the bill be enacted (see Appendix B).

The proposed bill provides for confidentiality of all communications relating to issues which are the subject of the controversy made between the parties, between a party and the mediator or between the parties or the mediator and a third person if made during the mediation process and not otherwise subject to discovery or disclosure. The mediation process begins with the initial contact between a party and the mediator and ends when the parties reach an agreement or discharge the mediator. Thus, all statements made, whether oral or written, if not available from a source independent from the mediation are confidential. Additional exceptions to the confidentiality provisions are provided for (i) any agreement between the parties resulting from the mediation in order not to impede any subsequent action brought relating to enforcement of the agreement and (ii) actions brought by a party against the mediator or a mediation program for actions which would not be covered by the immunity provisions, e.g., acts constituting gross negligence. The immunity provision is modeled after § 8.01-226.1. That section, enacted in 1987, grants immunity to persons who assist lawyers in substance abuse counseling.

Offer of Settlement

The joint subcommittee also spent considerable time reviewing a proposal submitted by the Virginia Bar Association. The "Offer of Settlement" proposal is based on Rule 68 of the Federal Rules of Civil Procedure. The proposed statutory language and comments submitted by the Bar Association are included in this report as Appendix C. Fred C. Alexander, Esquire, presented the proposal on behalf of the Bar Association.

As indicated by the papers submitted and testimony before the joint subcommittee, the proposal is intended to encourage the parties to promptly evaluate the realities of their case. Prompt and thorough evaluation would ideally lead to an equitable resolution of the controversy without the delay and expense of litigation. Six states currently have similar statutes. However, this proposal is unique in that it allows the plaintiff to make an offer. It was suggested that this is a more equitable approach and provides the greatest inducement to settlement.

The joint subcommittee noted the approval of the proposal by the Virginia Bar Association and the favorable vote of the Boyd-Graves conference. Although the proposal was recommended by a vote of 2-1, the rules of the conference preclude an endorsement absent a three-fourths majority vote.

Subsequent to the final meeting of the joint subcommittee, the Virginia Trial Lawyers Association indicated agreement with the purpose of the proposal, i.e., to encourage early settlements. However, the VTLA prefers to utilize Rule 4:13 of the Rules of the Supreme Court of Virginia to that end (see Appendix D).

The joint subcommittee recognizes that there is merit to any process which encourages early and equitable resolution of disputes.* Nonetheless, the joint subcommittee remains concerned over the possible chilling effect imposition of sanctions might have on the settlement process. The joint subcommittee makes no recommendation at this time.

Summary Jury Trials

In 1986 and again in 1987, Senator Mitchell introduced a bill which would have allowed the parties to have their case heard in a summary fashion by a mock jury (see Senate Bill No. 47, 1986; Senate Bill No. 363, 1987). The summary jury trial is a pre-trial device used to encourage settlements. Each party presents its best case in an abbreviated form to convince a jury and the other party of the merits of its case. The process frequently eliminates the cost and delay of litigation and helps the parties develop a realistic assessment of the merits of the case.

The summary jury trial process was adopted on an experimental basis by the Judicial Conference of the United States in 1984. Currently, approximately sixty-five federal district court judges are utilizing the process in their courts.[2] It has been reported that approximately 30-40% of the cases assigned to a summary jury trial settle,[3] resulting in a savings per case of $1,504.12.[4]

Under the federal program and Senate Bill No. 47, as introduced, the trial judge is authorized to assign a case to a summary jury without the consent of the parties. The proposal considered by the joint subcommittee contemplated only a voluntary process. The Virginia Trial Lawyers Association indicated no opposition to a voluntary process.

Some members of the joint subcommittee expressed concern about the potential for increasing the costs of litigation where the parties fail to settle after incurring the costs of participation in the summary jury trial process. Nonetheless, a majority of the joint subcommittee believes that parties should be encouraged to promptly evaluate and settle their disputes. A voluntary summary jury trial proposal will accomplish this result. The joint subcommittee recommends that a voluntary summary jury trial process be enacted (Appendix E).

Alternative Procedures - Medical Malpractice

Finally in the area of the alternative dispute resolution, the joint subcommittee considered two alternative procedures for handling medical malpractice cases. The first proposal is based on the process which was adopted in Indiana in 1975 (see Appendix G1). Ronald L. Dyer, Counsel to the Indiana State Medical Society, testified before the joint subcommittee (see Appendix F). He explained that the system has worked well in holding down the cost and assuring the availability of medical malpractice insurance. Rate increases in the medical malpractice line have generally been less than increases in the rate of inflation.

It was noted, however, that the limitation on recovery ("cap") in medical malpractice cases is $500,000, or one half the cap in Virginia. Perhaps more significantly, the Indiana Supreme court held in 1975 that the

cap was constitutional. The Indiana medical malpractice scheme also requires participation in a pretrial screening panel process for most claims and includes a strict two-year statute of limitations with an exception for minors similar to the law enacted in Virginia in 1987. No direct evidence was presented linking any one facet of the Indiana system to its favorable insurance experience.

The second proposal would have created a "no-fault" compensation system modeled after Virginia's Workers Compensation laws (see Appendix G2). Review of the claim by the Industrial Commission would be limited to a determination that the injury resulted from medical treatment and assessment of damages.

The joint subcommittee believes that the insurance climate for the medical malpractice line will continue to be volitile. Of particular concern is the fact that the St. Paul's Fire and Marine Insurance Company filed for a 47% rate increase[5] with the Bureau of Insurance in the Spring of 1987, notwithstanding the various reforms enacted in 1987. The joint subcommittee recognizes that it takes time for the effects of legislative reforms to be reflected in rate filings and premium costs. However, they believe this filing is some evidence that the medical malpractice "crisis" is not over.

The Medical Society of Virginia advised the joint subcommittee that in contrast to the situation in prior years, liability insurance is available to most health care providers in Virginia. However, the Medical Society is concerned about the cost and the possibility of future availability problems.

At the request of the Medical Society, the joint subcommittee deferred action on either proposal. The Medical Society requested additional time to study these issues. The Medical Society will conduct an in-depth actuarial analysis of these proposals and their effects. A thorough review of legislative actions in other states will also be undertaken. The joint subcommittee was cautioned that notwithstanding the current, relatively favorable insurance climate, further legislative action in the area of medical malpractice may be necessary. There is considerable interest in alternative procedures which would improve availability and affordability. However, the joint subcommittee recommends further study of these proposals. The joint subcommittee is reluctant to tamper with the current system in Virginia in the absence of such data.

2. Tort Reforms

The joint subcommittee considered, and in some cases reconsidered, a number of tort reform issues.

Collateral Source Rule

The joint subcommittee reconsidered the need for modification of the collateral source rule. Proponents of modification, including the Virginia Association of Defense Attorneys and the American Insurance Association, recommended a recently enacted Alabama law, House Bill No. 28, 1987. The Alabama law allows evidence to be introduced of amounts which have been or

will be paid to the plaintiff for his medical expenses. If this evidence comes in, the plaintiff may introduce evidence of the cost to him of securing the collateral benefit.

Proponents argue that (i) double recovery for the same injury is a windfall to the plaintiff, (ii) the increased costs of a system which allows double recovery are passed on to all insurance consumers and (iii) the proposal submitted does not require reduction of the verdict but ensures that the jury has the "complete picture." Opponents of a modification of the collateral source rule argue that a negligent defendant ought not be treated as a third-party beneficiary of an injured plaintiff's contract for insurance.

The joint subcommittee noted with particular interest the testimony suggesting that modification of the collateral source rule would significantly reduce the costs of the tort system. From a policy making standpoint, the proposal is a reasonably limited approach, which logically would reduce the overall costs to the insurance system. Any such reduction would benefit consumers in the form of lower premiums or less drastic premium increases.[6] However, conflicting testimony was received based upon experience in Kansas and Florida. Recent claim cost impact statements filed by the St. Paul and Aetna Insurance companies in Florida indicated "negligible" effects on insurance costs from reforms allowing evidence of collateral source benefits.[7]

The joint subcommittee believes that merely allowing introduction of evidence of receipt of the benefits and the cost of securing the benefits is preferable to an automatic reduction of the verdict. The jury's fact finding function is not significantly invaded. The limitation to evidence relating to medical expenses is also found to be desirable. However, the joint subcommittee was unable to agree on this issue and therefore makes no recommendation.

Nonsuits

Participants in the Boyd-Graves Conference submitted a proposal which would authorize the court to assess actual expenses incurred against a party who takes a nonsuit of right within seven days of trial, if the court finds the party abused the right (see Appendix H). The proposal was agreed to at the conference by a vote of 36-7. The Virginia Association of Defense Attorneys also supports this proposal.

In considering the proposal, the joint subcommittee noted that there are situations where a nonsuit is taken for an improper purpose. The effect is a needless increase in the costs of and time spent on litigation. It was also noted however that there are times when a last minute nonsuit is necessary to protect a client's interest. Some members of the joint subcommittee expressed concern that the statute would be interpreted to create a presumption that a nonsuit taken within seven days of trial was taken for an improper purpose.

Upon reflection, the joint subcommittee determined that the proposal was outside the scope of their charge. While there may be merit to such a provision, its adoption would not affect the availability or affordability

of liability insurance. Therefore, the joint subcommittee makes no recommendation on this proposal.

Expert Witnesses-Medical Malpractice

The joint subcommittee spent considerable time discussing the need to limit the use of "professional expert witnesses" in medical malpractice cases. The discussions focused on non-practicing health care providers who earn most, if not all, of their income testifying in civil cases. It was noted that this issue was discussed at some length during the two-year study of Virginia's Medical Malpractice Laws (see House Document No. 21, 1985 and House Document No. 12, 1986). The Medical Society of Virginia has long been interested in this issue.

The joint subcommittee believes that a tightly drawn limitation on the qualifications of experts is desirable.** Such a limitation would ensure that each case was evaluted by a true expert, i.e., a practitioner familiar with medical practices which are available and appropriate under the circumstances. The joint subcommittee notes that evaluation and testimony by an individual whose favorable testimony can be effectively bought subverts the judicial process.

While a majority of the joint subcommittee supports such a proposal in concept, they were unable to agree on specific statutory language. Some members expressed concern that a statutory limitation might further reduce the pool of qualified experts available to testify in a medical malpractice case. The adverse affect would be felt by both plaintiffs and defendants. Any limitation must be reasonably related to the qualifications of the expert to evaluate the defendants' actions and apply the appropriate standard of care. Representatives of the Medical Society of Virginia indicated a willingness to pursue the issue and develop a reasonable limitation as suggested by the discussions of the joint subcommittee.

Immunity for Alternative Sentencing Programs

Representatives of programs which supervise criminal defendants sentenced to perform community service work in lieu of incarceration testified before the joint subcommittee (see Appendix I). The testimony suggested that the continued viability of these non-profit or governmental programs was doubtful due to increasing costs and, in some cases, unavailability of insurance coverage. Representatives of the New River Community Sentencing program recommended for consideration by the joint subcommittee a Missouri law which grants immunity to these programs and to the work sites to which the defendant is assigned pursuant to these programs (Appendix II).

The joint subcommittee recognizes the significant benefits accruing to the Commonwealth through these programs. There is a need to ensure the continued availability of these programs as an alternative to the more costly process of incarceration. The joint subcommittee further recognizes that the unavailability or high cost of liability insurance poses a real threat. Therefore, the joint subcommittee recommended that staff review the Missouri statute and, as an alternative to an immunity provision, methods by which insurance coverage could be secured.

Subsequent to the last meeting of the joint subcommittee, representatives of New River Community Sentencing, Inc., presented a Missouri-based legislative proposal to the Virginia State Crime Commission. At the request of the Crime Commission, a meeting was held between representatives of the Office of the Attorney General, the Division of Risk Management and the Department of Criminal Justice Services, staff to the joint subcommittee and the Executive Director of the Crime Commission. There are currently twenty-eight community sentencing programs operating in the state. All but the New River program operate under contract with the Department of Corrections. The contract for these twenty-seven programs specifies that the Department is to provide liability insurance coverage. Four of these are independent, non-profit programs which have contracted with the local governments to provide community sentencing programs. As such, these programs are treated as local government programs. The New River program is a non-profit program which operates under contract with the Department of Criminal Justice Services. The contract requires that the New River program secure adequate liability insurance coverage.

In June 1987, the policy held by the Department of Corrections to cover the twenty-seven local programs lapsed. Alternative coverage could not be found. At the request of the Department of Corrections, the Division of Risk Management included the programs in their local law enforcement liability insurance plan. This was done as an accommodation to secure the coverage necessary to continue operation of these programs and required by the contract with the Department. However, because New River could not qualify as either a state or local program, it could not be included in the plan.

It was suggested that if the contract between the Department of Criminal Justice Services and New River were modified to require the Department to secure insurance coverage, the Division of Risk Management might be able to include the program in one of its plans. However, it must be emphasized that inclusion of these programs under one of the state or local plans is merely a band-aid approach to the problem. The Division of Risk Management has included the twenty-seven local programs with the understanding that an alternative, long-term solution must be found.

The joint subcommittee believes that immunity should not be granted lightly. Only where necessary to protect a significant public interest should the rights of injured persons be restricted. Therefore, the joint subcommittee encourages the Virginia State Crime Commission and the Office of the Attorney General to continue their efforts to develop alternatives which adequately protect (i) the community sentencing programs and work sites from potentially devastating liability exposure and (ii) persons who perform work in such programs and third parties who might suffer an injury as a result of their participating in the program or contact with the work site.

Hemophilia Treatment Programs

The final issue considered by the joint subcommittee in the area of tort reform involved the potentially devastating effect the unavailability

or high costs of certain products would have on state-run programs for the treatment of hemophilia (see Appendix J). The product currently provided to the Department of Health under contract costs approximately 6 to 9 cents per unit. The product, Factor VIII, is a heat-treated, donor-tested blood product. The heat treatment and donor testing have effectively reduced the risk of contamination of the product by the HIV ("AIDS") virus. In rare instances the product has tested positive for hepatitis. The companies producing Factor VIII have developed a non-blood product which is the genetic equivalent of Factor VIII. There is a growing fear of liability exposure by companies producing blood products. The company currently holding the contract with the Department will cease production of Factor VIII and begin offering only its genetic equivalent. It is anticipated that other producers of Factor VIII will follow suit. The genetic equivalent product, Monoclate, sells for 55 cents per unit.

The joint subcommittee believes it is in the public interest to control the costs of the hemophilia treatment program. Therefore, the joint subcommittee recommends that legislation be adopted to grant immunity to persons who, in accordance with law, manufacture, produce, distribute, sell, give or administer any blood product or genetic equivalent used in the treatment of hemophilia. The immunity and exceptions included in the proposed legislation are modeled after the vaccine related injury statute enacted in 1987 (§ 8.01-44.2). It is intended that the proposed legislation will improve the availability and reduce the costs of these products.

3. Insurance Reform

As noted above, the General Assembly adopted significant insurance regulatory reforms in 1987. These reforms became effective July 1. It is too early to meaningfully evaluate the effects of these reform.

However, the joint subcommittee believes that the favorable effects of the Neurologically Injured Infant Program should be immediately apparent. Considerable time was spent discussing the need to provide health care providers who participate in the fund with a credit against their malpractice premiums for the amounts paid into the fund. The joint subcommittee believes that the program will significantly reduce the liability exposure of companies insuring participating health care providers.

During the course of these discussions the joint subcommittee recommended that the Bureau of Insurance require malpractice insurers to file a rate differential for their insureds who participate in the program. The rate would be lower but not by an amount equal to payments made to the fund. Stephen Foster, Commissioner of Insurance, concurred in this recommendation. Because medical malpractice is a prior approval line, the Bureau has the inherent authority to require the differential filing. No statutory changes are necessary.

Throughout the year the joint subcommittee closely monitored the availability/affordability "crisis" affecting nurses and nurse practitioners. The Chicago Insurance Company had been writing most of the nurse practitioners coverage in Virginia. However, the Bureau of Insurance

has been involved in a dispute with the company regarding the authority of the company to increase its rates upon renewal of a policy. The Bureau has taken the position that Chicago is writing medical malpractice insurance for nurse practitioners. The malpractice line is subject to prior approval. Unless the company pre-files its rate, the Bureau argues that they are not eligible to write policies at the higher rate in Virginia.

The Chicago Insurance Co. claims that it is servicing a purchasing group located in Chicago and, therefore, is not doing business in Virginia. As a result the company takes the position that it is exempt from Virginia's forms and rate filing requirements. A federal district court in New York resolved a similar dispute in favor of the state. However, a recent report of the United States Commerce Department regarding the intent of the Federal Risk Protection Act supports the claimed exemption from the forms and rates requirements.

Nurse practitioners are thus caught in a catch-22 situation. One of the few companies providing coverage (Chicago) is doing so at a cost which in some cases exceeds the previous year's premium by 2,500%. A nurse practitioner who could afford to pay the increased cost, however, must face the fact the Bureau of Insurance does not recognize the company's authority to write the policy at that rate. Compounding the problem is the fact that the company will not renew existing policies effective May 1, 1988.

The joint subcommittee believes that the significant rate increases and the unavailability of coverage for nurse practitioners reflect the insurer's exposure concerns, based upon regional data. There are approximately 3,400 nurse practitioners in the country. The pool of potential insureds is so low that the companies rely on national data in their actuarial analysis. In many states, nurses are authorized to prescribe medication, a significant area of liability exposure. This is not the case in Virginia.

The joint subcommittee is concerned about the plight of these health care providers. It was suggested that the Bureau of Insurance explore the feasibility of expanding the joint underwriting association to cover nurses and nurse practitioners. It is recognized that such action addresses only the availability problem. The joint subcommittee recommends that the Bureau of Insurance continue to closely monitor this situation and take appropriate action to improve the availability and affordability of liability insurance coverage for nurse practitioners.

CONCLUSION

The joint subcommittee believes significant progress has been made in easing the liability insurance crisis and improving the civil justice system. The factors which contribute to such a crisis are diverse and the issues complex; solutions are not easily identified. The effects of actions taken by the General Assembly in 1987 and the recommendations contained in this report must continue to be evaluated. The Commonwealth must be prepared if we are to avert another, similar "crisis" in the future.

Respectfully submitted,

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

Footnotes

[1]Testimony of R. Edwin Burnett, Jr., Chairman of the Joint Committee of the Virginia State Bar and the Virginia Bar Association on Dispute Resolution, June 29, 1987.

[2]A.L.I. - A.B.A. Course of Study Materials, Alternative Dispute Resolution Techniques, 1987, pp. 35-53.

[3]Ibid, pp. 4-42.

[4]Ibid, p. 134.

[5]The Bureau of Insurance recommended a 15% increase. St. Paul's subsequently amended their rate filing to reflect this lower increase.

[6]Testimony of James C. Roberts, American Insurance Association, December 2, 1987.

[7]Testimony of Robert W. Mann, Virginia Trial Lawyers Association, December 2, 1987.

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* Mr. Morrison does not believe that the offer of settlement proposal would encourage early and equitable resolution of disputes.

** Mr. Forehand notes his disagreement with this statement. Mr. Forehand believes that a tightly drawn limitation on the qualifications of expert witnesses would further reduce the available persons who would be able to testify and might well act as an insurmountable bar to a plaintiff with limited funds who had a meritorious case.

Index to Appendices

APPENDIX A

SENATE JOINT RESOLUTION NO. 109

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

Agreed to by the Senate, February 4, 1987
Agreed to by the House of Delegates, February 25, 1987

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.

GENERAL ASSEMBLY OF VIRGINIA -- 1987 SESSION

HOUSE JOINT RESOLUTION NO. 221

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

Agreed to by the House of Delegates, February 8, 1987
Agreed to by the Senate, February 19, 1987

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 House of Delegates, the Senate 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.

D 12/11/87 Devine C 1/7/87 smw

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

A BILL to amend the Code of Virginia by adding in Title 8.01 a chapter numbered 21.2, consisting of sections numbered 8.01-581.21 through 8.01-581.23, relating to mediation; confidentiality; immunity.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 8.01 a chapter numbered 21.2, consisting of sections numbered 8.01-581.21 through 8.01-581.23, as follows:

CHAPTER 21.2.

MEDIATION.

§ 8.01-581.21. Definitions.--As used in this chapter:

"Mediation" means the process by which a mediator assists and facilitates two or more parties to a controversy in reaching a mutually acceptable resolution of the controversy and includes all contacts between the mediator and any party or parties, until such time as a resolution is agreed to by the parties or the parties discharge the mediator.

"Mediation program" means a program through which mediators or mediation is made available and includes the director, agents and employees of the program.

"Mediator" means an impartial third party selected by agreement of the parties to a controversy to assist them in mediation.

§ 8.01-581.22. Confidentialty; exceptions.--All memoranda, work

products and other materials contained in the case files of a mediator or mediation program are confidential. Any communication made in or in connection with the mediation which relates to the controversy being mediated, whether made to the mediator or a party, or to any other person if made at a mediation session, is confidential.

Confidential materials and communications are not subject to disclosure in any judicial or administrative proceeding except (i) where all parties to the mediation agree, in writing, to waive the confidentiality, (ii) a mediated agreement shall not be confidential as provided in this section, unless the parties otherwise agree in writing, (iii) in a subsequent action between the mediator and a party to the mediation for damages arising out of the mediation, or (iv) statements, memoranda, materials and other tangible evidence, otherwise subject to discovery which were not (i) prepared specifically for use in and (ii) actually used in the mediation.

§ 8.01-581.23. Civil immunity.--Mediators and mediation programs shall be immune from civil liability for, or resulting from, any act or omission done or made while engaged in efforts to assist or facilitate a mediation, unless the act or omission was made or done in bad faith, with malicious intent or in a manner exhibiting a willful, wanton disregard of the rights, safety or property of another.

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APPENDIX C

AN ACT TO ENCOURAGE EARLY AND REALISTIC SETTLEMENT BARGAINING IN CIVIL DAMAGE ACTIONS (TO REPLACE VA. CODE § 8.01-421B)

OFFER OF SETTLEMENT; COSTS

In any action at law for money damages between parties not under a disability, at any time more than 60 days after service of the notice of motion our judgment on a party but not less than 28 days (or 21 days if it is a counter-offer) before trial, either party may serve upon the other party, but shall not file with the court, a written offer, denominated as an offer under this Act, to settle a claim for the money amount specified in the offer and to agree to the final dismissal of the claim or to allow judgment to be entered accordingly. If, within 14 days after service of the offer, the adverse party serves written notice that the offer is accepted, either party may then move the court for entry of an appropriate order in accordance with the terms of the agreed settlement. An offer not accepted shall be deemed rejected and the evidence thereof is not admissible except in a proceeding to determine costs. If the judgment for the claimant is more favorable to the offeror of such offer than the offeree, the offeree must pay or forego, as the case may be, its costs incurred after the rejection of the offer. The fact that an offer is made but not accepted does not preclude a subsequent offer. When the liability of one party to another has been determined by a verdict or order or judgment, but the money amount remains to be determined by further proceedings, either party may make an offer of settlement which shall have the same effect as an offer made before trial if it is served within a reasonable time prior to the commencement of hearings to determine the money amount.

For the purposes of this Act only, "costs" shall be deemed to be (1) the costs of suit contemplated by VA CODE § 14.1-178; (2) expenses reasonably incurred by the offeror for depositions, travel, copying, expert witnesses and the court reporter; (3) prejudgment interest at the judgment rate on the amount of the offer from the date of its rejection; and (4) the costs of the civil jury.

COMMENTS

The premise of the draft Act is that the tort reparations system in Virginia would be improved if the parties are encouraged early in the litigation to come to a realistic settlement position. The essential scheme of the Act is modeled after Rule 68, Federal Rules of Civil Procedures, but it attempts to remedy a major deficiency of that Rule. The "offer of judgment" provided for in Rule 68 allows only the defendant to make an offer; sanctions for costs are imposed only on the plaintiff. The draft Act is mutual in that it permits either party to make a formal offer of settlement with consequential sanctions against the non-prevailing party. The draft Act also makes it clear that sanctions are triggered only when there is a judgment for the plaintiff, therefore making the Act useful only in those cases where there is a strong probability that the plaintiff will obtain a judgment but the amount of recovery is uncertain.

Application of the Act is limited to actions at law for money damages. Suits for equitable relief and law actions seeking non-monetary relief (e.g., detinue) are excluded since the primary purpose of the act is to make the tort reparations system work more efficiently and economically in Virginia and to avoid unnecessary and unwieldly complications. [Note: Federal Rule 68 does contemplate a broader application to all types of civil actions because of the combining the law and equity in the federal system.] An action involving a person under a disability is excluded because the court's supervision and approval required in such an action does not readily permit the imposition of sanctions.

An offer of settlement can be made by either party at any point in the litigation except that there is an initial waiting period of 60 days after service and a cutoff date for the offer four weeks before the trial to encourage the parties to consider settlement seriously at a reasonably early stage in the litigation, but after enough discovery has been had to appraise the strength and weaknesses of a claim or defense.

The written offer shall state the dollar amount which the defendant is willing to pay to have the action against him dismissed or the amount of the judgment and the terms thereof that he is willing to have entered against him. Conversely, plaintiff's offer (demand) will indicate the dollar amount the plaintiff is willing to accept for a dismissal of the action or as a judgment against the defendant. The offer must remain open for 14 days and cannot be withdrawn. An offer is deemed to be rejected if not accepted by its terms in writing served on the offeror within the 14 days. If accepted, either party may request the Court to enter judgment or dismiss the action in accordance with the terms of the accepted offer.

The rejection of the last offer made pursuant to the Act triggers the test for the application of sanctions for "costs" against the offense who fails to achieve a more favorable judgment award than that conveyed in the last offer. For example:

A. Plaintiff makes an offer of settlement for $50,000 which is rejected by the defendant. Judgment is entered on the jury's verdict for $75,000. Defendant must pay all "costs" as defined in the Act incurred from the date of the rejection which, in this example, will consist of (1) statutory costs to the plaintiff; (2) plaintiff's reasonable expenses for depositions, travel, copying and expert witnesses incurred from the date of the rejection and the fee for the court reporter at trial; (3) pre-judgment interest at 12% on $50,000 from the date of the rejection; (4) the cost of the jury as calculated by the clerk and paid, of course, to the court.

B. Plaintiff makes an offer of settlement for $50,000 which is rejected by the defendant. Judgment is entered on the jury's verdict for $40,000. The sanctions of the Act are not applicable and plaintiff gets his normal statutory costs, post-judgment interest under Va. Code § 8.01-382, and any pre-judgment interest allowed by the jury under the said section. (This example assumes that such pre-judgment interest does not make the total award more than $50,000; if it does, then the plaintiff would have prevailed as in example A above.)

C. Defendant makes an offer of settlement for $40,000 which is rejected by the plaintiff. Judgment is entered on the jury's verdict for $25,000. Plaintiff must pay (1) defendant's reasonable expenses for depositions, travel, copying and expert witnesses incurred from the date of the rejection and the fee of the court reporter at trial and (2) the cost of the jury. Plaintiff must also forego (1) his statutory costs and (2) any pre-judgment interest awarded by the jury for the period after the rejection (again assuming that pre-judgment interest does not make the total award more than $40,000).

D. Defendant makes an offer of settlement for $40,000 which is rejected, but judgment is entered on the jury's verdict for $50,000, costs and interest. The sanctions of the Act are not applicable.

E. Defendant makes an offer of settlement for $400 which is rejected by the plaintiff. Judgment is entered for the defendant. The sanctions of the Act are not applicable since there has been no judgment for the plaintiff. This approach is thought to be desirable for the policy reasons found in Delta Air Lines, Inc. v. August, 450 U.S. 346, 67 L. Ed. 2d 287, 101 S. Ct. 1146 (1981) where the Supreme Court so construed Rule 68. Otherwise, a defendant could frustrate the essential purposes of the Act by making a nominal (one cent?) offer in every case, with no possibility of its being accepted, purely for the tactical purpose of shifting costs should there be a defendant's verdict. A pragmatic justification for denying cost shifting on a defendant's verdict is that a judgment for substantial costs against the losing plaintiff would probably be uncollectible in a large majority of cases, whereas the award of costs can be offset against the judgment in favor of a "successful" but non-prevailing plaintiff as in Example C above.

Attorney's fees incurred by the prevailing offeror after the rejection of the offer have not been included in the award of costs[1] since (1) the defined "costs" are thought to be sufficient; (2) such would be contrary to the traditional "American rule" of attorney's fees; and (3) the court would be burdened with holding an extensive evidentiary hearing on virtually every fee award. However, where the award of attorney's fees is authorized by statute and is further defined as a statutory "cost of suit" (quite rare in Virginia but see, for example, Va. Code § 18.2-500), a rejected offer of settlement under the Act would terminate a non-prevailing plaintiff's right to such attorney's fees incurred after the rejection. See Marek v. Chesney, 473 U.S. __, 87 L.Ed.2d 1, 105 S. Ct. 3012 (1985).

The Act uses the term "claimant" rather than "plaintiff," since a claim subject to an offer of settlement could arise as a counterclaim, cross-claim, or as a third-party claim.

Successive offers of settlement are permitted under the Act as are "counter-offers" (which have the same effect as an offer under the Act) so long as they are made within the prescribed time limits.

The Act also permits an offer of settlement to be made in a bifurcated proceeding, after the liability of the defendant has been determined "by verdict or order or judgment," if it is made a reasonable time before the hearing to determine damages.

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[1]The proposed revision of Rule 68 by the Federal Commission on Rules of Practice and Procedures, 102 F.R.D. 407, 432 (1984), which did permit the shifting of attorney's fees, has been rejected by the Supreme Court and by the Congress (S. 2038, 99th Congress).

APPENDIX D

LAW OFFICES
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P. REID YOUNG, JR.
JAMES W. HASKINS
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* CERTIFIED SPECIALIST IN CIVIL TRIAL ADVOCACY BY THE NATIONAL BOARD OF TRIAL ADVOCACY

TELEPHONE
AREA CODE 703
638-2367

December 16, 1987

The Honorable William F. Parkerson, Jr.
State Senator
9816 St. Julians Lane
Richmond, VA 23233

Re: Offer of Judgment

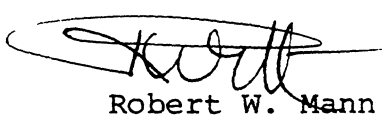
Dear Senator Parkerson:

When your committee discussed this matter on December 2, 1987, the Virginia Trial Lawyers Association had not taken a position. This was considered by our Board of Governors on Saturday, December 12, 1987.

We agree with the purpose of this legislation, that is, to encourage early settlements. However, we do not agree that this bill is an appropriate or necessary method of accomplishing this purpose. Alternatively, we would like to encourage judges to make more liberal use of existing Rule 4:13 pertaining to pretrial settlement conferences.

Unquestionably there are occasions when the legislation might be helpful to a plaintiff's case. The proposal is certainly more fair than its federal counterpart in that at least ostensibly plaintiffs and defendants are treated equally. The problem is, however, that in many instances the parties are inherently on unequal financial footing. The potential "cost" assessment in a particular case may well be inconsequential to a defendant or his insurance carrier. This very same "cost" may very well intimidate and force the less "well healed" plaintiff to accept an unfairly low first offer. In far too many instances we foresee a chilling effect on the right to trial by jury. In extreme situations the cost might exceed the jury verdict.

Very truly yours,



Robert W. Mann

RWM/tpb

cc: R. Gordon Smith

D 12/4/87 Devine T 12/4/87 jds

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

A BILL to amend the Code of Virginia by adding in Title 8.01 a chapter numbered 20.1, consisting of sections numbered 8.01-576.1 through 8.01-576.3, relating to procedures for summary jury trials in civil cases.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 8.01 a chapter numbered 20.1, consisting of sections numbered 8.01-576.1 through 8.01-576.3 as follows:

CHAPTER 20.1.

SUMMARY JURY TRIAL.

§ 8.01-576.1. Election by parties; order of court.--In any civil action pending before a circuit court, the parties may, by agreement in writing submitted to the court at any time prior to trial, elect to have a summary jury trial of the issues in the case in accordance with this chapter. However, where the court determines that the election is made for the purpose of delaying a trial on the merits, a summary jury trial shall not be had.

§ 8.01-576.2. Summary jury trial; selection of jury; fees.--Upon election of the parties, the court shall schedule a summary jury trial to be held within twenty-one days of such election or order. Notice shall be given to the parties by means adequate to ensure their presence at the time and place of the trial. Seven jurors shall be randomly selected in accordance with the procedures specified in

Chapter 11 (§ 8.01-336 et seq.) except that voir dire examination of and challenges to the jurors shall not be allowed. Fees shall be allowed to jurors selected for a summary jury trial as provided in § 14.1-195.1.

§ 8.01-576.3. Procedures; verdict not binding unless otherwise agreed.--A judge of the court having jurisdiction over the case shall preside over a summary jury trial. Counsel for the parties or, if a party is not represented by counsel, a party shall verbally present a summary of the issues in the case and the evidence on behalf of each party. Evidence for the plaintiff shall be presented first. Each party shall be given the opportunity to rebut the evidence of another party upon request. The testimony of witnesses and the submission of documentary evidence shall not be allowed.

Upon conclusion of the presentations of the summary evidence, the court shall instruct the jury on the law applicable to the cause. The jury shall advise the court of its verdict upon conclusion of the deliberations.

Unless otherwise agreed by the parties in writing submitted to the court prior to a jury being empanelled pursuant to this chapter, the verdict of a summary jury shall not be binding on either party and shall not be admissible on any subsequent trial of the case. If the parties have agreed to be bound by the verdict, judgment shall be entered by the court in accordance with the verdict.

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APPENDIX F

SUMMARY OF THE INDIANA MEDICAL MALPRACTICE ACT

A. Health Care Provider Definition (IC 16-9.5-1-1)

1. Amended in 1979 to include professional corporations and partnerships
2. Amended in 1985 to include community and migrant health centers
3. Amended in 1986 to include nurse midwives
4. Amended in 1987 to include health care facilities (nursing homes)

B. Implied or Expressed Contracts Prohibited as a Theory of Recovery unless in Writing (IC 16-9.5-1-4)

1. Creation of an "Informed Consent" rebuttable presumption, if in writing

C. Failure to Qualify (IC 16-9.5-1-5)

1. "Going Bare"
2. Failure to forward 125% surcharge

D. Filing Claims (IC 16-9.5-1-6)

1. Claims filed with the Department of Insurance, <u>not in court</u>
2. Prohibition of dollar demand

E. Qualification of HCP and Agents (IC 16-9.5-2-1)

1. Provide proof of financial responsibility (See G.)
2. Pay surcharge - currently 125%
3. Post cash or surety bond with Department of Insurance

F. Maximum Recovery (IC 16-9.5-2-2)

1. $500,000 limit for any injury or death
2. Qualified provider not liable in excess of $100,000
3. Excess will be paid by Patients Compensation Fund up to additional $400,000
4. Structured payments permitted

Prepared and submitted by Ronald L. Dyer, Counsel to
the Indiana State Medical Society, September 23, 1987.

G. Proof of Financial Responsibility (IC 16-9.5-2-6)

1. Proof of insurance - $100,000/$300,000
2. Hospital - 100 beds or less $2 million
   - 100 beds or more $3 million
3. Prepaid Health Care Delivery Plans - $700,000
4. Health care facility (nursing homes) - 100 beds or less $[illegible]0,000
   - more than 100 beds $500,000
5. Cash or surety bond
6. Each provider in a professional corporation must establish financial responsibility separate from the professional corporation.

H. Payment from Patients' Compensation Fund after Exhaustion of Insurance Coverage (IC 16-9.5-2-7)

1. Health care provider cannot object to settlement from Fund.
2. Insurance Commissioner and claimant may agree to a settlement.
3. If agreement can not be reached, the court will adjudicate settlement ~~and~~ no appeal will be permitted on settlement amount.

I. Statute of Limitations (IC 16-9.5-3-1)

1. Two years from the alleged date of negligence
2. Minor child under age of six shall have until his eighth birthday in which to file.

J. Patients' Compensation Fund (16-9.5-4-1)

1. Currently 125% surcharge on insurance premium
2. Premium due to Insurance Commissioner within 30 days of receipt (after 30 days: 10% penalty)
3. Proof of payment is established if surcharge is paid and policy filed within 90 days.
4. Top limit on fund is $30 million.

K. Attorney Fees

1. Plaintiff's attorney fees from the Fund are limited to 15 percent. No limit on attorney fees on first $100,000.

L. Reporting Claims Settled (16-9.5-6-1)

1. All malpractice claims settled must be reported within 60 days to Insurance Commissioner.
2. Insurer must report to Insurance Commissioner any case upon which it has placed a reserve of greater than $50,000.

M. Review of Provider Fitness (IC 16-9.5-6-2)

1. Insurance Commissioner must forward information to appropriate licensing board against whom adverse settlement is made.
2. Licensing Board shall report its findings to the Department of Insurance.

N. Medical Review Panel (IC 16-9.5-9-1)

1. Filing of complaint tolls Statute of Limitations until 90 days after receipt of panel decision.
2. Complaint is filed with Insurance Commissioner, and he notifies health care provider by registered mail within ten days.
3. Medical Review Panel may be formed within twenty days after filing of complaint.
4. No court action permitted until complaint is presented to Medical Review Panel, unless the claim is for less than $15,000.

O. Composition of Medical Review Panel (IC 16-9.5-9-3)

1. One attorney chairman, three health care providers (two of of whom must be from the same specialty as the defendant).
2. Must render written opinion within 180 days.
3. Compensation for Health Care Provider - not more than $250 plus travel; may charge extra if called as witness at trial. Compensation for Attorney Chairman - $200 per diem but not more than $1,000 plus travel (IC 16-9.5-9-10).
4. Medical Review Panel fees paid by winning side.

APPENDIX F

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA 46885

Professional Protection Exclusively since 1899

INDIANA RATE PROGRESSION

Class 1 - Non-Surgeon

	100,000/300,000 limits	no Fund available
1/1/70	109	
1/1/71	126	
1/1/72	126	
1/1/73	158	
1/1/74	237	
1/1/75	457	

	w/o Fund Surcharge	with Fund Surcharge
1/1/76	508	559
1/1/77	593*	652
1/1/78	593	652
1/1/79	672*	739
1/1/80	659	725
1/1/81	659	725
1/1/82	659	725
1/1/83	659	824
1/1/84	659	824
1/1/85	659	989
1/1/86	739	1293
1/1/87	823	1646

*Excess factor only increased

APPENDIX F

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46835

Professional Protection Exclusively since 1899

INDIANA RATE PROGRESSION

GP - Doing Surgery Class 3

	100,000/300,000 limits	no Fund available
1/1/70	316	
1/1/71	461	
1/1/72	461	
1/1/73	578	
1/1/74	685	
1/1/75	1236	

	w/o Fund Surcharge	with Fund Surcharge
1/1/76	2417	2659
1/1/77	2814*	3095
1/1/78	2814	3095
1/1/79	3387*	3726
1/1/80	1927	2120
1/1/81	1927	2120
1/1/82	1927	2120
1/1/83	1927	2409
1/1/84	1927	2409
1/1/85	1927	2891
1/1/86	1848	3234
1/1/87	2058	4116

*Excess factor only increased

APPENDIX F

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46885

Professional Protection Exclusively since 1899

INDIANA RATE PROGRESSION

Class 8 - Neurosurgeon and Ob-Gyn.

	100,000/300,000 limits	no Fund available
1/1/70	746	
1/1/71	1089	
1/1/72	1089	
1/1/73	1361	
1/1/74	1613	
1/1/75	2903	

	w/o Fund Surcharge	with Fund Surcharge
1/1/76	3289	3618
1/1/77	3830*	4213
1/1/78	3830	4213
1/1/79	4609*	5070
1/1/80	5271	5798
1/1/81	5271	5798
1/1/82	5271	5798
1/1/83	5271	6589
1/1/84	5271	6589
1/1/85	5271	7907
1/1/86	6503	11381
1/1/87	6996	13992

*Excess factor only increased

APPENDIX F

Michigan - Indiana

*100,000/300,000 Limits

Class I - No Surgery

	1970	1976	1970-1976 Avg Inc Per Yr	1987	1976-1987 Avg Inc Per Yr
Detroit	153	1185	(68%)	7953	(52%)
Kalamazoo	153	746	(65%)	4881	(50%)
Ft. Wayne	109	508	(61%)	823	(6%)

Class III - G.P. Surgery

	1970	1976	1970-1976 Avg Inc Per Yr	1987	1976-1987 Avg Inc Per Yr
Detroit	710	3338	(62%)	19883	(45%)
Kalamazoo	536	2204	(52%)	12203	(41%)
Ft. Wayne	316	1401	(57%)	2058	(4%)

Class V - General Surgery

	1970	1976	1970-1976 Avg Inc Per Yr	1987	1976-1987 Avg Inc Per Yr
Detroit	1114	5249	(62%)	46127	(71%)
Kalamazoo	834	3432	(54%)	28310	(66%)
Ft. Wayne	546	2417	(57%)	4773	(9%)

Class VIII - Neurosurgery

	1970	1976	1970-1976 Avg Inc Per Yr	1987	1976-1987 Avg Inc Per Yr
Detroit	1668	7863	(62%)	71577	(74%)
Kalamazoo	1114	4584	(52%)	43929	(78%)
Ft. Wayne	746	3289	(57%)	6996	(10%)

APPENDIX F

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46885
Professional Protection Exclusively since 1899

RATE COMPARISON
$100,000/$300,000 LIMITS
AS OF 1/1/87

NO SURGERY	
Detroit	$7,953
Chicago	4,909
Kalamazoo	4,881
Peoria	3220
Cleveland	1,838
Defiance, O.	1,478
Louisville	1,238
Fort Wayne	823

GP - Surgery	
Detroit	$19,883
Kalamazoo	12,203
Chicago	11,782
Peoria	7728
Cleveland	4,595
Defiance, O.	3,695
Louisville	3,095
Fort Wayne	2,058

GENERAL SURGERY	
Detroit	$46,127
Kalamazoo	28,310
Chicago	24,545
Peoria	16,100
Cleveland	10,660
Defiance, O.	8,572
Louisville	7,180
Fort Wayne	4,773

OB-GYN	
Detroit	$71,577
Chicago	44,181
Kalamazoo	43,929
Peoria	28,980
Cleveland	15,623
Defiance, O.	12,563
Louisville	11,142
Fort Wayne	6,996

Summary

Patients' Compensation Fund (LD# 0549127) (based on Indiana Statutes, Chapter 1 of Article 9.5)

Creates a Patients' Compensation Fund to be administered by the Commissioner of Insurance. Requires participating health care providers to maintain minimum insurance ($250,000/occurrence and $500,000/annual aggregate for individuals; $2 million for hospitals with fewer than 101 beds or $3 million for hospitals with 101 beds or more; $700,000/annual aggregate for prepaid health services plans) or by filing other proof of financial responsibility approved by the Commissioner (§ 8.01-581.27). Provides that all payments due under a malpractice settlement or judgment in excess of the participating health care provider's annual aggregate, up to the maximum $1 million or $750,000 cap, are payable from the fund. The fund is created by payment of an annual surcharge equal to a percentage of the cost to the health care provider of maintaining minimum proof of financial responsibility (§ 8.01-581.24). The draft contemplates a fund of approximately $15 million and authorizes the Commissioner to adjust the surcharge as necessary to maintain the stability of the fund or reduce a surplus (§ 8.01-581.24).

Prescribes procedures for claimant to file a petition with the circuit court for approval of settlements in excess of the policy limits or annual aggregate (§§ 8.01-581.27 and 8.01-581.28). Provides that court-approved settlements cannot be appealed. Authorizes payments from the fund in a lump sum, periodic payments and/or purchase of an annuity. Limits payment of attorneys contingent fee as to amounts payable from fund to 15%.

Voluntary panel process and cap on recovery are retained.

D 11/24/86 Devine T 11/24/86 smw

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

A BILL to amend the Code of Virginia by adding in Chapter 21.1 of Title 8.01 an article numbered 3, consisting of sections numbered 8.01-581.21 through 8.01-581.34, relating to creation of a patients' compensation fund.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 21.1 of Title 8.01 an article numbered 3, consisting of sections numbered 8.01-581.21 through 8.01-581.34, as follows:

Article 3.

Patients' Compensation Fund.

§ 8.01-581.21. Definitions.--As used in this article:

"Annual aggregate" means the limitation on a health care providers liability as provided in § 8.01-581.26.

"Commissioner" means the Commissioner of Insurance as defined in § 38.2-100.

"Cost of the periodic payments agreement" means the amount expended by the health care provider or its insurer, the Commissioner, or the Commissioner and the health care provider or its insurer, at the time the periodic payments agreement is made, to obtain the commitment from a third party to make available money for use as future payment, the total of which may exceed the limits provided in § 8.01-581.26.

"Periodic payments agreement" means a contract between a health care provider or its insurer and the patient or the patient's estate, whereby the health care provider is relieved from possible liability in consideration of (i) a present payment of money to the patient or the patient's estate and (ii) one or more payments to the patient or the patient's estate in the future, whether or not some or all of the payments are contingent upon the patient's survival to the proposed date of payment.

"Representative" means the spouse, parent, guardian, trustee, attorney, or other legal agent of the patient.

"Tort" means any legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury or damage to another.

§ 8.01-581.22. Limitation on claim for damages.--Subject to the provisions of Article 1 of this chapter, a patient or his representative having a claim under this article for bodily injury or death on account of malpractice may file a complaint in any court of law having requisite jurisdiction and demand right of trial by jury.

§ 8.01-581.23. Attorney's fees.--When the plaintiff is represented by an attorney in the prosecution of a claim cognizable under this chapter, the plaintiff's attorney's fees from any award made from the patient's compensation fund pursuant to this article shall not exceed fifteen percent of any recovery from the fund.

A patient has the right to elect to pay for the attorney's services on a mutually satisfactory per diem

basis. However, the election must be exercised in written form at the time of employment.

§ 8.01-581.24. Creation of fund; purpose; annual surcharge; effects of failure to pay; rules; time for payment of claims.--There is created a patients' compensation fund to be collected and received by the Commissioner to be used exclusively for the purposes stated in this article. The fund and any income from it shall be held in trust, deposited in a segregated account, invested, and reinvested by the Commissioner and shall not become a part of the general fund.

To create the fund, an annual surcharge shall be levied on all health care providers. The surcharge shall be determined by the Commissioner based upon actuarial principles.

The annual surcharge shall not exceed seventy-five percent of the cost to each health care provider for maintenance of financial responsibility. However, at any time when the balance in the fund is less than fifteen million dollars, the surcharge may be increased, by a rule adopted by the Commissioner, to a percentage less than or equal to 100 percent of the cost to each health care provider for maintenance of financial responsibility. In no event shall the surcharge levied be less than five dollars.

The surcharge shall be collected on the same basis as premiums by each insurer, the risk manager, or the surplus lines agents and shall be due and payable within thirty days after the premium for malpractice liability insurance has

been received by the insurer, risk manager, or surplus lines agent from the health care provider. If the surcharge is not paid as provided under this subsection, then the insurer, risk manager or surplus lines agent responsible for the delinquency shall be liable for the surcharge plus a ten percent penalty.

Receipt of proof of financial responsibility and the surcharge constitutes qualification and compliance with § 8.01-581.25 as of the date of receipt thereof, or as of the effective date of the policy, provided this proof is filed with and the surcharge paid to the Commissioner not later than ninety days after the effective date of the insurance policy. If proof of financial responsibility and the payment of the surcharge is not made within ninety days after the policy effective date, compliance occurs on the date when proof is filed and the surcharge is paid.

The Commissioner shall promulgate rules providing for the manner in which the surcharge for health care providers establishing financial responsibility other than by a policy of malpractice liability insurance shall be determined and the manner of payment. In no event shall this surcharge exceed the surcharge that would be charged by the joint underwriting authority if the health care provider electing to establish financial responsibility in this manner had applied to the authority for insurance pursuant to Chapter 28 of Title 38.2 (§ 38.2-2800 et seq.).

If the annual premium surcharge is not paid within the above time limits, the certificate of authority of the

insurer, risk manager, and surplus lines agents shall be suspended until the annual premium surcharge is paid.

The Commissioner, using money from the fund, may purchase the services of persons, firms, and corporations to aid in protecting the fund against claims. All expenses of collecting, protecting, and administering the fund shall be paid from the fund. Technical contractual personnel and services retained by the Commissioner for protecting and administering the fund and the purchase of annuities for structuring settlements from the fund or in combination with the fund and a health care provider's insurer are exempt from the Virginia Public Procurement Act (§ 11-35 et seq.).

If the fund exceeds the sum of fifteen million dollars at the end of any calendar year after the payment of all claims and expenses, the Commissioner shall reduce the surcharge provided in this section in order to maintain the fund at an approximate level of fifteen million dollars.

Claims for payment from the patients' compensation fund that become final during the first six months of the calendar year must be computed on June 30 and must be paid no later than the following July 15. Claims for payment from the fund that become final during the last six months of the calendar year must be computed on December 31 and must be paid no later than the following January 15. If the balance in the fund is insufficient to pay in full all claims that have become final during a six-month period, the amount paid to each claimant must be prorated. Any amount left unpaid as a result of the proration must be paid before

the payment of claims that become final during the following six-month period.

§ 8.01-581.25. Qualification of health care provider or insurer; effect of failure to qualify.--To be qualified under the provisions of this article, a health care provider or his insurance carrier shall (i) file with the Commissioner proof of financial responsibility as provided by § 8.01-581.27 and (ii) pay the surcharge assessed pursuant to § 8.01-581.24.

The officers, agents or employees of a health care provider, while acting in the course and scope of their employment, are qualified under the provision of this article if they are individually named, or are members of a named class, in the proof of financial responsibility filed by the health care provider and if the surcharge assessed is paid.

A health care provider who fails to qualify under this article is not covered by the provisions of this article and is subject to liability under the law without regard to the provisions of this article. If a health care provider does not so qualify, the patient's remedy will not be affected by the terms and provisions of this article.

§ 8.01-581.26. Maximum recovery.--A. The total amount recoverable for any injury or death of a patient shall not exceed the amounts specified in § 8.01-38 or § 8.01-581.15, whichever is applicable.

B. A health care provider qualified under this article shall not be liable for damages in excess of $250,000 for an

occurrence of malpractice.

C. Any amount due from a judgment or settlement which is in excess of the total liability of all liable health care providers shall be paid from the patients' compensation fund pursuant to the provisions of § 8.01-581.23.

D. In the event a health care provider qualified under this article admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who is an officer, agent or employee of the health care provider acting in the course and scope of his employment and qualified under this chapter, the total amount which shall be paid to the claimant on behalf of the officer, agent or employee and the health care provider by such health care provider or its insurer shall be $250,000 and any balance of an adjudicated sum to which the claimant is entitled shall be paid by other liable health care providers, the patients' compensation fund or both.

§ 8.01-581.27. Proof of financial responsibility.--A. Financial responsibility of a health care provider and its officers, agents, and employees while acting in the course and scope of their employment with such health care provider under this chapter may be established:

1. By the health care provider's insurance carrier filing with the Commissioner proof that the health care provider is insured by a policy of malpractice liability insurance for at least $250,000 per occurrence and $500,000 in the annual aggregate, except that:

a. If the health care provider is a hospital, as

defined in this article, the minimum annual aggregate insurance amount is:

(i) For hospitals of 100 beds or fewer, two million dollars; or

(ii) For hospitals of more than 100 beds, three million dollars; and

b. If the health care provider is a prepaid health services delivery plan as that term is defined in § 38.2-4201, the minimum annual aggregate insurance amount is $700,000;

2. By filing and maintaining with the Commissioner cash or surety bond approved by the Commissioner in the amounts set forth in subsection 1; or

3. If the health care provider is a hospital, by submitting annually a verified financial statement which, in the discretion of the Commissioner, adequately demonstrates that the current and future financial responsibility of the health care provider is sufficient to satisfy all potential malpractice claims incurred by it or its officers, agents, and employees while acting in the course and scope of their employment up to a total of $250,000 per occurrence and annual aggregates as follows:

a. For hospitals of 100 beds or fewer, two million dollars; and

b. For hospitals of more than 100 beds, three million dollars.

The filing of proof of financial responsibility with the Commissioner shall constitute a conclusive and

unqualified acceptance of the provisions of this article on the part of the insurer.

The Commissioner may require the deposit of security to assure continued financial responsibility.

B. Security provided pursuant to subsection A2 may be held in any manner mutually agreeable to the Commissioner and the health care provider. The agreement shall provide that the principal may not be withdrawn prior to receiving the written permission of the Commissioner. However, any interest may be withdrawn at any time by the health care provider.

In order to establish financial responsibility under this section, each individual who is a member of a partnership or professional corporation shall establish financial responsibility separate from that partnership or professional corporation, as well as pay the surcharge required under § 8.01-581.24. However, this provision shall not be construed to require any health care provider to "qualify" under this article.

§ 8.01-581.27. Payment from patient's compensation fund after exhaustion of insurance coverage; limitation on appeals.--If the annual aggregate for a health care provider qualified under this article has been paid by or on behalf of the health care provider, all sums which may thereafter become due and payable to a claimant arising out of an act of malpractice by the health care provider occurring during the year in which the annual aggragate was exhausted shall be paid from the patients' compensation fund.

The health care provider whose annual aggregate has been exhausted shall have no right to object to or refuse permission to settle any such claim. If the health care provider or the Commissioner and claimant agree on a settlement, a petition shall be filed by the claimant with the court in which the action is pending against the health care provider or, if no action is pending, in the circuit court which would have jurisdiction of the claim, seeking approval of the agreed settlement. A copy of the petition shall be served on the Commissioner and the health care provider at least ten days before filing and shall contain sufficient information to inform the other parties about the nature of the claim and the amount of the proposed settlement. The Commissioner may agree to the settlement, or the Commissioner may file written objections thereto. The agreement or objections shall be filed within twenty days after the petition is filed. The court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider and the Commissioner.

At the hearing the Commissioner, the claimant and the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the Commissioner and the claimant cannot agree on the amount, if any, to be paid out of the patients' compensation fund, then the court shall determine the amount

for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patients' compensation fund, the court shall consider the liability of the health care provider as admitted and established.

Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil case.

The Commissioner may promulgate rules and regulations implementing the provisions of this section.

§ 8.01-581.28. Claims in excess of policy limits; procedure; appeals.--If a health care provider or its insurer has agreed to settle its liability on a claim by payment of its policy limits of $250,000 and the claimant is demanding an amount in excess thereof, a petition shall be filed by the claimant in the circuit court seeking (i) approval of an agreed settlement, if any, or (ii) demanding payment of damages from the patients' compensation fund. A copy of the petition with summons shall be served on the Commissioner, the health care provider and his insurer, and shall contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded. The Commissioner and either the health care provider or the insurer of the health care provider may agree to a settlement with the claimant from the patients'

compensation fund, or the Commissioner, the health care provider or the insurer of the health care provider may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty-one days after service of the summons and petition.

The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, the insurer of the health care provider and the Commissioner. At the hearing the Commissioner, the claimant, the health care provider, and the insurer of the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the Commissioner, the health care provider, the insurer of the health care provider, and the claimant cannot agree on the amount, if any, to be paid out of the patients' compensation fund, then the court, after hearing any relevant evidence on the issue of the claimant's damages submitted by any of the parties shall determine the amount of the claimant's damages, if any, in excess of the $250,000 already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patients' compensation fund, the court

shall consider the liability of the health care provider as submitted and established.

Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to rules governing appeals in other civil cases.

A release executed between the parties shall not bar access to the patients' compensation fund unless the release specifically provides otherwise.

§ 8.01-581.29. Failure of health care provider to pay or comply; payment from fund; revocation of policy.--If a health care provider, his surety or liability insurance carrier fails to pay any agreed settlement or final judgment within ninety days, the same shall be paid from the patients' compensation fund. The fund shall be subrogated to any and all of the claimant's rights against the health care provider, his surety or his liability insurance carrier, with interest, reasonable costs and attorney's fees.

Additionally, if an insurer fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails or refuses to comply with any provisions of this article, the Commissioner may revoke the approval of its policy form until the insurer pays the award or judgment or has complied with the violated provisions of this article and has resubmitted its policy form and received the approval of the Commissioner.

§ 8.01-581.30. Payment of claims against fund; procedure.--The State Comptroller shall issue a warrant in the amount of each claim submitted to him against the fund on June 30 and December 31 of each year. The only claim against the fund shall be a voucher or other appropriate request by the Commissioner after he receives a certified copy of a final judgment against a health care provider, or a certified copy of a court-approved settlement against a health care provider.

The obligation to pay an amount from the patient's compensation fund under §§ 8.01-581.26, 8.01-581.27 or 8.01-581.28 may be discharged through (i) payment in one lump sum; (ii) an agreement requiring payments from the fund over a period of years, (iii) the purchase of an annuity payable to the patient, or (iv) any combination of (i) through (iv), above.

The Commissioner may contract with approved insurers to insure the ability of the fund to make periodic payments under (ii), above.

§ 8.01-581.31. Periodic payments by health care provider.--In a case in which the possible liability of the health care provider to the patient is discharged solely through an immediate payment, the limitations on recovery from a health care provider stated in § 8.01-581.26 B or D apply without adjustment.

In a case in which the health care provider agrees to discharge its possible liability to the patient through a periodic payments agreement, the amount of the patient's

recovery from a health care provider is the amount of any immediate payment made by the health care provider or the health care provider's insurer to the patient, plus the cost of the periodic payments agreement to the health care provider or the health care provider's insurer.

For the purpose of determining the limitations on recovery stated in subsections B and D of § 8.01-581.26 and for the purpose of determining whether the health care provider or the health care provider's insurer has agreed to settle its liability by payment of its policy limits pursuant to § 8.01-581.28, the sum of the present payment of money to the patient or the patient's estate by the health care provider or the health care provider's insurer plus the cost of the periodic payments agreement expended by the health care provider or the health care provider's insurer must exceed $75,000.

More than one health care provider may contribute to the cost of a periodic payments agreement. In such instance the sum of the amounts expended by each health care provider for immediate payments and for the cost of the periodic payments agreement shall be used to determine whether or not the $75,000 requirement has been satisfied. However, one health care provider or its insurer must be liable for at least $50,000.

§ 8.01-581.32. Periodic payments from fund.--In a case in which the possible liability of the fund to the patient is discharged solely through a direct payment made under § 8.01-581.28, the limitations on recovery from the patient's

compensation fund established under § 8.01-581.26 apply without adjustment.

In a case in which an agreement is made to discharge the fund's possible liability to the patient through a periodic payments agreement, for the purposes of the limitations on recovery from the fund established under § 8.01-581.26, the amount of the patient's recovery from the fund is (i) the amount of any immediate payment made directly to the patient from the fund, plus (ii) the cost of the periodic payments agreement paid by the Insurance Commissioner on behalf of the fund.

§ 8.01-581.33. Discharge of fund's liability through periodic payments agreement; paying cost of agreement.--Notwithstanding §§ 8.01-581.24 and 8.01-581.30, the Commissioner may:

1. Discharge the possible liability of the patients' compensation fund to a patient through a periodic payments agreement; and

2. Combine money from the fund with money of the health care provider or its insurer to pay the cost of the periodic payments agreement with the patient or the patient's estate. In no event shall the amount provided by the Commissioner exceed eighty percent of the total amount expended for such agreement.

§ 8.01-581.34. Prospective application.--The provisions of this article apply to any act of malpractice occurring on or after July 1, 1988.

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Summary

Medical Malpractice Claim Compensation Act (LD# 5198127) (based on Virginia Workers Compensation Statutes)

Creates a system for determination of medical malpractice claims against participating health care providers by the Industrial Commission; civil action against a participating provider is barred. The Commission's determination is limited to (i) finding whether injury or death resulted from medical treatment and (ii) awarding compensation for damages incurred or to be incurred, including attorneys fees, without regard to fault. Awards are subject to a $1 million cap and cannot include punitive damages.

Fund is created by initial assessments of $5,000 per individual and $25,000-$100,000 per corporation, facility or institution based upon a formula established by the Commission. Annual assessments to be determined by the Commission based on loss experience by specialty or area of practice.

LD5198127 JS

D 09/16/86 Devine C 09/29/86 owj

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

A BILL to amend the Code of Virginia by adding in Title 65.1 a chapter numbered 14, consisting of sections numbered 65.1-164 through 65.1-179, relating to the Medical Malpractice Claim Compensation Act.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 65.1 a chapter numbered 14, consisting of sections numbered 65.1-164 through 65.1-179 as follows:

CHAPTER 14.

MEDICAL MALPRACTICE CLAIM COMPENSATION ACT.

§ 65.1-164. Creation of Fund.--There is hereby created the Medical Malpractice Claim Compensation Fund ("the Fund"). On or before January 1, 1989, every health care provider, as defined in § 8.01-581.1 (1), desiring to participate in the program established under this chapter shall pay into the Fund an initial assessment $5,000, if an individual, or an amount not less than $25,000 nor more than $100,000 as specified by the Industrial Commission, if a corporation, facility or institution. The Commission shall establish a formula for determining the initial assessment for such corporations, facilities or institutions based upon the number of beds or individuals served, or utilizing such other factors as may be relevant, subject to the minimum and maximum amounts specified in this section. Annual

assessments to cover the continuing cost of the program shall be made of all health care providers participating in the program by the Commission based upon the loss experience of the program by specialty or area of practice. The assessed amounts shall be payable on or before June 30 of each year.

The Fund shall be administered, maintained and disbursed by the Industrial Commission. The amounts due shall be paid into the state treasury to the credit of the Medical Malpractice Claim Compensation Fund and shall be disbursed solely for the payment of awards as provided in this chapter.

§ 65.1-165. Definitions--As used in this chapter, "injury resulting from medical treatment" means any injury or death proximately resulting from (i) medical care or treatment received, provided the injury is not a usual or common risk associated with the particular type of care or treatment received from the health care provider who advised the patient of the risk or (ii) the failure to provide medically indicated care or treatment.

§ 65.1-166. Application of program.--All claims against a health care provider who has paid into the fund for injury resulting from medical treatment based upon acts or omissions occurring on or after January 1, 1988, shall be determined by the Industrial Commission in accordance with this chapter. The provisions of Chapter 2 of this title shall apply, mutatis mutandis, and use of the term "employer" in that chapter shall be deemed to refer to a

participating health care provider for purposes of this chapter. A claim against a health care provider electing not to participate in the program shall be subject to the provisions of Chapter 21.1 (§ 8.01-581.1 et seq.) of Title 8.01.

§ 65.1-167. Agreement as to compensation.--If, after injury or death resulting from medical treatment, the health care provider and the injured person or his dependents reach an agreement in regard to compensation or in compromise of a claim for compensation under this Act, a memorandum of the agreement in the form prescribed by the Industrial Commission shall be filed with the Commission for approval. If approved, the agreement shall be binding, and an award of compensation entered upon such agreement shall be for all purposes enforceable by the court's decree as elsewhere provided in this Act. If not approved, the agreement shall be void. The agreement may be approved only when the Commission, or any member thereof, is clearly of the opinion that the best interests of the injured person or his dependents will be served thereby. Approval of such agreement shall bind infant or incompetent dependents affected thereby. Any agreement entered into during the pendency of an appeal to the Court of Appeals shall be effective only with the approval of the Commission as herein provided.

§ 65.1-167. Disagreement on compensation.--If the health care provider and the injured person or his dependents fail to reach an agreement in regard to

compensation under this Act, or if they have reached such an agreement which has been signed and filed with the Commission and compensation has been paid or is due in accordance therewith and the parties thereto then disagree as to the continuance of any payment under such agreement, either party may apply to the Industrial Commission for a hearing in regard to the matters at issue and for a ruling thereon as provided in § 65.1-168.

Immediately after such application has been received, the Commission shall set the date for a hearing, which shall be held as soon as practicable, and shall notify the parties at issue of the time and place of such hearing. The hearing shall be held in the city or county where the injury occurred, or in a contiguous city or county, unless otherwise agreed to by the parties and authorized by the Industrial Commission.

§ 65.1-168. Filing of claims.--No civil action for compensation for an injury resulting from medical treatment may be filed against any health care provider who has paid into the Fund. All such claims for compensation shall be filed with the Industrial Commission within two years of the date of the injury. The provisions of §§ 8.01-229 and 8.01-243 C shall apply to extend the two-year period.

The claimant or the person in whose behalf the claim is made shall file with the Commission a verified petition in duplicate, setting forth the following information:

1. The name and address of the claimant;

2. The name and address of each respondent;

3. The amount of compensation in money and services sought to be recovered;

4. The time and place where the injury occurred;

5. A brief statement of the facts and circumstances surrounding the injury and giving rise to the claim.

Immediately upon receipt of the claim, the Commission shall serve a copy of the verified petition on each respondent by registered or certified mail. The Commission shall also send a copy of the vertified petition to the appropriate licensing authority for each respondent named.

§ 65.1-169. Interrogatories and depositions.--Any party to a proceeding under this Act may, upon application to the Commission setting forth the materiality of the evidence to be given, serve interrogatories or cause the depositions of witnesses residing within or without the Commonwealth to be taken, the costs to be taxed as other costs by the Commission. Such depositions shall be taken after giving the notice and in the manner prescribed by law for depositions in actions at law, except that they shall be directed to the Commission, the Commissioner or the deputy commissioner before whom the proceedings may be pending.

§ 65.1-170. Determination of claims.--The Commission shall determine, on the basis of the evidence presented to it, (i) whether any injuries alleged in the claim resulted from medical treatment provided by a respondent health care provider and (ii) how much compensation, if any, is awardable pursuant to § 65.1-171.

If the Commission determines that the injuries alleged

in the claim did not result from medical treatment, it shall render a decision denying any compensation. If the Commission decides that any of the injuries resulted from medical treatment, it shall make an award without regard to any fault on the part of a respondent health care provider pursuant to guidelines it establishes specifically adopted to relate to injuries resulting from medical treatment.

§ 65.1-171. Commission award for injuries resulting from medical treatment.--Upon determining that a claimant has sustained an injury as provided in § 65.1-167, the Commission shall make an award providing compensation or services for any or all economic or noneconomic damages incurred or to be incurred as a result of the injury, including reasonable attorneys fees. The total amount awarded for any such injury shall not exceed $1 million. Additionally, no award shall be made for punitive damages.

The award may be payable in a lump sum or periodic payments, or both, as the Commission determines.

A copy of the award shall be sent immediately to the parties.

§ 65.1-172. Rehearing on award.--If an application for review is made to the Commission within twenty days from the date of the award, the full Commission, if the first hearing was not held before the full Commission, shall review the evidence or, if deemed advisable, as soon as practicable, hear the parties at issue, their representatives and witnesses and shall make an award which, together with a statement of the findings of fact, rulings of law and other

matters pertinent to the questions at issue, shall be filed with the record of the proceedings. A copy of the award shall be immediately sent to the parties at issue.

Any member of the Commission who hears the parties at issue and makes an award under the provisions of § 65.1-170 shall not participate in a rehearing and review of such award under this section. When a member is absent or is prohibited by the provisions of this section from sitting with the full Commission to hear a review, the Chairman shall appoint one of the deputies to sit with the other Commission members.

§ 65.1-173. Conclusiveness of award; appeal.--The award of the Commission, if not reviewed in due time, or an award of the Commission upon such review, as provided in § 65.1-172, shall be conclusive and binding as to all questions of fact. No appeal shall be taken from the decision of one Commissioner until a review of the case has been had before the full Commission, as provided in § 65.1-172, and an award entered by it. Appeals shall lie from such award to the Court of Appeals in the manner provided in the Rules of the Supreme Court.

The notice of appeal shall be filed with the clerk of the Industrial Commission within thirty days from the date of such award or within thirty days after receipt of notice to be sent by registered or certified mail of such award. A copy of the notice of appeal shall be filed in the office of the clerk of the Court of Appeals as provided in the Rules of Court.

Cases so appealed shall be placed upon the privileged docket of the Court and be heard at the next ensuing term thereof. In case of an appeal from the decision of the Commission to the Court of Appeals, the appeal shall operate as a suspension of the award and no health care provider shall be required to make payment of the award involved in the appeal until the questions at issue therein have been fully determined in accordance with the provisions of this Act.

§ 65.1-174. Interest on appealed award.--All awards entered by the Commission shall take effect as of the date thereof. To the extent that payments due thereunder are delayed beyond their due dates by reason of an appeal to the full Commission or to the Court of Appeals, then such payments so delayed shall bear interest at the rate of ten percent annually.

§ 65.1-175. Review of award on change in condition.--Upon its own motion or upon the application of any party in interest, on the ground of a change in condition, the Industrial Commission may review any award and on such review may make an award ending, diminishing or increasing the compensation previously awarded, subject to the maximum amount provided in this Act. The Commission shall immediately send to the parties a copy of the award. No such review shall be made after twenty-four months from the last day for which compensation was paid, pursuant to an award under this Act.

§ 65.1-176. Fees of attorneys and physicians and

hospital charges.--Fees of attorneys and physicians and charges of hospitals for services, whether employed by a respondent health care provider, the injured person or an insurance carrier under this Act, shall be subject to the approval and award of the Commission. If a contested claim is held to be compensable under this Act and, after a hearing on the claim on its merits, benefits for medical services are awarded and inure to the benefit of a third party insurance carrier or health care provider, the Commission shall award to the injured person's attorney a reasonable fee and other reasonable pro rata costs as are appropriate from the sum which benefits the third party insurance carrier or health care provider.

§ 65.1-177. Enforcement, etc., of orders and awards.--Orders or awards of the Commission may be recorded, enforced, and satisfied as orders or decrees of a circuit court upon certification of such order or award by the Commission. The Commission shall certify such order or award upon satisfactory evidence of noncompliance with the same.

§ 65.1-178. Costs.--If the Industrial Commission or any court before whom any proceedings are brought or defended under this Act determines that such proceedings have been brought or defended without reasonable grounds, it may assess against the claimant or health care provider who has so brought or defended them the whole cost of the proceedings, including a reasonable attorney fee, to be fixed by the Commission.

§ 65.1-179. Report to state licensing board.--If the

Commission determines, based upon the evidence before it that there is reasonable cause to believe that the claimant's injuries were the result of medical malpractice, as defined in § 8.01-581.1, the Commission shall report that fact and the evidence supporting the belief to the appropriate licensing authority for the health care provider involved. It shall be the duty of the medical licensing board to conduct a prompt and thorough review of the matter and to report its finding to the health care provider, the claimant and the Commission.

A determination of fault made pursuant to this section shall in no way be considered in determining whether to enter an award or the amount of any award pursuant to this Act.

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APPENDIX H

McGUIREWOODS
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November 19, 1987

Hon. Wiley F. Mitchell, Jr.
511 Canterbury Lane
Alexandria, VA 22314

Re: Boyd-Graves Conference

Dear Wiley:

The language on the nonsuit as to which we agreed at the Conference on Saturday comes from something that was originally agreed to in 1982. The vote in favor of it last Saturday was 36-7.

The language is as follows:

> The court has the discretion to assess reasonable and actual expenses not including attorney's fees occasioned by a nonsuit not made more than seven days prior to trial if the court finds the exercise of the right to nonsuit has been abused.

Because we are talking about the right to nonsuit which only exists in respect to the first nonsuit, it seems to me that the language ought to be added to paragraph A of § 8.01-380, although an argument could be made for having it as a separate paragraph and renumbering paragraphs B and C.

This proposal does not deal with how you enforce the claim. Last year's bill provided that the expenses would be assessed in the second proceeding and the plaintiff would be precluded from moving forward with the second suit until the expense were paid (see House Bill 1356). While I think there ought to be some mechanism set up in the statute to enforce the right, I would suggest that the bill be introduced with the language set forth above. If the Committee then chooses to amend the proposal, that would be a Committee decision.

I am sorry that I have to be out of town on December 2. Please let me know whether the Committee endorses the proposal.

Sincerely,

Henry H. McVey, III

pak

cc: Leigh B. Middleditch, Jr., Esq.

APPENDIX I

New River Community Sentencing, Inc.

205 West Main Street, B-2

Post Office Box 543
Christiansburg, Virginia 24073

(703) 382-0802

Sentencing offenders to perform unpaid work is less costly than incarceration. It provides valuable services to the community. Used to allow indigent probationers to pay court costs, it also results in restitution payments to victims and savings associated with earlier release from supervision.

Currently, non-profit and governmental agencies operate programs to supervise offenders in performing community service under Virginia Code provisions. The community service takes place at units of local government or at non-profit organizations. While judges assigning individuals to community service are immune from suit, cooperating agencies and their employees can be held liable. The State of Missouri adopted limitations on liability for cooperating agencies when it enacted its community service statute in 1981. This statute has remained in effect for six years with only minor changes. (See attachment.) The lack of such provisions in Virginia affects the viability of the community service sanction in several ways.

First, program operators must find liability coverage. Inability by State-operated Community Diversion Incentive (CDI) programs to find such coverage resulted in self-insurance through the Division of Risk Management. This coverage is not available to our program; nor is adequate coverage easily available on the private market, at any price. Only one local agent responded

to our request for a bid and provided sub-standard insurance at a premium of $2,731, versus $382 last year. (See attachments)

Second, work sites worry about potential liability. In two cases already, a local government and a public library system elected to withdraw as our worksites, not in response to problems with offenders assigned, but as a result of liability concerns. Some sites elect not to consult their insurance agents regarding participation in our program, out of concern as to how it would effect their premiums. Last year one local government carried a liability policy to cover acts by offenders on work release or enrolled through our program at an annual premium of almost $4,000.

One municipality temporarily refuses referrals because our agency can find no workers compensation coverage for offenders and instead purchased an accident policy identical to that used by the CDI programs. Even if our agency finds a carrier, the current Workman's Compensation Act may not prevent injured offenders from suing an agency such as ours or the worksite. Unlike workers compensation, accident and liability coverage does not prevent suits, it only defends them. If our agency or one of the sites were to be sued, our Board fears other sites would cancel and we could not longer operate a program.

We are addressing the Joint Sub-Committee on this issue at the advice of the Crime Commission. Our agency requests the Sub-Committee's advise on how best to get the State to address these concerns, whether through legislation or other means.

APPENDIX I

Conditions of probation--compensation of victims--free work, public or charitable.--

559.021. 1. The conditions of probation shall be such as the court in its discretion deems reasonably necessary to insure that the defendant will not again violate the law. When a defendant is placed on probation he shall be given a certificate explicitly stating the conditions on which he is being released.

2. In addition to such other authority as exists to order conditions of probation, the court may order such conditions as the court believes will serve to compensate the victim, any dependent of the victim, or society. Such conditions may include, but shall not be limited to

(1) Restitution to the victim or any dependent of the victim, in an amount to be determined by the judge; and

(2) The performance of a designated amount of free work for a public or charitable purpose, or purposes, as determined by the judge.

3. The defendant may refuse probation conditioned on the performance of free work. If he does so, the court shall decide the extent or duration of sentence or other disposition to be imposed and render judgment accordingly. Any county, city, person, organization, or agency, or employee of a county, city organization or agency charged with the supervision of such free work or who benefits from its performance shall be immune from any suit by the defendant or any person deriving a cause of action from him if such cause of action arises from such supervision of performance, except for an intentional tort or gross negligence. The services performed by the defendant shall not be deemed employment within the meaning of the provisions of chapter 288, RSMo.

4. The court may modify or enlarge the conditions of probation at any time prior to the expiration or termination of the probation term.

D 12/3/87 Devine C 12/18/87 owj

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

A BILL to amend the Code of Virginia by adding a section numbered 19.2-303.2, relating to immunity for persons supervising or benefiting from court-ordered community service work.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 19.2-303.2 as follows:

§ 19.2-303.2. Immunity for supervision of community service work.--Any person, charged with supervision of an individual performing community service work for a public or charitable purpose pursuant to a court order and any person who benefits from the performance of such work, shall be immune from suit for damages arising out of such supervision which is (i) caused by the negligence of the individual so ordered or (ii) incurred by the individual while performing such work. However, the immunity granted by this section shall not apply to acts or omissions made or done in bad faith, with malicious intent or in a manner exhibiting a willful, wanton disregard of the rights, safety or property of another.

As used in this section, the term "person" includes an individual, partnership, corporation, company, society, association and governmental and other legal entities.

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D 12/3/87 Devine C 12/29/87 smw

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

A BILL to amend the Code of Virginia by adding in Article 3 of Chapter 3 of Title 8.01 a section numbered 8.01-44.3, relating to immunity for injury or death due to certain products used in treatment of hemophilia; exception.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia amended by adding in Article 3 of Chapter 3 of Title 8.01 a section numbered 8.01-44.3 as follows:

§ 8.01-44.3. Action for injury or death resulting from certain blood products.--No civil action for injury or death resulting from an adverse reaction to blood products or genetically equivalent products used in the treatment of hemophilia and related diseases, shall lie against any person who manufactures, produces, distributes, sells, gives or administers the product in accordance with law, except where such injury or death was caused by gross negligence or intentional misconduct.

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