REPORT OF THE
KENTUCKY INSURANCE AND LIABILITY TASK FORCE

Research Report No. 232
Legislative Research Commission
Frankfort, Kentucky

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KENTUCKY INSURANCE AND LIABILITY TASK FORCE

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Research Report No. 232
Frankfort, Kentucky
January, 1988

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KENTUCKY INSURANCE AND LIABILITY TASK FORCE

Capitol Annex, Room 20
Frankfort, Kentucky 40601
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Speaker Donald J. Blandford
President Pro Tem John "Eck" Rose
Co-Chairmen, Legislative Research Commission
State Capitol
Frankfort, Kentucky 40601

Dear Speaker Blandford and President Pro Tem Rose:

It is my privilege, pursuant to HJR 139, to submit to the Legislative Research Commission the Report of the Kentucky Insurance and Liability Task Force. The Report is the product of eighteen months of deliberation, study, debate; and reflects an effort to mold diverse philosophies and opinions into cohesive, workable, and lasting solutions which address the problems of insurance affordability and availability.

Procedurally, the Task Force included as a part of its recommendations those proposals which received support from a majority of the members voting. Given the controversial nature of the problems and the numerous interests involved, it was inevitable that no single comprehensive report would generate unanimous support on all issues.

The Report, as reflected through the General Findings and the Issue Statements, is not argumentative in tone, rather informative. Where there was substantial support for conflicting points of view, an attempt has been made to include the basic reasoning of each side. Approaching the format in this manner, we received near unanimity on the overall Report.

Thank you for allowing us the opportunity to serve on this most important Task Force.

Respectfully yours,

W. STEPHEN WILBORN
Chairman

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Mr. Jim Wiseman, President
Kentucky Chamber of Commerce
Frankfort, Kentucky

KENTUCKY INSURANCE AND LIABILITY TASK FORCE

SCHEDULE OF MEETINGS

MEETING	DATE	MEETING TIME	LOCATION
# 1	July 31, 1986	10:00 a.m. - 11:55 a.m.	Frankfort
# 2	September 17, 1986	9:00 a.m. - 4:15 p.m.	Louisville
# 3	October 8, 1986	10:00 a.m. - 4:10 p.m.	Frankfort
# 4	November 19, 1986	10:00 a.m. - 4:50 p.m.	Frankfort
	November 20, 1986	9:00 a.m. - 4:20 p.m.	Frankfort
# 5	December 10, 1986	10:00 a.m. - 1:30 p.m.	Prestonsburg
# 6	January 15, 1987	10:00 a.m. - 5:00 p.m.	Owensboro
	January 16, 1987	9:00 a.m. - 5:00 p.m.	Owensboro
# 7	February 18, 1987	10:00 a.m. - 1:30 p.m.	Frankfort
# 8	March 9, 1987	10:00 a.m. - 2:55 p.m.	Frankfort
# 9	April 14, 1987	9:00 a.m. - 12:20 p.m.	Lexington
#10	April 20, 1987	10:00 a.m. - 5:45 p.m.	Shakertown
	April 21, 1987	9:00 a.m. - 11:30 a.m.	Shakertown
#11	May 27, 1987	10:00 a.m. - 11:10 a.m.	Frankfort
#12	July 1, 1987	10:00 a.m. - 4:30 p.m.	Frankfort
#13	July 16, 1987	10:00 a.m. - 5:35 p.m.	Frankfort
	July 17, 1987	9:00 a.m. - 4:35 p.m.	Frankfort
#14	August 6, 1987	1:00 p.m. - 6:10 p.m.	Lexington
	August 7, 1987	9:00 a.m. - 3:30 p.m.	Lexington
#15	August 27, 1987	1:00 p.m. - 6:00 p.m.	Louisville
	August 28, 1987	9:00 p.m. - 4:00 p.m.	Louisville
#16	September 3, 1987	2:00 p.m. - 5:40 p.m.	Frankfort
#17	October 1, 1987	10:00 a.m. - 7:45 p.m.	Frankfort
	October 2, 1987	9:00 a.m. - 4:45 p.m.	Frankfort
#18	October 19, 1987	10:00 a.m. - 4:45 p.m.	Frankfort
#19	December 3, 1987	7:00 p.m. - 12:15 a.m.	Frankfort
	December 3, 1987	9:00 a.m. - 4:30 p.m.	Frankfort

PRESENTATIONS

Meeting #1 Frankfort	Brenda Trolin, National Conference of State Legislators
Meeting# 2 Louisville	Edward J. Muhl, President, National Association of Insurance Commissioners and Commissioner of Insurance, State of Maryland; Robert Hunter, President, National Insurance Consumers Organization; Frank Nutter, President, Alliance of American Insurers; James Coyne, President, American Tort Reform Association; Robert L. Habush, President, American Trial Lawyers Association; James Shamberger, Vice President, Reinsurance Association of America; Charles W. Havens, III, U.S. General Counsel's Office, Lloyd's of London
Meeting #3 Frankfort	Susan Pippen, Staff, Legislative Research Commission; Kentucky Department of Insurance: Gil McCarty, Commissioner; Judy Maynard, Director, Administrative Services Division; Gayle Baldree, Director, Agents Licensing Division; Matthew Johnson, Director, Life and Health Division; Ed Fossett, General Counsel; Wendell Clark, Director, Financial Standards and Examinations; Leroy Morgan, Director, State Risk and Insurance Services Division; Bill Coleman, Director, Property and Casualty Division; Roger Kephart, President, Independent Insurance Agents of Kentucky; Linda Davies, Professional Insurance Agents of Kentucky; Larry Westmoreland, Chartered Property and Casualty Underwriters of Kentucky
Meeting #4 Frankfort	Darryl Callahan, Kentucky Society of Architects; Jim Parsons, Consulting Engineers Council of Kentucky; David Oliver, Kentucky Motor Transport Association; Robert Weiss, Home Builders Associations of Kentucky; Ruth Beeman, Frontier Nursing Association; Joe B. Campbell, Kentucky Bar Association; David Thompson and Homer Marcum, Kentucky Press Association; Bill Greely, Keeneland Association; Dr. Nelson Rue, Kentucky Medical Association; Dr. Larry Griffin, Kentucky Chapter of American College; of Obstetrics and Gynocology;

PRESENTATIONS

Meeting #4
Continued
Frankfort

Dr. Greg Cooper, Kentucky Medical Association ;
Dr. E. G. Houchin, Physician, Corrections Cabinet;
Tom Robeson, Cabinet for Human Resources;
William S. Conn, Kentucky Hospital Association;
Gary Marsh, Kentucky Association of Health Care Facilities;
Camille Haggard, Kentucky Association for Child Care Management;
Linda Locke, Community Coordinated Child Care;
Johnny King, Head Start of Kentucky (written testimony only);
Jean Duncan, Kentucky Nurses Association
Jack Blanton, University of Kentucky
Larry Owsley, University of Louisville;
George Woodward, Kentucky Tourism Federation;
Johnny Shea, Kentucky Restaurant Association;
John Bush, Kentucky Council of Churches;
Sam Crawford, Kentucky Farm Bureau;
Tom Edwards, Burley Auction Warehouse Association;
Ben Gratzer, Kentucky Society of Certified Public Accountants;
Tom Duncan, Kentucky Coal Association;
Buddy Adams, Bill St. Pierre and Elsie Atherton, United Way of Kentucky;
Louis Igert, III, Associated Industries of Kentucky/Igert, Inc.;
Ed Griffin, Kentucky Municipal League;
Phil Williams, Kentucky Association of County Officials;
R. C. Riley, Peel and Holland, Inc.;
Bill Caylor, Kentucky Coal Association;
Larry Herman, General Counsel, U.S. Senate Judiciary Committee;
Sister Margaret Kern, Catholic Conference of Kentucky;
William Stone, Louisville Plate Glass Company;
Jerry Haase, Canteen Service Company of Owensboro;
David Osbourne, Keneco and Associates;
James Carter, Jaggers Equipment Company;
George Wilson, III, Kentucky Automotive Wholesalers Association;
Edward Bowman, National Federation of Independent Business;
Tom Burton, Kentucky LP Gas Association;
John Delaney, Olin Chemicals Corporation;
Rick Wilson, Railroad Excursions (written testimony only);
Alan Day and Carl Dills, Kentucky Department of Agriculture

PRESENTATIONS

Meeting #5 Jenny Wiley State Park Prestonsburg	Melvin Wilson, Big Sandy Claims Service; Tony Shannon, Insurance Services Office, Ohio; Roger Rechtenwald and Rob Nicholas, Big Sandy Area Development District; Doug Hinkle, Walter P. Walters Insurance Agency; Jack Maranda, Farm Bureau Insurance; John Waddell, Pikeville City Schools; Ann Latta, Mayor of Prestonsburg; Larry Henderson, Arson Division, Kentucky State Police; Treva Mae King, Head Start Programs; Mr. Billy Arms, Johnson County Concerned Citizens, Inc.; Mrs. Debbie Gambill, Citizen from Floyd County; Dr. Ellen Joyce, Mud Creek Free Clinic; Bill Role, Prestonsburg Businessman; Al Gilliam, Prestonsburg Businessman; H. D. Fitzpatrick, FADA, Prestonsburg
Meeting #6 Executive Inn Owensboro	William E. Doll, Jr., Tort Reform Association of Kentucky Kevin George, Attorney, Louisville; Steve Masterson, Florida Trial Lawyers Academy; Richard Rawdon, Attorney, Georgetown; Larry Webb, Barren River District Health Department; Libby Alexander, United Way of the Ohio Valley Hiram Hogg, Spinal Cord Injury Foundation Phyllis Barnes, Kentucky Marina Association; Jeff Oldham, Taylor's Package Liquor; George Burger, Insurance Services Office, New York; Pat Casey, Insurance Services Office, Chicago; Leslie Cheek, Vice President for Government Affairs, Crum & Forster Insurance Company, Washington, D.C.; Joe B. Campbell, KBA Committee on Lawyers Malpractice Insurance; Gerard P. Breslin, Humana, Inc.; Janice Scott, Director of Insurance Programs, Kentucky School Boards Association; David Keller, Executive Director, Kentucky School Board Association; Gregory Berg, Tillinghast, Nelson, Warren, Inc.; Patrick Watts, Kentucky Department of Insurance
Meeting #7 Frankfort	Carl Wedekind, President, Kentucky Medical Insurance Company Robert Buchanan, Alexander and Alexander; Charles Cunningham, National Rifle Association (written testimony only)

PRESENTATIONS

Meeting #8 Frankfort	Carl Henlein, Brown, Todd and Heyburn Elizabeth Tannon, Commercial Dispute Resolutions, Louisville; Chief Justice Robert F. Stephens, Supreme Court of Kentucky; George Bender, Kentucky Association of Fair and Horseshows; James Stephens, Hopkins County-Madisonville Fair; Mike Patton, Allen County Fair; Jamie McMillam, Murray-Calloway County Fair; Eric S. Tachau, Insurance Consultant; Gary Marsh, Kentucky Association of Health Care Facilities
Meeting #9 Lexington	John E. Washburn, Illinois Director of Insurance Fred E. Wright, West Virginia Insurance Commissioner; James P. Corcoran, Superintendent of Insurance, New York; Lyndon Olson, Jr., Texas Chairman, State Board of Insurance; Dick Marquardt, Commissioner of Insurance, State of Washington; Judge L. T. Grant, Chief Circuit Judge, 22nd Circuit
Meeting #10 Shakertown	Peter Lardner, Chief Executive Officer, Bituminous Insurance Companies, Illinois; Bill Conn, Kentucky Hospital Association; Bob O'Daniel, Kentucky Hospital Association; Gene Ensor, Kentucky Hospital Association; Carl Wedekind, President, Kentucky Medical Insurance Association; Tom Russell and Jack Ballantine, Kentucky Defense Counsel

Meeting numbers 11 through 17 consisted of discussion of testimony and issues being considered for recommendation to the 1988 Kentucky General Assembly.

TABLE OF CONTENTS

		Page
I.	Overview	1
II.	Activities of the Task Force	3
III.	General Findings	14
IV.	Issue Statements	
	A. Civil Justice System	
	1. Joint and Several Liability	19
	2. Section 54 of the Kentucky Constitution	20
	3. Punitive Damages	22
	4. Frivolous Lawsuits	24
	5. Offer of Judgment	26
	6. Collateral Sources	27
	7. Discoverability of Insurance	28
	8. Remittitur and Additur	29
	9. Structured Settlements	30
	10. Limits on Attorney's Fees	31
	11. Alternate Dispute Resolution	32
	12. Patients' Compensation Plan	35
	13. Statute of Limitation for Minors	37
	14. Statute of Limitation--Property Damage	39
	15. Standards of Conduct for Directors and Officers of For-profit Corporations	40
	16. Standard of Conduct for Directors, Officers and Volunteers of Non-profit Corporations and Charitable Organizations	42
	17. Sovereign Immunity / Insurance for Government Entities and Employees	44
	18. Municipal Tort Claims Act	45
	B. Insurance Regulation	
	19. Creation of a Mechanism to Assure Availabiliity	47
	20. Self Insurance / Local Government / Fictitious Group Statute	49
	21. Extended Notification for Cancellation and Non-renewal of Insurance	51

Page

22. Increased Reporting of Medical Malpractice and Confidentiality of Peer Review Records 52
23. Triggered Filing Approach / Flex Rating..... 54
24. Kentucky Claims Experience..... 59
25. Consent to Rate and Coverage..... 60
26. Closed Claim Information..... 61
27. Policy Simplification..... 63
28. Surplus Lines Policies..... 64
29. Insurance Settlement..... 65
30. Unfair Claims Settlement Practices Act..... 66
31. Insurance Consumer's Advisory Council..... 67
32. Municipal Insurance Premium Tax..... 68
33. Insurance Premium Surcharge / Fire Protection Improvement Fund..... 69
34. Increased Funding / Department of Insurance..... 72
35. Repeal McCarren-Ferguson Act..... 74
36. Child Care Facility Liability Insurance..... 75

V. Bill Drafts and Recommended Rule Changes

1 Joint and Several (Apportionment)..... 77
2 Amend Section 54..... 79
3 Punitive Damages..... 80
4 Certificate of Merit..... 83
5 Offer of Judgment..... 85
6 Collateral Sources..... 87
8 Remittitur/Additur..... 88
9 Structured Settlements..... 90
12 Patients' Compensation Plan..... 91
14 Statute of Limitations -- Property Damage.... 143
15 Standard of Conduct for Directors and Officers of For-Profit Corporations..... 146
16a Standard of Conduct for Directors and Officers of Non-Profit Corporations..... 153
16b Standard of Conduct for Directors and Officers and Volunteers for Non-Profit Organizations..... 160
18 Municipal Tort Claim Act..... 162
19 Expanded Fair Plan..... 169
20a Liability Insurance for Local Governments.... 176
20b Repeal of Fictitious Group Statute..... 178
21 Extended Notification for Cancellation and Non-Renewal..... 180

22. Confidentiality of Peer Review Records..... 192
23a. Triggered Rate Filing..... 198
23b. Flex Rating..... 200
24. Kentucky Experience in Rate Making..... 204
26. Closed Claim Information..... 205
27. Insurance Policy Simplification..... 208
28. Surplus Lines Policies..... 213
29. Insurance Settlement..... 214
30. Unfair Claims Settlement Practices..... 215
31. Insurance Consumer's Advisory Council..... 221
33. Fire Protection Improvement Fund..... 223
34a. Increase in Department's Carryover..... 237
34b. Funding Assessment 238
34c. Insurance Fees by Regulation..... 240

VI. ADDENDUM..... 244

Settlement Incentive..... 246
Professional Malpractice Review..... 253

VII. MINORITY REPORT..... 266

VIII. APPENDIX

HJR 139..... 292
Minutes, Tapes and Folders..... 297
ABA Report/Alternate Dispute Resolution..... 298
KRS 304.99-020 Civil Penalties..... 300
CHR, Department for Social Services
Liability Coverage for Foster Parents..... 301
CHR, Liability Insurance Advisory Committee
Report Recommendations..... 303
Proposed Regulation/Closed Claim Study..... 306
Texas Closed Claim Questionnaire..... 312
Report on Kentucky's Insurance Taxes..... 316
Report on KLEFPF..... 330
HO-322..... 336

I. OVERVIEW

The Kentucky Insurance and Liability Task Force was created by HJR 139, 1986 Regular Session of the General Assembly, to study the insurance industry in Kentucky with special emphasis on the problems of availability and affordability of liability insurance. The resolution was introduced by the leadership of the General Assembly in the midst of a legislative atmosphere which reflected a national, public debate on the crisis in liability insurance. Starting in 1985 businesses, professionals and certain segments of the service industry experienced dramatic increases in the cost of liability or casualty insurance.

There was, and remains today, a great deal of "finger pointing" with blame usually directed toward someone else. Some would have us believe poor management and bad underwriting practices by the insurance industry caused high premiums; when interest rates were high, insurers made profits from investments and kept premiums artificially low; when interest rates dropped, insurers sought to quickly recoup losses with dramatic increases in premiums. Others place blame on the civil justice system, saying, "We sue each other too much, juries hand out higher and higher awards, and the whole system is fueled by the economic motivation of trial lawyers." These problems, coupled with judicial activity, have caused the civil justice system to become unpredictable, with premiums being charged to cover the worst case scenario.

In this atmosphere, the General Assembly was confronted with conflicting "answers" to these significant problems. To gain a better understanding of the reforms being advocated and the causes of the insurance crisis, the General Assembly created the Insurance and Liability Task Force, with direction to report back by December of 1987. Twenty six members were appointed representing various interests in the Commonwealth affected by the crisis, including attorneys (both plaintiff and defense), doctors, architects, engineers, cities, counties, insurers, insurance agents, child care providers, homebuilders and business, as well as the Commissioner of Insurance and the Chairmen of the House and Senate Committees on Banking and Insurance as ex-officio members.

II. ACTIVITIES OF THE TASK FORCE

The liability insurance crisis is not unique to Kentucky. It is national, if not international, in scope.

Staff from the National Conference of State Legislators speaking at the first meeting of the Task Force in July of 1986, indicated the liability insurance crisis was the number one issue facing state legislators in 1986. More than two thirds of the states enacted legislation to address the liability insurance crisis in 1986 and 1987. Kentucky's Task Force has been able to look at the actions taken by the other states and benefit from their analysis of the issues. The Task Force also benefited from the national dialogue on the liability insurance crisis.

At its second meeting in September of 1986, the Task Force heard from seven speakers with a national perspective. Those speakers were: Mr. Edward Muhl, Maryland Insurance Commissioner and President of the National Association of Insurance Commissioners; Mr. Robert Hunter, President of the National Insurance Consumers Organization; Mr. Frank Nutter, President of the Alliance for American Insurers; Mr. James Coyne, President of the American Tort Reform Association; Mr. Robert Habush, President of the American Trial Lawyers Association; Mr. James Shamberger, Senior Vice President, Reinsurance Association of America; Mr. Charles Havens, U.S. General Counsel's Office, Lloyd's of London.

In October, the Kentucky Department of Insurance division directors provided the Task Force with information regarding the primary responsibilities of their divisions and answered any questions regarding funding, staffing, etc.

In November, the Task Force held a two-day hearing to gain an understanding of the scope of the liability insurance crisis in Kentucky. Over forty groups experiencing liability insurance problems were identified and asked to testify before the Task Force.

The Kentucky Society of Architects reported coverage had been reduced; deductibles increased, and premiums had gone up several hundred percent. The number of companies writing insurance for architects had dwindled from 13 in 1984 to 3 companies today.

The Consulting Engineers Council of Kentucky stated professional liability insurance for their members presently costs them 12% of their gross income.

The Kentucky Motor Transport Association testified that an average premium increase of 463% occurred since 1982, consuming 8% of gross income. Both state and Federal government require certain types of haulers to carry minimum amounts of liability coverage.

The Home Builders Association of Kentucky reported an increase for their directors and officers liability policy of 433% over last year's, even though they had not had a single claim since their inception in 1957.

The Frontier Nursing Service testified premiums have increased over 100% since 1984. They have been asked to expand their nursing-midwifery practice in Kentucky but can find no liability insurance for birthing centers. Kentucky's only nursing industry birthing center closed because of the malpractice crisis.

The Kentucky Press Association said their libel insurance premiums have increased 500% since 1980 and the deductibles increased 400%.

The Keeneland Association, on behalf of the race tracks, said that participants liability insurance is generally unavailable at any cost.

Kentucky Medical Association reported doctors' rates have increased an average of 25% every year since 1981. That includes a 44% increase in 1985, the same year in which their premiums for excess coverage increased 135%. The number of underwriters for physician malpractice has decreased in 5 years from 10 to 2. They also reported that 28% of the OB/GYN's in Kentucky have

stopped their OB practice altogether within the past 8 years and half of those have done so in the past year and one half.

The Kentucky Department of Corrections reported they are unable to obtain medical malpractice insurance for their physicians treating prisoners.

The Cabinet for Human Resources reported they are having difficulty obtaining coverage for state social workers and foster parents. They also expressed concern that if they do obtain coverage that it might constitute a waiver of any protection available under the state's sovereign immunity.

The Kentucky Association of Health Care Facilities testified nursing homes have experienced an increase of 150% for the last two years.

The Community Coordinated Child Care and the Kentucky Association of Child Care Management testified day care centers reported premium increases from 53% to 900% with over 41% of licensed child care programs responding that their policies had been cancelled or not renewed.

The University of Kentucky reported at that time that the liability coverage for their employees, including

faculty, had been cancelled and they were unable to get coverage. The University of Louisville reported a similar difficulty in obtaining coverage.

The Kentucky Tourism Federation reported some regional and local festivals have had to pay out 10% to 30% of their budgets for liability coverage. Directors and officers coverage for the Federation had increased 600% in one year.

The Kentucky Council of Churches testified that their directors and officers liability coverage increased by 300% over the last three years and as a result they are looking at self insurance and pooling. Though there has not been an increase in claims against churches in Kentucky, over the past two years there have been over 2000 actions brought against churches nationally.

The Burley Auction Warehouse Association reported that their "high value coverage" covering tobacco stored in warehouses was not renewed for any of Kentucky's tobacco warehouses this past fall.

The Kentucky Society of Certified Public Accountants reported that liability coverage for CPA firms increased 900% to 1000% over the past two years.

United Way of Kentucky reported liability insurance increases of 45% to 160% over the past year, causing more of their limited dollars to be directed to administrative costs rather than agency programs. Some agencies are having trouble obtaining insurance, discouraging volunteers from service.

The Kentucky Municipal League reported premium increases of 100% to 700% for Kentucky's cities. The league has actively been developing an insurance pool for their members. Kentucky's courts have said that Kentucky's cities do not enjoy the same protection under sovereign imunity as do the state and counties.

The Catholic Conference of Kentucky reported that in 1985 their premiums increased 500% from $12,000 to $60,000 and in 1986 an additional 300% to $195,000 with a reduction in coverage and additional exclusions.

Several business groups and individual businesses also reported significant increases: Louisville Plate Glass Company, a 3 1/2 times increase over last year; Canteen Service of Owensboro, 49% increase in 1985 and 70% increase in 1986; Jaggers Equipment Company of Louisville, a 968% increase since 1984; Kentucky Automotive Parts Wholesalers Association, over 200%

increase in the last three years causing 20% or better of the wholesalers to go bare or without coverage altogether; the Kentucky Chapter of the National Federation of Independent Business, with 7,000 members in Kentucky, said over half of their members had premium increases in excess of 25% over last year.

Other groups testifying as to problems with increasing liability insurance premiums and/or availability problems included the Kentucky Farm Bureau, Kentucky Coal Association, Associated Industries of Kentucky, Kentucky Association of County Officials, Kentucky LP Gas Association, railroad excursions, amusement rides and shows and fairs.

In December of last year the Task Force held a public hearing in Floyd County, Kentucky on problems of availability and affordability of automobile and home owners insurance in the mountains and so called "red-lining," where some insurers decline to write property and casualty insurance in the area. Among those testifying were spokesmen for the Insurance Services Office, Farm Bureau Insurance, the Big Sandy Area Development District, and several local insurance agencies and claims adjusting services. The Insurance Services Office, or ISO, prepares the "Fire Suppression Rating Schedule," which insurers use to determine property and casualty insurance rates by area. Local officials testified that the lack of adequate

water systems and fire fighting equipment, as well as, higher incidences of arson and lower arson conviction rates contributed to the poor rating of many counties in Eastern Kentucky. Others testified that insurers "red-line" because it is not possible to make a profit on the sale of insurance in certain areas.

In January, the Task Force held a two-day meeting in Owensboro. On the first day it heard again from the Insurance Services Office on how rates are determined. ISO compiles advisory rates for each state which many medium and small insurers use to determine the actual premium charged their customers. ISO indicated that Kentucky experience is maintained by them and currently available in the Department of Insurance. Mr. Leslie Cheek, Vice President of Crum and Forster Insurance Company, testified on the factors considered by insurers in determining rates and premiums. On the second day the Task Force heard presentations by the Kentucky Association of Trial Attorneys calling for increased regulation of the insurance industry in Kentucky and more disclosure of financial information to better determine the fairness of insurance rates. The Tort Reform Association of Kentucky also presented their recommendations for changes in the civil justice system, including limits on non-economic damages, reduction of the statute of limitation with regard to minors and offsets for collateral sources. During the public hearing portion of the Owensboro meeting, the Task Force heard testimony from several groups indicating that they had experienced significant

increases in their liability insurance premiums or had their policies cancelled altogether and were unable to obtain coverage. Those groups included United Way of the Ohio Valley, Barren River Health Department, the Kentucky Marina Association, the Owensboro Regional Airport and several area tourist facilities and tavern owners.

In February, the Task Force met in Frankfort and heard from the Kentucky Medical Insurance Corporation on their claims experience. KMIC is a doctor-owned insurance company insuring nearly half of Kentucky's doctors for medical malpractice. Mr. Carl Wedekind, president of KMIC and a member of the Task Force, testified that from 1981 to 1984, KMIC had an average premium increase from 10% to 20%. KMIC reported, in a closed claim study based 100% on Kentucky experience, of all dollars paid out by KMIC on 268 cases, 62% went to pay attorneys and court costs and 38% ended up in the hands of claimants. In 1985, their premium increased 70%; in 1986, 27%; and for 1987 would increase 46%. The Task Force also heard testimony from Mr. Robert Buchanan with Alexander and Alexander, which insures approximately 60% of the attorneys in Kentucky. He discussed the potential hazards with the mutual program being proposed for the attorneys.

In March, the Task Force heard from Mr. Carl Henlein, an attorney from Louisville. Mr. Henlein spoke on Alternate Dispute Resolution Systems, or ADR's; i.e., alternatives to the regular civil justice litigation process for resolving disputes. Mr. Henlein has been involved in establishing an ADR

for the Louisville Chamber of Commerce for resolving business disputes. He testified that the purpose of ADR's was to compensate people reasonably with minimal administrative expenses. The Task Force also heard from Kentucky's Chief Justice of the Supreme Court, Robert F. Stephens, on the efforts of Kentucky Judiciary to streamline the judicial process, including their study of Alternative Dispute Resolution Systems. The Chief Justice outlined a number of steps they have already taken to address the problem of the court's handling of litigation in a timely fashion. Mr. Eric Tachau also testified before the Task Force that the capacity of the property and casualty insurance companies appeared to be increasing, which should make liability insurance more available. Mr. Tachau also supports legislation making alternatives to commercial insurance more available to consumers and repeal of the McCarran-Ferguson Act, to allow for Federal regulation of insurers.

In April, the Task Force held a special meeting in conjunction with the Zone meeting of the National Association of Insurance Commissioners held in Lexington. At that meeting, the Task Force heard testimony on different insurance rate regulatory systems used by other states. Those testifying included John Washburn, Director of Insurance for Illinois; Fred Wright, Commissioner of Insurance for West Virginia; James Corcoran, Superintendent of Insurance for New York; and Lyndon Olson, Chairman, Texas State Board of Insurance. Despite their different approaches to regulation of insurance rates, each of

these states felt the effects of the liability insurance crisis. Also testifying was Fayette County Chief Circuit Judge L. T. Grant, who discussed the civil justice system from the perspective of a trial judge.

April 20th and 21st the Task Force met in Shakertown and heard from Mr. Peter Lardner, President and Chief Executive Officer of the Bituminous Insurance Companies, who testified that from his perspective Kentucky was a good state in which to do business. He also urged the Task Force to look at the "unfairness" and "high cost" of the civil justice system. Mr. Carl Wedekind also made his proposal for a no-fault medical malpractice insurance program and Mr. Tom Russell and Mr. Jack Ballantine, Kentucky Defense Counsel, Inc., spoke on tort reform from the perspective of the defense bar. The Task Force also heard the results of a survey on the insurance rate experience of Kentucky hospitals conducted by the Kentucky Hospital Association.

III. GENERAL FINDINGS

* The Task Force found no evidence of conspiracy among the insurance companies to raise insurance rates; nor was there a banding together in restraint of trade. The insurance industry is remarkably fragmented, with no company holding a major share of the overall market. Pricing appears to be the result of competition among insurers both in price and for market shares. Small and medium sized insurers rely heavily on shared data from rating bureaus like the Insurance Services Offices, ISO, for rate making purposes, thus following similar patterns in pricing. In that insurance pricing is based upon estimated future happenings and costs, there is considerable reliance on perception in establishing price. One Insurance Commissioner called it "newspaper headline underwriting"; a jury awards damages for child molestation by a day care operator in California and suddenly all day care operators are potential child molesters, with insurance premiums priced accordingly.

The insurance industry is subject, on a cyclical basis, to wide swings in the price of its product, suggesting it is not capable of conspiring to set prices, and is driven by fierce competition. Sudden price increases or price shocks are causing insurers to lose customers, with many seeking alternatives to commercial insurance such as self-insurance or pooling.

The Task Force believes Kentucky experienced, along with all the other states, a liability insurance crisis because we, too, fell victim to the industry's pricing cycle.

* The Task Force found no evidence nor heard testimony that caused them to conclude that there is a litigation explosion in Kentucky, although it does appear that in some areas, such as professional liability and product liability, clams have increased, while in other areas there has been a decline. Evidence from other states suggest the frequency and size of jury awards has increased in recent years. As a result, the insurance industry feels the civil justice system is becoming unpredictable.

* Experience in other states suggests that changes in the civil justice system or "tort reform" do not result, at least in the short term, in reduced liability insurance premiums. The Task Force does not believe the civil justice system is the driving cause of the liability insurance crisis; however, it does believe some changes in the civil justice system are necessary to bring about a greater degree of efficiency, predictability and cost-effectiveness.

There is concern with the tendency of our Courts to broaden the opportunities for recovery of damages for a greater array of injuries, economic and non-economic. The evolution of these policies adversely affects the predictability of the civil justice system. In addition, we are concerned with the

cost and efficiency of the civil justice system as a means of compensating victims of torts.

Despite its faults, the Task Force remains deeply committed to and supportive of the civil justice system, with its right of jury trial, particularly in those areas where it continues to operate effectively. The important function of the civil justice system as a deterrent to harmful social behavior is also recognized. All citizens should have the right to recover for injuries caused by the negligence of others; however, life itself poses risks and persons who engage in certain activities expose themselves to those risks, and have no inherent right to recover from persons only indirectly responsible for those risks.

* The Task Force recognizes state governments are at a disadvantage in attempting to force insurance companies to "behave" in a certain manner. Onerous regulation in one state causes insurers to leave for other markets. Regulation of the industry must be fair and reasonable if we are to encourage insurers to do business in Kentucky while safeguarding the interests of our citizens. The more companies which write insurance in Kentucky, the more likely insurance will be available and affordable. There are advantages to encouraging insurance companies to domicile in Kentucky; not only does it bring jobs and capital, but also, it enhances the likelihood the company will continue to provide services for Kentucky citizens when out of state companies may choose not to.

* The Task Force studied the rating systems used in other states; regardless of the regulatory system in place, no system was immune from the effects on the insurance crisis. Our open competition approach may well have been beneficial to the Kentucky consumer during the "soft market" of a few years ago.

* The Kentucky Department of Insurance did everything within its power to expeditiously deal with the problems our citizens were having with affordability and availability of insurance. Enhancing the Department of Insurance with additional funds, staff, and equipment will give it the wherewithall necessary to continue to serve the Commonwealth in the future.

* The recommendations of the Kentucky Insurance and Liability Task Force do not offer quick fix solutions. The causes of the liability insurance crisis and the complexities of the insurance industry do not lend themselves to simple solutions. The Task Force has chosen to propose a list of changes which address the problem from various angles; in combination, we believe these changes can and will have a lasting positive impact.

The Task Force has attempted to weigh the interest of our citizens as potential victims of negligence against their interest as consumers of insurance. Recommendations for changes in the civil justice system are intended to help make

the system "fairer" and deter unnecessary and frivolous legal action, which has, to some degree, become a part of the system. While these changes will not result in an immediate reduction in insurance rates, we believe they send a signal that Kentucky wants greater predictability and efficiency in our civil justice system. Certain of the recommendations are designed to make consumers of insurance more knowledgeable about what they are buying, while others require sellers of insurance to be more accountable for the type of product sold, how it is sold, and for what price. Enhancing the state's regulatory authority over insurers to help deal with the extremes of insurance pricing cycles, and creating a mechanism to provide our citizens an alternative source of insurance, thereby assuring availability, are additional proposals we believe merit consideration.

ISSUE STATEMENTS

CHANGES IN THE CIVIL JUSTICE SYSTEM

Issue #1: Joint and Several Liability

(Bill Draft #1, Page 77)

Joint and several liability is at the top of the list of "tort reform" issues debated in other states. Under joint liability, if one or more defendants are unable to pay their share of a damage award, the responsibility for the entire award falls to the remaining defendant or defendants. The doctrine can be abused with plaintiffs' lawyers naming defendants in lawsuits based upon their financial resources, so-called "deep pockets", rather than their liability based on fault.

The law in Kentucky, KRS 454.040, as interpreted by court decisions, allows the jury to apportion damages among joint tortfeasors; however, there remains a question to what extent apportionment applies to third party defendants and settling parties. The Task Force believes it would be well to mandate apportionment, thereby assuring consistency in the future. The language in draft #1 requires juries be instructed to determine "a percentage of fault to each claimant, defendant, third party defendant" and defendants settling out of court and then determine each party's "equitable share... in accordance with the respective percentages of fault."

Issue #2: Section 54 of the Kentucky Constitution (Bill Draft #2, Page 79)

The awarding of non-economic damages in personal injury cases (including such things as pain and suffering, inconvenience, mental anguish, emotional distress, loss of society and companionship, loss of consortium, injury to reputation, humiliation, and destruction of the parent-child relationship), it is argued, has created jury awards that go beyond "fair compensation". Many states have enacted statutory limits or caps on non-economic damages.

The Task Force was urged to recommend amending Section 54 to permit the General Assembly to "limit the amount to be recovered for non-economic loss, punitive damages and all other non-pecuniary damage arising from injuries resulting in death or from injuries to person or property". Similar legislation was considered this summer by the Legislative Research Commission's Constitutional Revision Committee. The Commission ranked it fifth among the sections that should be amended. Section 54 now provides "the General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death or for injuries to person or property". Kentucky is one of only five states which have a provision in their Constitution similar to Section 54.

The Task Force chose instead to recommend repeal of Section 54. In reaching this conclusion, different factors influenced different members of the Task Force. Those factors are: (1) Section 54 prohibits jury awards being limited ; (2) it impedes innovative approaches to social problem solving; and (3) it limits the power of the General Assembly to counter-balance judicial decisions with statements of public policy through legislative enactments.

Issue #3: Punitive Damages

(Bill Draft #3, Page 80)

When wrongful conduct is more than mere negligence--a deliberate or malicious act--an individual may be liable for punitive damages. Punitive damages are a means of punishing conduct in a civil action with a monetary award designed to deter such conduct in the future. In most instances, punitive damages, when awarded, significantly increase the amount of the award over and above compensatory damages. Although the Task Force found no evidence of a dramatic increase in the number or amount of punitive damage awards in Kentucky, it is argued that punitive damages are an unfair windfall to a plaintiff, attorneys seek punitive damages to increase their fees and to coerce a larger settlement from the defendant, and demands for punitive damages are used to get additional evidence before a jury in an attempt to prejudice them toward the defendant.

The Task Force considered and rejected: abolishing punitive damages; prohibiting insurability of punitive damages and requiring punitive damage coverage be added to rather than included in insurance policies (and priced separately); and mandating that punitive damages be awarded to the benefit of the Commonwealth rather than the individual.

The Task Force recommends more definite standards of conduct under which punitive damages may be awarded. In suits

for punitive damages, the standard of evidence shall be "clear and convincing" rather than a "preponderance of evidence"; and the conduct must be "oppressive, fraudulent or malicious".

Issue #4: Frivolous Lawsuits / Certificate of Merit

(Recommended Rule Change #4, Page 83)

There was considerable discussion concerning frivolous suits and what might be recommended to discourage nonmeritorious claims. Proliferation of frivolous claims exacerbates the problems of affordability and availability of liability insurance, as well as destroying the integrity of our civil justice system.

The Supreme Court of Kentucky has adopted Civil Rule 11, which requires an attorney to sign pleadings and motions certifying "to the best of his knowledge...and belief...the motion or pleading is grounded in fact and warranted by existing law...and that if it is interposed for any improper purpose, such as to harass or cause unnecessary delay or needless increase in the cost of litigation" the court may impose "appropriate sanction," which may include "reasonable expenses incurred..." and "a reasonable attorney's fee". Rule 11 allows defendants named in a frivolous suit to recoup their defense costs.

The Task Force supports the use of sanctions as provided for in Rule 11 and strongly urges the judiciary to invoke the rule in appropriate cases; however, Rule 11 should not be used to stifle "good faith argument for the extension, modification or reversal of existing law."

It was also brought to the attention of the Task Force that allegations of Rule 11 violations are becoming increasingly common in an attempt to intimidate opposing counsel. The Task Force believes use of Rule 11 in this manner is counterproductive to its purpose.

As an enhancement to the purpose of Rule 11, the Task Force urges the Supreme Court to adopt a provision providing for a "certificate of merit". Within 90 days of filing a lawsuit, the plaintiffs' attorney would file with the court a certificate saying he believes the case to have merit and that he has an expert witness who will testify in support of the allegations, if needed. The attorney for the defense must also file a similar certificate. Failure to file the certificates by either party could be grounds for the court to dismiss the complaint or counterclaim. The Task Force believes the certificate of merit can be a valuable tool in helping to weed out frivolous suits, because it should require attorneys to consult with other professionals to determine whether the cause of action has merit.

Issue #5: Offer of Judgment

(Recommended Rule Change #5, Page 85)

All reasonable efforts should be made to encourage fair, equitable and prompt settlement of claims involved in litigation. To this end, the Task Force recommends to the Supreme Court of Kentucky that Civil Rule 68 be amended so as to give greater incentives for its proper use.

By directing that all costs, including attorney fees, are to be awarded against the party who fails to accept a reasonable offer of settlement, we hope that plaintiffs and defendants alike will avail themselves of the opportunity to evaluate the case and move expeditiously toward resolution before the parties incur substantial expenses often associated with litigation.

Issue #6: Collateral Source Rule

(Bill Draft #6, Page 87)

Under the collateral source rule, juries cannot be informed of any other sources of compensation for the injuries or damages the plaintiff may have suffered, such as government disability payments, health and disability insurance benefits.

There is concern that if juries are not told about these other sources of compensation, plaintiffs "double up", thus adding to the cost of insurance. Others felt plaintiffs should be entitled to the benefit of these sources without deduction. The Task Force has recommended, with the exception of life insurance, that juries be informed of each collateral source, its right of subrogation, and the cost of the premiums for that collateral source. Additionally, a plaintiff is required to notify all entities known to have subrogation rights that an action has been filed. If the party with subrogation rights fails to intervene, it loses its subrogation rights.

Issue #7: Discoverability of Insurance

It is common practice for plaintiffs to demand payment for the full amount of a defendant's insurance policy. The existence, content, and amount of coverage of an insurance policy which may be liable for a judgment is discoverable but not admissible under Civil Rule 26.02. The plaintiff can find out how much insurance a defendant has but that information cannot be shared with the jury. Because of the influence an insurance policy's monetary limits have on the dollar amount of relief sought for damages, the Task Force considered legislation which would have prohibited the discoverability of insurance. However, the Task Force rejected the idea in the belief that sharing of the information with both parties encouraged settlement.

Issue #8: Remittitur and Additur

(Recommended Rule Change #8, Page 88)

An alternative to statutory limits on the amount of awards is the use by the courts of the power to raise or lower damage awards that by reasonable standards would appear to be excessive or inadequate.

Presently in Kentucky, under Civil Rule 59.01, the Court may grant a new trial if it finds that the damages awarded were either "excessive or inadequate..., appearing to have been given under the influence of passion or prejudice or in disregard of the evidence or the instructions of the Court."

The Task Force believes that the trial court should have the authority, upon motion by either party, to review an award and to lower or raise it if it believes that the amounts are excessive or inadequate. If the affected party disagrees with the order of remittitur or additur, then the matter can be tried again. The Task Force recommends to the Supreme Court, for its consideration, the rule change language as contained in Rule Change #8 with regard to remittitur and additur.

Issue #9: Structured Settlements

(Bill Draft #9, Page 90)

In personal injury cases involving permanent disability, a plaintiff may receive an award to compensate for future medical expenses, pain and suffering and lost income. In many instances these awards are paid in a lump sum. The argument is made that some plaintiffs cannot adequately manage large sums and find themselves in a few years with nothing, needing to turn to public assistance.

Structured settlements may in some cases ease the financial burden of the defendant. The cost of purchasing a structured settlement, which provides compensation to the plaintiff in the future, may be cheaper for the defendant.

Structured settlements are permitted in Kentucky but not mandated. An attorney can suggest to his client that the award be invested to provide regular future payments.

The Task Force recommends that structured settlements be ordered by the Court, subject to good cause being shown by any party, when the amount of the award for loss of future wages, pain and suffering, and medical expense exceeds ten times the state's average annual wage.

Issue #10: Limits on Attorney's fees

One of the "tort reform" recommendations is the adoption of a fee schedule to limit attorney contingency fees, by reducing the percentage in proportion to the dollar amount of the total award. Some contend that contingency fees are the only basis upon which injured parties, without financial resources, can acquire the service of an attorney to present their case.

The Task Force feels attorney's fees are best regulated by the Court, if at all; and the amount of an attorney's fee should be protected by the right of an individual to contract with an attorney. The Task Force, therefore, makes no recommendation with regard to attorney's fees.

Issue #11: Alternate Dispute Resolution

The Task Force heard testimony that the civil justice system is subject to abuse by participants on both sides and because of high transactional costs is an inefficient means of compensating injured parties. The Task Force sought testimony on alternatives to the civil justice system for the resolution of disputes. ADR's, or Alternate Dispute Resolutions as they are called, involve any means for resolving disputes other than the full-blown judicial process, including court annexed arbitration, mediation, summary jury trials and mini-trials. The Task Force found several ADR's to be available in Kentucky. Commercial Dispute Resolution, Inc., a non-profit corporation sponsored by the Louisville Chamber of Commerce and several area law firms, offers business an alternative to the civil litigation process for resolving commercial disputes. The process involves use of the mini-trial. The idea is to have the parties involved look at the dispute with a neutral advisor prior to involving the court. If the parties cannot agree, they can walk away and still have the matter litigated. They can also agree to bind themselves to arbitration under KRS 417.120. The Louisville Chamber is the first chamber in the country to offer an ADR service. The Task Force believes the Louisville Chamber of Commerce should be recognized and complimented for providing this service. The Task Force

encourages its use by the Louisville business community as an alternative to the potentially lengthy and costly settlement of difference through the courts.

In 1984, Kentucky adopted the Uniform Arbitration Act to provide a voluntary means of settling disputes outside the regular system. The Act, however, is not applicable to disputes between employers and employees or insurance contracts nor does it appear suitable for personal injury cases. Several other states have utilized mandatory arbitration to help clear a backlog of cases. Our Chief Justice and several legislators have examined the mandatory arbitration systems used in other states, and concluded that while some sort of ADR might help to improve the efficiency of the litigation process, the case load in Kentucky at lower court levels did not warrant mandatory arbitration.

Several years ago, the Supreme Court undertook an Economical Litigation Project which seeks to streamline the system through limitations of the pretrial discovery process. The Court is also in the process of adopting time standards for the hearing of cases. Settlement conferences and special appeals panels have also been used to help reduce the case load before the Court of Appeals. The Task Force supports these and other efforts by the Court to make the civil justice system work more efficiently in Kentucky. It also encourages Kentuckians to seek alternative means to settle their legal disputes, not only for the potential saving of time and money

to them, but also for the relief it would provide to Kentucky's courts so that those disputes which can only be resolved in court are given a fair and thorough hearing.

Issue #12: A Patients' Compensation Plan

(Bill Draft #12, Page 91)

Physicians were joined by many other groups in feeling the impact of this liability insurance crisis. At the peak of the last insurance pricing cycle, around 1975, physicians were fighting another medical malpractice insurance crisis.

Rising cost of medical malpractice insurance continues to be a problem, as is evidenced by the dramatic premium increases doctors experienced with the recent insurance pricing cycle. Some have alleged the heart of the problem is the cost of the civil justice system as a means of compensating victims of malpractice.

Mr. Carl Wedekind, a member of this Task Force, is President of the Kentucky Medical Insurance Corporation, a doctor-owned insurance company providing medical malpractice insurance for approximately half the doctors in Kentucky. He testified before the Task Force that out of every dollar paid out by KMIC in 1986, 62¢ went for court costs and attorney's fees and 38¢ ended up in the hands of the claimant. He and others have expressed the opinion the tort system has become so lengthy, expensive and uncertain that it is in the interest of both patients and health care professionals to investigate alternative systems for determining medical malpractice disputes.

Mr. Wedekind has proposed the creation of a Patients' Compensation Plan which would compensate those who are injured

in the health care system. Utilizing a system similar to worker's compensation, the Patients' Compensation Plan would pay injured parties, regardless of fault, for lost wages and medical expenses as determined by an impartial board assisted by medical specialists. It would not pay for injuries that are the result of risks that are inherent to a particular medical procedure and would require proof of negligence only where injury results in death. Such a plan could reduce the cost of medical malpractice insurance, increase the availability of insurance, and provide fairer compensation to injured parties.

Some questioned the appropriateness of a radical change from our present system; others were concerned the benefits were inadequate to compensate a seriously injured individual. However, it was the majority view that the medical malpractice situation is out of hand, with the costs having a deleterious effect on health care delivery. The Task Force endorsed the no-fault Patients' Compensation Plan as a possible solution to an extremely serious problem.

Issue #13: Statute of Limitation for Minors

Under current law in Kentucky, individuals have one year from the date of occurrence to initiate a suit for personal injury. Minors have one year from the date they reach the age of majority (18 years) in which to file a suit. Minors are treated differently under the theory that, until the age of majority, they are not capable of making a knowledgeable decision concerning whether someone may be responsible for their injury.

This expanded statute of limitation for personal injury involving minors is of particular concern to certain of our doctors. While in most cases the period of exposure to suit for malpractice is one year from the date of injury and no more than five years if the injury is not discovered immediately, with medical treatment of a minor, the period of exposure to a lawsuit is over 18 years. This lengthened period of exposure to lawsuits is reflected in the cost of medical malpractice insurance for doctors, with obstetricians paying the second highest rate of medical malpractice premiums, second only to neurosurgeons.

In addition, 28% of the obstetricians in Kentucky have stopped their obstetrics practice in the past eight years, and one half of these in the past year and a half. The average cost of liability insurance exceeded $260 per child delivery;

and in many communities doctors in general practice are ceasing the practice of obstetrics altogether.

Although the Task Force was very concerned with the effect rising medical malpractice insurance costs have on the availability of obstetric care in some areas of Kentucky, a recommended reduction in the statute of limitation for personal injury involving a minor was rejected in the belief it would unfairly penalize children in those rare cases where they are injured and their parent or guardian does not pursue the cause of action on their behalf.

Issue #14: Statutes of Limitation -- Property Damage

(Bill Draft #14, Page 143)

Under current law, a party who has suffered damages to his property has five years from the date of the occurrence to file a suit to recover compensation for the damages. The Task Force felt that five years was longer than necessary to allow for the filing of a suit. The argument for reducing the statutes of limitation is to encourage bringing of actions within a reasonable period of time of the occurrence while the particulars of the incident are still fresh in the minds of the parties involved and evidence of the incident is still intact. The Task Force considered making both the statutes of limitation for property damage and personal injury two years; however, increasing the statute on personal injuries would double the exposure period for suits to be brought, wreak havoc with an actuarial system based on a one-year statute, and result in an increase in medical practice and other liability insurance premiums. The Task Force's recommendation urges the statute of limitation for property damage be reduced from five years to two years.

Issue #15: Standards of Conduct for Officers and Directors of For-Profit Corporations (Bill Draft #15, Page 146)

The impact of the liability insurance crisis has been felt in many diverse sectors of the Commonwealth.

The Task Force heard testimony that Kentucky's corporations were becoming increasingly concerned about the personal liability of their officers and directors for actions they may take in their official capacity. Premiums for directors and officers liability insurance have increased and coverage has been reduced. Some smaller corporations faced the dilemma of whether they could afford directors and officers insurance. In what is perceived to be an atmosphere created by recent case law of increased uncertainty over the personal liability of directors and officers, companies without directors and officers coverage are finding it difficult to recruit and retain qualified directors. It is tough enough to find good people to serve on boards without asking them to put their personal assets at risk in order to serve.

While reviewing the issue, the Task Force discovered that a committee of the Kentucky Bar Association had undertaken a study of Kentucky's corporate statutes. Examination of the statutory basis for liability of corporate officers and directors was a part of their review. The report of the

Committee, which has been endorsed by the Kentucky Bar's Board of Governors, sets out the duties of officers and directors and provides monetary damages may be awarded upon "clear and convincing" evidence that the conduct was "willful, wanton or reckless disregard" for the interest of the corporation or its shareholders. Additionally, the KBA report urges the adoption of a "Delaware provision," which allows corporations, through shareholder action, to amend the articles of incorporation to assume greater responsibility for the liability of their directors.

The Task Force believes the adoption of these standards of conduct for officers and directors will help encourage service on corporate boards and, with the "Delaware provision", enhance the image of Kentucky as a good place in which to do business.

Issue #16: Standards of Conduct for Officers, Directors, and Volunteers of Non-profit Corporations and Charitable Organizations

(Bill Draft #16a, Page 153)
(Bill Draft #16b, Page 160)

Like business corporations, non-profit and charitable organizations also feel the impact of the liability insurance crisis. The Task Force heard testimony from United Way of Kentucky, the Kentucky Council of Churches, the Catholic Conference of Kentucky and others, that they and their affiliated organizations had experienced dramatic increases in the cost of their liability insurance, both general liability and for directors and officers. Because these organizations depend upon contributions and donations for their operating expenses, any increase in administrative costs, such as liability insurance, reduced the funds available for programs. Non-profit corporations which could not afford insurance coverage for their directors and officers found it increasingly difficult to recruit and retain qualified individuals to serve on the boards.

The increasing uncertainty about personal liability of individuals doing volunteer work for community service agencies has caused some organizations to experience great difficulty in recruiting volunteers to help in their programs. The Task

Force was urged to find legislative solutions to provide relief, including grants of immunity for officers, directors and volunteers of charitable groups. The Task Force believes Section 54 of the Kentucky Constitution prohibits the General Assembly from granting immunity to any organization or individual .

First, the Task Force recommends the adoption of language almost identical to the provisions adopted by the Kentucky Bar Association regarding the conduct of officers and directors of for-profit corporations amended to apply to non-profit corporations organized under KRS 273.405 to 273.453. Adoption of these provisions would define standards of conduct for which officers and directors could not be held personally liable.

Second, the Task Force recommends the adoption of language which provides that volunteers for non-profit organizations as defined under 501(c) of the Internal Revenue Code should not be held personally liable unless the conduct falls substantially below standards generally practiced by persons performing similar duties. The organization itself, however, could be held liable for damages or injury resulting from negligent acts. With this approach the Task Force believes it is not recommending limitations on liability or awards but is undertaking to define liability and establishing which parties should be responsible for negligent acts attributable to the organization.

Issue #17: Sovereign Immunity / Insurance for Governmental Entities and Employees

In 1986 the Secretary of Human Resources created a Liability Insurance Advisory Committee to examine the problems of availability and affordability of liability insurance for employees of the Cabinet for Human Resources. While it is assumed that employees of the Commonwealth are protected by the state's sovereign immunity when they act within the course and scope of their duties and under the direction of state law or policy, there is some concern that the purchase of liability insurance by the employee or the Commonwealth on behalf of the employee may constitute a waiver of the protection of sovereign immunity. Such concern may not be without some foundation.

The Task Force concurs with the provisions of KRS 44.073 (14) and believes that the purchase of liability insurance by the Commonwealth, for its employees or by an employee, whether to cover his activities as an employee or related activities outside his state employment, should not constitute a waiver of the protection available under the doctrine of sovereign immunity, as long as they are within the scope of their duties and under the direction of state law or policy.

Issue #18: Municipal Tort Claims Act
Section 231 of the Kentucky Constitution
(Bill Draft #18, Page 162)

The Task Force believes the Kentucky General Assembly should enact a "Municipal Tort Claims Act" which, at a minimum, would contain the following elements:

A. The Act should apply to all state court actions in tort brought against any city.

B. The Act should limit the damages recoverable against a city to the amount of damages determined to have been caused by the city.

C. The Act should broadly define "legislative, quasi-legislative, judicial and quasi-judicial functions" and exempt cities from liability in performance or failure to perform these types of functions.

D. The Act should authorize periodic payments of large judgments which are not covered by liability or property insurance.

E. The Act should provide for the defense and indemnification of city officials and employees acting in good faith within the scope of their employment.

F. The Act should allow cities to utilize taxes free of existing statutory limitations when necessary to pay large tort judgments.

The Task Force believes that Section 231 of the Kentucky Constitution should be amended to read as follows: "The General Assembly may, by law, direct in what manner, to what extent and in what courts or other tribunals, suits may be brought against the Commonwealth, its counties, cities and other governmental units." This would grant to cities the same sovereign immunity now enjoyed by counties and state government.

ISSUE STATEMENTS

INSURANCE REGULATION

Issue #19: Creation of a Mechanism to Assure Availability

(Bill Draft #19, Page 169)

At the height of the recent liability insurance crisis, insurance was unavailable for some at any price. While some competition appears to have returned to the market, making insurance generally available for most lines, at a price, the Task Force believes the dynamics of the insurance market may again cause us to find ourselves in a situation where insurance for some risks would be extremely difficult, if not impossible, to obtain. In anticipation of such a market situation, the Task Force recommends amending the Kentucky FAIR plan (fair access to insurance requirements) to expand its authority for casualty and liability insurance. The Kentucky FAIR plan currently operates as source of last resort for homeowners and other property insurance. All insurers licensed to write property and casualty insurance in Kentucky participate in the current plan and pay assessments to the plan based upon a percentage of premiums voluntarily written in Kentucky. The amendments proposed by the Task Force would allow the Commissioner of Insurance, if reasonable competition did not exist in the market for certain lines of insurance, to amend the plan to provide insurance for those lines. An assessment of the participants of up to 1/4 of 1% of premiums written would

fund the program. The expanded FAIR plan could immediately go into operation should market conditions occur again that would warrant it.

Issue #20: Self Insurance / Local Government Insurance / Fictitious Group Statute

(Bill Draft #20a, Page 176)

(Bill Draft #20b, Page 178)

During the insurance crisis individuals with certain types of risks experienced particular difficulty in obtaining regular commercial insurance, especially at what they considered to be reasonable rates. Kentucky's cities are a prime example of a type of risk that experienced extreme difficulty. Environmental hazards continue to experience difficulty in obtaining coverage. In the effort to find insurance at reasonable rates, some groups sought to self-insure as a group. In 1981, Congress adopted the "Risk Retention Act," allowing greater flexibility for groups to be formed for the purpose of self-insurance. In 1986 the General Assembly adopted Senate Bill 294, exempting "members of a bona fide association who join together to self insure against professional liability or public liability risks for bodily injury or property damage" from many of the regulatory requirements applicable to regular commercial insurers.

Much of the emphasis of government regulation of insurers is to determine financial integrity. While the Task Force believes that many traditional barriers should be

lowered, allowing more opportunities for groups to self-insure, as an alternative in tight market situations, it also believes that self insurance groups would be well served to observe many of the regulatory requirements commercial insurers must meet. The Task Force recommends clarifying the authority by which local governments can procure insurance, including the use of revenue bonds. The Task Force further recommends repeal of the "Fictitious Group Statute", KRS 304.12-210. The fictitious group statute, in effect, prohibits groups that are not under common ownership or management from purchasing property, marine or casualty insurance. In urging its repeal, the Task Force believes, particularly in today's volatile commercial market, that individuals should be able to band together for the purpose of purchasing insurance, as well as self-insuring.

Issue #21: Extended Notification for Cancellation and Non-renewal of Insurance (Bill Draft #21, Page 180)

Current Kentucky law requires at least twenty (20) days notice by the insurer of intent to cancel or not renew an automobile insurance policy and at least thirty (30) days notice of cancellation or non-renewal on homeowners or other types of property or casualty insurance. The Task Force believes these notification requirements are too short a period of time, particularly in tight insurance market situations where finding alternate sources of insurance may prove difficult. The Task Force recommends the current statutes be amended to require at least seventy (75) days notice of intent to cancel or not renew for property and casualty insurance.

Issue #22: Increased Reporting of Medical Malpractice and Confidentiality of Peer Review Records (Bill Draft #22, Page 192)

The Task Force heard testimony urging the adoption of legislation requiring increased reporting to appropriate state regulatory officials of incidents of medical malpractice. Such information would be of help to the agency charged with the responsibility of licensing and disciplining physicians, the state Board of Medical Licensure, and of benefit to the General Assembly and other agencies to determine whether there are patterns of high awards or increased suits with regard to medical malpractice claims. The current law, KRS 304.40-310, requires reporting of medical malpractice claims, settled or adjudicated, to the Commissioner of Insurance, who in turn is required to forward the information to "the appropriate licensure board or regulatory agency for review of the fitness of the health care provider to practice his profession". The information is being reported to the Department of Insurance, forwarded to the licensing boards, and is available in a form that does not identify individual practitioners to the public. Public Law 99-660, the Health Care Quality Improvement Act of 1986, requires insurers, health care facilities, professional societies and state medical licensure boards to report to the U.S. Secretary of Health and Human Services incidences of medical malpractice and malpractice payment. This federal

legislation is designed to help identify health care practitioners found guilty of medical malpractice in one state who flee to another state to avoid identity with their past actions. Between the state and federal malpractice reporting requirements, as well as the peer review programs, the Task Force believes that current law requires sufficient reporting of medical malpractice information.

Legislation enacted by the General Assembly authorized the Board of Medical Licensure, for the purpose of disciplinary actions, to require hospitals to produce records of physician peer review. Prior to the adoption of this Act, peer review records were held to be confidential and protected from discovery or introduction in any civil act or administrative proceeding. The sharing of this information with the Medical Licensure Board raises the question of its confidentiality and the liability of individuals making statements about the health care practitioner in the peer review process. The Kentucky Medical Association and Kentucky Hospital Association jointly propose amendments to KRS 311.377 to clarify these questions of confidentiality and liability of individuals participating in the peer review process. The Task Force endorses these amendments.

Issue #23: Triggered Filing Approach

(Bill Draft #23a, Page 198)

Flex Rating

(Bill Draft #23b, Page 200)

In the context of its regulation of insurance rates, Kentucky is an open competition state; i.e., insurers may charge whatever rate they wish or whatever rate the market will bear. The law requires the rates charged to be filed with the Department of Insurance. Kentucky became an "open competition" state in 1982. Before its enactment, Kentucky was a prior approval state; ie., rates were filed with the Department of Insurance and approved by the Commissioner before they could be charged. Under "prior approval" rate regulation, the Commissioner reviewed rates to determine whether they were "excessive" or "inadequate". Rates were "inadequate" if they failed to generate sufficient premium to permit the insurers to set aside adequate reserves to cover potential claims. Rates were excessive if they generated more than a "reasonable" profit for the insurer. It should be noted that, historically, state regulation of insurance rates has emphasized the question of making sure that insurance companies were financially solvent to pay claims. Government regulation to assure a "fair" or "reasonable" rate is a relatively recent emphasis.

There are four basic approaches by which states regulate or review insurance rates: (1) Prior approval; (2) Open competition; (3)rate bureaus or state set rates, with insurers being required to justify to the state regulatory agency any deviation from state set rates; and (4) "flex rating", a mix of "open competition" and "prior approval", where the state sets a ceiling and floor within which open competition without prior approval may occur. Insurance rates which exceed a certain percentage or drop below that same percentage of the previous year's rate must be justified under a prior approval system to the Commissioner of Insurance. Rates which stay within the corridor may be charged without prior approval by the Commissioner.

The proponents of an "open competition" system argue that the forces of the marketplace will ultimately result in a cheaper product for the consumer. Less government regulation or intervention in the marketplace makes it easier for companies to enter the market and compete for customers. The argument against "open competition" is that it allows wild swings in insurance pricing to occur and places no restraint on the insurance industry to protect insurance consumers.

There is general agreement on all sides of the liability insurance debate that insurers kept insurance premium prices unrealistically low because profits were coming in from interest income on reserves. When interest rates dropped, insurers suddenly sought to recover losses from premiums, causing rapid increases in price.

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Gil McCarty, Commissioner of Insurance, has proposed a "Triggered Filing" system of property and casualty insurance rate regulation. Under "triggered filing" the information on rates and the finances of each company by line of insurance would be examined to determine whether rates are "excessive" or "inadequate". If the Department sees activity beyond the limits set for those lines of insurance, the company would be required to justify its rates to the Department.

The firm of Tillinghast, Nelson and Warren, Inc. assisted in preparing this proposal; it stated that "the triggered filing approach is not designed to address specifically questions of availability and affordability of insurance. However, to the extent the triggered filing approach is successful in 'dampening' the property and casualty insurance industry's pricing cycle, insurance costs to the public should be more stable and periodic availability and affordability problems should ease."

The Task Force believes the program may be an important step in helping to quantify the longstanding regulatory criteria of whether insurance rates are excessive or inadequate.

There was equal support on the Task Force for establishing a flex rating system in lieu of the Triggered Filing Approach. Under such a system, rates could not increase or decrease by more than 25% without filing the rates and getting prior approval from the commissioner. This system

utilizes only current information on file with the commissioner and does not depend upon prior years' experience, as is required by the triggered filing approach.

The Task Force believes that both the flex rating systems and the triggered filing approach are worthy of consideration and either would limit questionable rate changes.

Issue #24: Kentucky Claims Experience

(Bill Draft #24, Page 204)

There has been considerable discussion whether Kentuckians pay for the "sins" of other states when we purchase insurance. In that insurance is the spreading of risk, do Kentuckians pay for the higher jury awards and greater number of lawsuits occurring in states like New York, California and Florida, even though we don't sue each other as much as they do? The Task Force found this to be a double-edged sword. We want to price our insurance on Kentucky experience--when the price benefits Kentuckians--but want the benefit of risk spreading when it doesn't. As an extreme example, assume that there are only five haulers of nitroglycerin insured in Kentucky. If one hauler's conduct resulted in $5 million damages, and rates were based solely on Kentucky's experience, the remaining four haulers would have to pay premiums that reflect the $5 million damage award. The Task Force rejected proposals which would have required the use of the Kentucky experience for insurance rate making purposes. Instead, we recommend insurers be required to annually provide to the Commissioner of Insurance information which would identify to what extent Kentucky's experience is being used in determining the rates charged in Kentucky. With this information, the Commissioner and the General Assembly can determine to what extent we are truly paying for the "sins" of others and can take appropriate action, if necessary.

Issue #25: Consent to Rate and Coverage

Since 1980, Kentucky has been an "open competition" state. A company charges whatever rate it chooses but is required to file with the Department of Insurance the rates charged. It is possible, however, to purchase insurance at a different rate and coverage from that filed with the Department. Under 806 KAR 13:020, an insurer and an applicant for insurance may agree to a rate in excess of that filed with the Department. A "consent to rate" form is required, which provides information including limited coverage, premium charged, and a disclosure that the rate exceeds the filed rate. The Task Force was concerned that insurance consumers are not always aware they are purchasing insurance at a higher rate or with more restrictive coverage than other consumers. This is a particular problem in tight market situations, when some consumers feel compelled to accept anything offered. In order that consumers of insurance might be more fully informed, the Task Force urges the Commissioner of Insurance to amend 806 KAR 13:020 to require the agent to sign the "consent to rate" form with the insured and sign an affidavit that he has thoroughly explained the restrictions of the policy to the purchaser.

Issue #26 Closed Claim Information

(Bill Draft #26, Page 205)

The debate concerning the causes of the liability insurance crisis is two-pronged: (1) there are those who say there is rampant abuse of the civil justice system, we sue each other too much, jury awards have become excessive and the system itself extracts an inordinate cost as a means of compensating injured parties; (2) others say insurance companies are to blame, they have made poor management decisions, and are now trying to recoup losses with exorbitant increases in premiums while blaming the civil justice system for their problems. With the exception of a closed claim survey conducted by the Kentucky Medical Insurance Corporation, based upon the claims experience of roughly half the doctors in Kentucky, the Task Force heard little evidence to substantiate many of these claims.

The Task Force believes state government should be gathering information on insurance claims and civil litigation so we can determine now and for the future the extent and nature of any problem. The Administrative Office of the Courts gathers information concerning case loads of the various courts; however, that information lacks the specificity needed to determine if we are experiencing a "litigation explosion" or if the insurance companies are incurring increased payouts.

The Task Force recommends that the insurance industry provide information similar to that required in Texas. The Commissioner of Insurance would annually compile the information and submit a report to the Governor and General Assembly. These additional reporting requirements should not place an unreasonable burden on insurance companies. Insurers already compile most of the information and report it to the Department of Insurance in their annual statements. Additionally, our study would gather information in the normal course of business rather than requiring a past review of cases.

Issue #27: Insurance Policy Simplification

(Bill Draft #27, Page 208)

Kentucky currently has no statutory standard for the way policies are to be written. Many people do not fully understand the coverage provided by their insurance policy and rely on their insurance agent for information about the extent of coverage or exclusions in a particular policy. There should be uniform standards required for insurance policies to help the consumer. The Task Force recommends bill draft #27, which authorizes the Commissioner of Insurance, by regulation, to set standards regarding the readability and intelligibility of insurance policies.

Issue #28: Surplus Lines Policies

(Bill Draft #28, Page 213)

Some risks occurring in Kentucky are insurable only through surplus lines. Surplus lines are insurers not licensed in Kentucky, therefore not subject to the regulatory authority of the Department of Insurance, but are licensed in at least one state. Surplus lines policies are sold through surplus lines brokers who are licensed in Kentucky. Whether a particular risk is insurable through surplus lines or conventional insurers often depends upon the market. Daycare centers in Kentucky during the recent crisis found themselves having to insure through surplus lines when their regular insurers declined to renew their policies. Because surplus lines are not licensed in Kentucky, they are not required to participate in the Kentucky Insurance Guaranty Association, which operates to protect insureds in Kentucky who may have claims against a company that becomes insolvent. Buyers of insurance in Kentucky should be made aware that insurance purchased through surplus lines does not carry with it the protection and benefits of the Insurance Guaranty Association; therefore, we recommend that surplus lines policies be required to so advise the purchaser, in bold print, on the face of the policy.

Issue #29 Insurance Settlement

(Bill Draft 29, Page 214)

When an individual purchases a policy of insurance, he is entitled to the benefits of that contractual obligation. Under current Kentucky law, an insurance company is not penalized for a failure to pay to its insured promptly the amount due him pursuant to the terms of his policy. Recently, the Supreme Court of Kentucky has removed "bad faith" as a claim which can properly be made against an insurance company by its insured; consequently, the Task Force felt it was appropriate to assist named insureds by requiring an insurer to settle claims against it within a reasonable time and in a reasonable manner. Failure to act accordingly can result in the company paying interest as well as attorney fees.

Issue #30: Unfair Claims Settlement Practices Act

(Bill Draft 30, Page 215)

In 1984, the General Assembly adopted an Unfair Claims Settlement Practices Act based upon model legislation. KRS 304.12-230 lists fourteen separate acts, any of which constitute an unfair claims settlement practice. If violations occur with "such frequency as to indicate a general business practice" the Commissioner of Insurance may, after a hearing, refuse to continue or may suspend or revoke an insurer's certificate of authority or may in lieu thereof fine a company up to $10,000, an agent, broker or solicitor up to $1,000 or an adjuster, administrator or consultant up to $2,000. The Task Force feels consumers of insurance should have the benefit of the Act, upon any violation, and therefore, recommends that KRS 304.12-230 be amended to allow the Commissioner to reprimand or fine a violator for a single violation of the Act.

Issue #31: Insurance Consumer's Advisory Council

(Bill Draft #31, Page 221)

The use of the police powers of the state to regulate the sale of insurance in Kentucky requires that it be done in a manner consistent with the common good of the people. It is the duty of the Commissioner of Insurance to regulate the sale of insurance in a manner to protect the interest of the buyers of insurance, and in this regard he can be considered a consumer advocate. Part of any Commissioner's concern is fairness to the industry so insurers will be induced to offer their product in Kentucky and consumers will have access to insurance. The balance a Commissioner must strike between these interests can be difficult. The Task Force has advocated the creation of an Insurance Consumer's Advisory Council to monitor the sale and pricing of insurance in Kentucky and recommend changes in the law to the Commissioner, the Governor and the General Assembly on behalf of the consumers of insurance. The Advisory Council might also review consumer complaints.

Issue #32: Municipal Insurance Premium Tax

The Municipal Insurance Premium tax should ultimately be altered or eliminated in order to help attract and encourage insurance providers to conduct business in Kentucky. The more insurers writing insurance in Kentucky, the more competition and a better, cheaper product for our citizens. Currently over 200 cities and urban county governments impose the tax on insurers at varying rates, ranging from 2% to 14%. Citing their authority under "Home Rule", four counties are currently collecting an "Insurance Premium Tax". Kentucky is only one of four states that allow cities to impose such a tax and the only state that requires quarterly rather than annual payments. Testimony before the Task Force indicated that compliance with the tax was a disincentive for insurers to do business in Kentucky. Most cities lack the capacity to audit insurers to assure proper collection. A standard rate among all cities, as well as annual rather than quarterly payments, would encourage compliance with the tax.

The Task Force recognizes that the Municipal Premium Tax currently plays an important role in providing sufficient revenue for the operation of Kentucky's cities; therefore, we see the need to broaden local government taxing authority before any significant changes in the Municipal Premium Tax, or even its elimination, would be possible.

Issue #33: Insurance Premium Surcharge
Fire Protection Improvement Fund
(Bill Draft #33, Page 223)

The Task Force examined taxes and other governmental receipts generated by the insurance industry in Kentucky.

Two reports from the Appropriations and Revenue staff relating to insurance taxes and surcharges are included in the appendix. Several issues emerged from these reports, including the existence of a challenge to Kentucky's different insurance premium tax rates for domestic and out-of-state companies, expanded use of the receipts from the insurance premium surcharge and problems with the municipal insurance premium tax.

Premiums collected by domestic life and domestic mutual insurance companies are exempt from the insurance premium tax. Kentucky is not alone among states treating domestic insurance companies differently from foreign companies. This discrimination in taxation has been challenged; the United States Supreme Court has ruled a similar tax levied in Alabama unconstitutional. Several out of state companies have now challenged Kentucky's insurance premium taxes as discriminatory. At issue is the possibility that all taxes collected from out of state insurers must be refunded (an amount which exceeded $21 million in 1985-86), and that we be required to impose the same taxes and rates on Kentucky's

domestic insurance companies or remove the taxes imposed on foreign insurers.

Since 1982 Kentucky has also imposed an insurance premium surcharge of $1.50 per $100 of premium. The surcharge came about as an alternative to the General Fund to provide annual salary supplements to local law enforcement officials completing certain training requirements. With the imposition of the surcharge, professional firefighters were also qualified for the salary supplements. Currently the insurance premium surcharge collects a significant amount in excess of the demands for salary supplements. Accumulating excess has caused additional groups in recent legislative sessions to seek inclusion in the training/salary supplement program. The excess funds were intended to accumulate a balance that at some point in time would allow the two funds--one for law enforcement and the other for professional firefighters--to become self-sufficient. As of July 1, 1987, the two funds had a combined balance amounting to $23,554,822. Under current levels of income and expenditure, with a 7.5 percent rate of return on investments, the funds would become self-sustaining by the close of the calendar year 1996, with an accumulated balance of $106 million.

The Task Force studied the problem certain geographic areas of the Commonwealth have in obtaining homeowners insurance. In testimony at Jenny Wiley State Park, we learned that the greatest factor in determining homeowners insurance

rates, and thus its affordability and availability, is the rating given certain territories by the "Fire Suppression Rating Schedule" administered by the Insurance Services Office. The Rating Schedule is designed to objectively measure different levels of public fire suppression capability. It considers such factors as effectiveness of state and local building and electrical codes, enforcement of fire prevention efforts, water supply, fire department capabilities and equipment and fire alarm operations. The designation of these territories on a scale of 1 to 10, good to bad, has a direct bearing on homeowners insurance rates. Many areas are disadvantaged because of lack of firefighting equipment, personnel, and available water supplies. These disadvantages result in higher insurance premiums and problems finding insurers who are willing to write the coverage.

Considering the difficulty many local governments are experiencing in finding sufficient revenues to fund essential services, the Task Force believes it would be a highly appropriate use of the excess funds generated by the insurance premium surcharge to assist local governments in upgrading their firefighting capabilities. The establishment of a "Fire Protection Improvement Fund" would provide grants to fire protection districts and local governments to improve fire protection and safety for the residents, such as the purchase of equipment or construction of water lines and other capital expenditures, which would upgrade the rating designated by the fire suppression rating schedule.

Issue #34: Increased Funding / Department of Insurance
(Bill Draft #34a, Page 237 -Carryover)
(Bill Draft #34b, Page 238 - Assessment)
(Bill Draft #34c, Page 240 - Insurance Fees by regulation)

Through fees, taxes, fines and penalties, the Department of Insurance generates revenues far in excess of the costs of the operation of the Department . The receipts over and above the amounts allocated to the Department are deposited in the General Fund. The insurance industry pays, collects or otherwise hands over to the General Fund approximately $62 million per year, based on FY 86-87.

Our recommendations require that increased regulatory responsibility be assumed by the Department, and we believe it is our responsibility to recommend a source of funds to cover the additional expenses.

The Task Force recommends that the Commissioner be allowed to assess insurers, based on a factor not to exceed .000235% of gross direct written premiums from Kentucky, as reported in insurers' annual statements for the immediate preceding calendar year. It is estimated that the maximum limits of the assessment would generate $1,000,000 in revenue available to the Department to carry out the responsibilities recommended for it by the Task Force.

Additionally, we have proposed that the Department of Insurance be allowed to carryover funds and be granted authority to set fees by regulation. These suggested changes will allow the Department to function in a manner in keeping with the great responsibility it has.

Issue #35: Repeal McCarran-Ferguson Act

The Task Force was urged to recommend the repeal of the McCarran-Ferguson Act. The McCarran-Ferguson Act, adopted in 1944, grants insurers a limited exemption from Federal anti-trust laws and gives to the states jurisdiction to regulate the sale of insurance. Proponents of repeal say insurance companies fixed prices and boycotted certain lines of insurance during the insurance crisis, and that they should be brought to task by making them accountable to the same anti-trust rules that apply to other business. They also argue that Federal regulation is necessary because most state regulatory agencies are "hopelessly overmatched" by the large national or even multinational insurance companies.

Opponents of repeal respond that it would not add to anti-trust regulation of the industry because the Act does not now apply to "boycott, coercion or intimidation" by insurers. They point with skepticism at the effectiveness of the Federal government in other regulatory roles, and cite the ability of state agencies to deal with the unique characteristics of each state.

The increased role of the National Association of Insurance Commissioners is providing necessary coordination of activities among the states. This will go a long way toward facilitating needed regulation. The Task Force does not recommend repeal of the McCarran-Ferguson Act.

Issue #36: Child Care Facility Liability Insurance

Child day care facilities in Kentucky have been hard-hit by the unavailability and excessive cost of commercial liability insurance. In addition, licensed family day care homecaring for small groups of children in the insured's private residence have encountered non-renewal problems with their homeowners policies. This problem has continued even though separate commercial liability policies have been purchased to cover the liability exposure for the day care operation.

The Task Force recommends that:

1. Any insurer that delivers a policy or contract of homeowners liability insurance in Kentucky shall not deny coverage solely on the basis that the insured is licensed to provide care for children under KRS 199.892 to KRS 199.896.
2. The ISO endorsement HO-322 (Ed. 10/85) should be included in policies written for insureds licensed to provide care for children under KRS 199.892 to KRS 199.896.
3. Homeowners policies carrying the ISO endorsement 322 and issued to insureds licensed to provide care for children under KRS 199.892 to KRS 199.896 shall not constitute liability coverage for losses arising out of the operation of the

child day care facility as defined in KRS 199.892 to KRS 199.896 shall not constitute liability coverage for losses arising out of the operation of the child day care facility as defined in KRS 199.892 to KRS 199.896.

A copy of ISO endorsement HO-322 is included for reference in the Appendix.

PROPOSED BILL DRAFTS

AND

RECOMMENDED RULE CHANGES

Bill Draft #1

APPORTIONMENT

SECTION 1. A NEW SECTION OF KRS CHAPTER _____ IS CREATED TO READ AS FOLLOWS:

(1) In actions involving fault of more than one party to the action, including third party defendants and persons who have been released under subsection (4) of this section, the court, unless otherwise agreed by all parties, shall instruct the jury to answer interrogatories or, if there is no jury, shall make findings indicating:

(a) The amount of damages each claimant would be entitled to recover if contributory fault is disregarded; and

(b) The percentage of the total fault of all the parties to each claim that is allocated to each claimant, defendant, third party defendant, and person who has been released from liability under subsection (4) of this section.

(2) In determining the percentages of fault, the trier of fact shall consider both the nature of the conduct of each party at fault and the extent of the causal relation between the conduct and the damages claimed.

(3) The court shall determine the award of damages to each claimant in accordance with the findings, subject to any reduction under subsection (4) of this section, and shall

determine and state in the judgment each party's equitable share of the obligation to each claimant in accordance with the respective percentages of fault.

(4) A release, covenant not to sue, or similar agreement entered into by a claimant, and a person liable discharges that person from all liability for contribution, but it does not discharge any other persons liable upon the same claim unless it so provides. However, the claim of the releasing person against other persons is reduced by the amount of the released persons equitable share of the obligation, determined in accordance with the provisions of this section.

Bill Draft #2

AMEND SECTION 54

AN ACT proposing an amendment to Section 54 of the Kentucky Constitution relating to restrictions on recovery for injury or death.

SECTION 1. IT IS PROPOSED THAT SECTION 54 OF THE KENTUCKY CONSTITUTION IS AMENDED AS FOLLOWS:

[***54. The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property.***]

SECTION 2. This amendment shall be submitted to the voters of the Commonwealth for their ratification or rejection at the time and in the manner provided for under Sections 256 and 257 of the Constitution and under KRS 118.415.

Bill Draft #3

PUNITIVE DAMAGES

SECTION 1. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

(1) As used in this Act, unless the context requires otherwise

(a) "Oppression" means conduct which is specifically intended by the defendant to subject the plaintiff to cruel and unjust hardship.

(b) "Fraud" means an intentional misrepresentation, deceit, or concealment of material fact known to the defendant and made with the intention of causing injury to the plaintiff.

(c) "Malice" means either conduct which is specifically intended by the defendant to cause tangible or intangible injury to the plaintiff or conduct that is carried out by the defendant both with a flagrant indifference to the rights of the plaintiff and with a subjective awareness that such conduct will result in human death or bodily harm.

(d) "Plaintiff" means any party claiming punitive damages.

(e) "Defendant" means any party against whom punitive damages are sought.

(f) "Punitive damages" includes exemplary damages and means damages, other than compensatory and nominal damages, awarded against a person to punish and to discourage him and others from similar conduct in the future.

(2) In any civil action where claims for punitive damages are included, the plaintiff shall have the burden of proving, by clear and convincing evidence, that the defendant acted towards the plaintiff with oppression, fraud, or malice.

(3) In no case shall punitive damages be assessed against a principal or employer for the act of an agent or employee unless such principal or employer authorized or ratified or should have anticipated the conduct in question.

(4) In no case shall punitive damages be awarded for breach of contract.

(5) This statute is applicable to all cases in which punitive damages are sought and supersedes any and all existing statutory or judicial law insofar as such law is inconsistent with the provisions of this statute.

SECTION 2. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

(1) In any civil action where claims for punitive damages are included, the jury or judge if jury trial has been waived, shall determine concurrently with all other issues presented, whether punitive damages may be assessed.

(2) If the trier of fact determines that punitive damages

should be awarded, the court shall then assess the sum of punitive damages. In determining the amount of punitive damages to be assessed, the court should consider the following factors:

(a) The likelihood at the relevant time that serious harm would arise from the defendant's misconduct;

(b) The degree of the defendant's awareness of that likelihood;

(c) The profitability of the misconduct to the defendant;

(d) The duration of the misconduct and any concealment of it by the defendant;

(e) Any actions by the defendant to remedy the misconduct once it became known to the defendant;

(f) The financial condition of the defendant and the effect of an award of punitive damages on the defendant and others who are or may be affected by such award;

(g) The total effect of other punishment imposed or likely to be imposed upon the defendant as a result of the misconduct, including punitive damage awards to persons similarly situated to the plaintiff and the severity of criminal penalties to which the defendant has been or may be subjected; and

(3) This statute is applicable to all cases in which punitive damages are sought.

Recommended Rule Change #4

CERTIFICATE OF MERIT

SECTION 1. A NEW RULE OF CIVIL PROCEDURE IS CREATED TO READ AS FOLLOWS:

(1) Within ninety (90) days of the filing of a lawsuit, the attorney for the plaintiff, if any, shall file a certificate of merit with the court and serve a copy on opposing counsel. The certificate shall state:

(a) The amount of money claimed due in the prayer of a complaint;

(b) That the attorney has investigated the case, believes it to have merit as to each defendant, and as to the amount of money claimed in the prayer of the complaint;

(c) That the attorney has an expert witness if needed who will testify in support of the allegations of the complaint.

(2) Within thirty (30) days of the filing of plaintiff's certificate of merit or ninety (90) days after filing the answer and counterclaim, which ever is later, the attorney for the defendant, if any, shall file a certificate of merit with the court and serve a copy upon opposing counsel. The certificate shall state:

(a) The amount of money claimed due in the prayer of the counterclaim, if any;

(b) That the attorney has investigated the case, believes that there is merit as to each defense, and as to the counterclaim and the amount of money claimed due in the prayer of the counterclaim, if any; and

(c) That the attorney has an expert witness if needed who will testify in support of the allegations of the defenses and the counterclaim.

(3) If certificates of merit are not filed when due, the court in its discretion may, on motion of the opposing party, impose any appropriate sanctions against the party or the attorney for that party as provided in Rule 11 and may dismiss the complaint or the counterclaim or strike any pleading.

(4) Filing of the certificate of merit as herein provided shall not affect or be affected by other rules of the Court or the time limits as provided in those rules.

Recommended Rule Change #5

OFFER OF JUDGMENT

Rule 68 with Amendment

(1) At any time more than 10 days before the trial begins, any [a] party [defending against a claim] may serve upon an [the] adverse party an offer of [to allow] judgment he will accept [to be taken against him] for [the] money or property, or to the effect specified in the [his] offer, with costs, less attorneys fees, then accrued. The offer may be conditioned upon the party's failure in his defense. If within 10 days after service of the offer the adverse party serves written notice that the offer is accepted, either party may then file the offer and notice of acceptance, together with the proof of service thereof, and there upon judgment shall be rendered accordingly, except when the offer is one conditioned upon failure in defense, in which case the judgment shall be rendered when the defense has failed.

(2) When the liability of one party to another has been determined by verdict or order of judgment, but the amount or extent of the liability remains to be determined by further proceedings, any [the] party [adjudged liable] may make an offer of judgment, which shall have

the same effect as an offer made before trial if it is served within a reasonable time not less than ten (10) days prior to the commencement of hearings to determine the amount or extent of liability.

(3) An offer not accepted shall be deemed withdrawn and evidence thereof is not admissible except in a proceeding to determine costs. [~~If the judgment finally obtained by the offeree is not more favorable than the offer, the offeree must pay the costs incurred after the making of the offer.~~] The fact that an offer is made but not accepted does not preclude a subsequent offer.

(4) If the final judgment obtained is equal to or more favorable than the offer, the offeree shall pay the costs incurred by the other party after the making of the offer. If the judgment obtained is less favorable than the offer, the offerer shall pay the costs incurred by the other party after the making of the offer.

(5) Costs are defined for the purpose of the Rule as costs of pleadings, depositions, motions or other papers, expert witnesses fees, and reasonable attorney fees.

Bill Draft #6

COLLATERAL SOURCES

SECTION 1. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

(1) This act applies to all actions for damages, whether in contract or tort, commenced after the effective date of this act.

(2) At the commencement of an action seeking to recover damages, it shall be the duty of the plaintiff or his attorney to notify, by certified mail, those parties believed by him to hold subrogation rights to any award received by the plaintiff as a result of the action. The notification shall state that a failure to assert subrogration rights by intervention, pursuant to Kentucky Civil Rule 24, will result in a loss of those rights with respect to any final award received by the plaintiff as a result of the action.

(3) The existence of a collateral source, except life insurance, the value of any premiums paid by or on behalf of the plaintiff for same, and known subrogation rights shall be an admissible fact in any civil trial.

(4) A certified list of the parties notified pursuant to section (2) shall also be filed with the clerk of the court at the commencement of the action.

Recommended Rule Change #8

REMITTITUR/ADDITUR

SECTION 1. A NEW RULE OF CIVIL PROCEDURE IS CREATED TO READ AS FOLLOWS:

(1) In any action to which this section applies wherein the trier of fact determines that liability exists on the part of the defendant and a verdict is rendered which awards money damages to the plaintiff, it shall be the responsibility of the court, upon proper motion, to review the amount of such award to determine if such amount is excessive or inadequate in light of the facts and circumstances which were presented to the trier of fact.

(2) If the court finds that the amount awarded is excessive or inadequate, it shall order a remittitur or additur, as the case may be, and advise the effected party that failure to accept the order of remittitur or additur will result in the granting of a properly made motion for a new trial.

(3) In determining whether an award is excessive or inadequate in light of the facts and circumstances presented to the trier of fact and in determining the amount, if any, that such award exceeds a reasonable range

of damages or is inadequate, the court shall consider the following criteria:

(a) Whether the amount awarded is indicative of prejudice, passion, or misconduct on the part of the trier of fact; or

(b) Whether it appears that the trier of fact ignored the evidence in reaching a verdict or misconceived the merits of the case relating to the amounts of damages recoverable; or

(c) Whether the trier of fact took improper elements of damages into account or arrived at the amount of damages by speculation and conjecture; and

(d) Whether the amount awarded bears a reasonable relation to the amount of damages proved and the injury suffered; and

(e) Whether the amount awarded is supported by the evidence and is such that it could be adduced in a logical manner by reasonable persons.

Bill Draft #9

STRUCTURED SETTLEMENTS

SECTION 1. A NEW SECTION OF KRS CHAPTER _____ IS CREATED TO READ TO FOLLOWS:

(1) For the purpose of this Act "structured settlement" shall mean an agreement, approved by the trial court, whereby a party found monetarily liable to another party liquidates that liability on an installment basis.

(2) In all civil actions commenced after the effective date of this Act wherein a portion of the award is for the loss of future wages, medical expenses or pain and suffering, the trial court shall mandate that such portion of the award be liquidated by a structured settlement if such portion meets or exceeds ten (10) times the average state annual wage. The structured settlement shall be subject to the approval of the court and must provide for prior payment of all costs, all attorney's fees, and adequate security for future payment of the structured settlement.

(3) Any party may, upon motion with good cause shown, request the judgement be satisfied in a manner other than a structured settlment.

Bill Draft #12

A PATIENTS' COMPENSATION PLAN

SECTION 1. KRS CHAPTER 311A IS ESTABLISHED AND A NEW SECTION THEREOF CREATED TO READ AS FOLLOWS:

As used in this Act unless the context otherwise requires:

(1) "Incident" means any harmful change in the human organism arising out of and in the course of undergoing health care treatment rendered, or which reasonably should have been rendered, but does not include any result which could reasonably be anticipated as an inherent risk of the health care treatment being received.

(2) "Health care treatment" means any treatment received or course of action followed at the direction of any health care professional or agent or employee of any health care institution for the purpose of health care.

(3) A "health care professional" is any person licensed to practice medicine, osteopathy, chiropractic, podiatry, dentistry, nursing, physician assistant, emergency medical service, midwifery, or any other form of treating or healing art in Kentucky that is now or may subsequently be authorized and licensed by Kentucky law.

(4) A "health care institution" is any entity licensed to provide hospital, nursing, physical therapy, emergency, outpatient, or other health related services that are now or may subsequently be authorized and licensed by Kentucky law.

(5) A "patient" is any individual receiving health care treatment from a health care professional or in a health care institution in Kentucky.

(6) "Inherent risks" are those ordinary risks reasonably apparent to the lay person, and those medical, technical and procedural risks determined by the health care professional or institution and communicated in writing to the patient or his representative prior to his treatment. Such inherent risks are those that exist and occur without a deviation from a reasonable standard of care. When, due to a medical emergency, there is neither time nor opportunity to communicate inherent risks to the patient or his representative prior to treatment, the nature of such inherent risk shall be as determined by the Advisory Board to the Patient's Compensation Board.

(7) "Death" will be considered an inherent risk in certain medical and surgical procedures as defined by the Board on the recommendation of the Advisory Board, and in all such instances, death benefits will be available under this Act only upon a showing by a preponderance of the evidence that death

SECTION 2. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Every health care professional and health care institution subject to this Act shall be liable for compensation for any incident resulting from health care treatment without regard to fault as a cause of the incident.

(2) If the incident occurs to the victim through the deliberate intentions of the health care professional or agent or employee of the health care institution to produce such incident, the victim or his dependents may receive compensation under the provisions of this Act, or in lieu thereof, have a cause of action at law against the health care professional or health care institution as if this Act had not been passed, for such damage so sustained by the victim, his dependents or personal representatives as is recoverable at law. If a suit is brought under this subsection, all rights to compensation under this Act shall thereby be waived as to all persons. If a claim is made for the payment of compensation or any other benefit provided by this Act, all rights to sue the health care professional or health care institution for damages on account of such incident shall be waived as to all persons.

was caused or brought about by a deviation of a reasonable standard of care by the health care professional or institution.

(8) "Disability" means a decrease of wage earning capacity due to injury or loss of ability to compete, to obtain the kind of work that the patient is customarily able to do, in the area where he lives, taking into consideration his age, occupation, education, effects upon the patient's general health of continuing in the kind of work he is customarily able to do, and impairment or disfigurement.

(9) "Income benefits" means the payment made under the provisions of this Act to the disabled patient or his dependents in case of death, excluding medical and related benefits.

(10) "Medical and related benefits" means payments made for medical, hospital, burial and other services as provided in this Act other than income benefits.

(11) "Compensation" means all payments made under the provisions of this Act representing the sum of income benefits and medical and related benefits.

(12) "Medical services" means medical, surgical, dental, hospital, nursing and medical rehabilitation services, medicines and fittings for artificial or prosthetic devises.

(13) "Beneficiary" means any person who is entitled to income benefits or medical and related benefits under this Act.

care professional or in a health care institution shall be subject to the provisions of this Act.

(3) Any person who would otherwise be covered but who elects in writing not to be covered in accordance with the rules and regulations promulgated by the Board shall be exempt from the coverage provided by this Act.

(4) Any person for whom a rule of liability for injury is provided by the laws of the United States shall be exempt from the coverage provided by this Act.

SECTION 4. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) If a health care professional or institution secures payment of compensation as required by this Act, the liability of such professional or institution under this Act shall be exclusive and in place of all other liability of such professional or institution to the patient, his legal representative , husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to recover damages from such professional or institution at law on account of such injury. The liability of such professional or institution to another person who may be liable for or who has paid damages on account of injury of a patient shall be limited to the amount of compensation and other benefits for which such professional or institution is liable under this Act on

(3) If the incident is caused in any degree by the intentional failure of the patient to comply with the reasonable health care treatment prescribed, the compensation for which the health care professional or institution would otherwise have been liable under this Act shall be decreased fifteen percent (15%) in the amount of payment.

(4) Where a claim is made for an incident arising out of health care treatment in which it is alleged that treatment reasonably should have been rendered, but was not, the Board may seek the advise and assistance of the Advisory Board in determining the question of whether the omitted treatment reasonably should have been rendered.

SECTION 3. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Any health care professional rendering treatment in the Commonwealth or any health care institution, including any agency of the state, county or city government or any public or quasi-public corporation or entity thereof, providing health care treatment in the Commonwealth shall be subject to the provisions of this Act.

(2) Except for persons seeking exemption under the provisions of subsection (3) every person, including a minor, who receives health care treatment from a health

account of such injury, unless the professional or institution by written contract have agreed to share liability in a different manner. The exemption from liability given such professional or institution by this section shall also extend to the professional's and institution's carrier and to all employees, officers or directors of such professional or institution or carrier, provided the exemptions from liability given an employee, officer or director or such professional or institution or carrier shall not apply in any case where the injury is proximately caused by the willful and unprovoked act of such employee, officer or director.

(2) If such professional or institution fails to secure payment of compensation as required by this Act, an injured patient, or his legal representative, may claim compensation under this Act and in addition, may maintain an action at law for damages on account of such injury, provided that the amount of compensation shall be credited against the amount received in such action, and provided that, if the amount of compensation is larger than the amount of damages received, the amount of damages less the patient's legal fees and expenses shall be credited against the amount of compensation. In such action the defendant may not plead as a defense that the patient

assumed the risk of his treatment, or that the injury was due to the contributory negligence of the patient .

(3) A professional or institution shall retain all common law defenses against any action by a patient who elects not to be covered as provided under Section 3.

SECTION 5. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Every health care professional or health care institution subject to this Act shall keep a record of all incidents occurring to patients in the course of their health care treatment. Within one week after the occurrence and knowledge as provided in Section 11, of such an incident to a patient, a report thereof shall be made in writing and mailed to the Board on forms procured from the Board for that purpose.

SECTION 6. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Where a health care professional or a health care institution is subject to this Act, then every patient of such professional or institution as a part of his contract for becoming a patient, or who may be a patient at the time of the acceptance of the provisions of this Act by such professional or institutional shall be deemed to have accepted all the provisions of this Act and shall be bound thereby unless he shall have filed prior to

the injury or incident, written notice to the contrary with such professional or institution. The Patients' Compensation Board shall not give effect to any rejection of this Act not voluntarily made by the patient. If a patient withdraws his rejection, the professional or institution shall notify the Patients' Compensation Board.

(2) Until notice of rejection is given to the professional or institution, the measure of liability of such professional or institution shall be determined according to the compensation provisions of this Act. Any such patient, may, without prejudice to any existing right or claim, withdraw his election to reject the compensation available under the provisions of this Act by filing with the professional or institution a written notice of withdrawal, stating the date when the withdrawal is to become effective. With the filing of such notice, the status of the party withdrawing shall become the same as if the former election to reject the compensation available under the provisions of this Act had not been made, except that withdrawals shall not be effective as to any injury sustained or incident occurring less than one (1) week after the notice is filed.

(3) When a patient enters the health care system under circumstances where he cannot reasonably exercise his right to elect not to come under the terms of this

Act, such right of election shall be continued for a period of ninety (90) days after such patient or his representative is able to reasonably exercise such election, regardless of the occurrence of any incident during the lapsed period of time.

(4) All notices of rejection of the provisions of this Act by patients shall, when executed, be preserved by the health care professional or institution during the continuation of the rendering of health care treatment to the patient.

SECTION 7. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The Patients' Compensation Board, the director, or his authorized representative, upon showing a certificate of noncompliance, may temporarily restrain or permanently enjoin the further operation of any health care professional or institution covered by this Act. Such actions shall be brought in Franklin Circuit Court.

SECTION 8. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The Patients' Compensation Board shall consist of fifteen (15) members appointed by the governor to be divided into five (5) panels of three (3) members each, and shall be attached to the Department of Human Resources for administrative purposes.

(2) Five (5) of the members shall be representatives of health care deliverers, five (5) shall be attorneys with the qualifications of circuit judges, and five (5) shall be representatives of the public, with one (1) member from each group serving on each three (3) member panel, and each panel selecting its own chairman. The governor shall designate the chairman of the entire Board. Each member of the Board shall be paid a salary equal to that of circuit judges plus reasonable expenses.

(3) A decision concurred in by any two (2) members of a panel will constitute a decision of the Board unless altered by a majority of the entire Board.

(4) The Board and its panels may hold sessions at any place within the state where necessary and may sue or be sued in any court of this state under existing laws. Unless consented to by the Board, all actions or proceedings against it, or a member in his official capacity, shall be brought in the courts of Franklin County.

(5) Any investigation, inquiry or hearing which the Board is authorized to hold or undertake may be held or undertaken by or before any three (3) member panel, a director or hearing officer acting under the authorization of the Board.

SECTION 9. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The governor shall appoint a director of the Board who shall have immediate supervision of the employees of the Board, perform such duties as are assigned him, and have complete authority to carry out the administrative functions of the Division of Patients' Compensation. The director shall be an attorney admitted to practice law in Kentucky and who has practiced law for at least three (3) years. He shall keep and be the custodian of the records of the Board, shall annually report the activities of the Board to the governor, and shall devote his full time to the duties of the office. He shall receive a salary to be fixed by the governor.

(2) The governor shall appoint the number of hearing officers authorized by regulation of the Board, each of whom shall be an attorney admitted to practice law in Kentucky who has practiced law for at least three (3) years. These officers, upon the direction of the director of the Board, shall conduct hearings and otherwise supervise the presentation of evidence and perform all other duties assigned to them by the director or the Board except that such hearing officer shall not render final decision, orders or awards. However, such hearing officers may, in receiving the evidence, on behalf of the

Board make such ruling effecting the competency, relevancy and materiality of the evidence about to be presented, and upon motions presented during the taking of evidence as will expedite the preparation of the case.

(3) The Board may at any time recommend the removal of the director or any hearing officer upon filing with the governor a full written statement of its reason for such removal.

SECTION 10. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The Board shall prepare such rules and regulations as it considers necessary to carry on its work and may make rules not inconsistent with this Act for carrying out the provisions of this Act.

(2) Processes and procedure under this Act shall be as summary and simple as reasonably possible. The Board or any member thereof, for the purpose of this Act, may subpoena witnesses, administer or cause to have administered oaths and examine or cause to have examined such parts of the books and records of the parties to a proceeding as relate to question in dispute.

(3) The Sheriff shall serve all subpoenas of the Board and shall receive the same fee as provided by law for like service in civil actions. Each witness who appears in obedience to such subpoena of the Board shall

receive for attendance the fees and mileage for witnesses in civil cases in the circuit courts.

(4) The circuit court shall, on application of the Board or any member thereof, enforce by proper proceedings the attendance and testimony of witnesses and production examination of books, papers and records.

SECTION 11. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) No proceeding under this Act for compensation for an incident shall be maintained unless a notice of claim shall have been given to the health care professional or institution as soon as practicable after the happening thereof, and unless an application for adjustment of claim for compensation with respect to such incident shall have been made with the Board within one (1) year after the date the injury was first discovered, or in the exercise of reasonable care should have been discovered, provided that such claim shall have been made with the Board within five (5) years from the date on which the incident is said to have occurred. A minor under the full age of six (6) years shall have until his eighth birthday in which to file a claim. This section applies to all persons regardless of minority or other legal disability, and is unaffected by the provisions of KRS 413.170.

SECTION 12. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) If the patient and health care professional or health care institution reach an agreement conforming to the provisions of this Act in regard to compensation, a memorandum of the agreement shall be filed with the Board, and, if approved by it, shall be enforceable as is herein provided for the enforcement of awards by the Board. Nothing herein shall prevent the voluntary payment of compensation, the amounts, and for periods prescribed in this Act without formal agreement, but nothing shall operate as a final settlement except the memorandum of agreement filed with and approved by the Board in accordance with this section. No limitation of time shall begin to run until the date upon which such agreement is filed and approved by the Board.

SECTION 13. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) If the parties fail to reach an agreement in regard to compensation under this Act, either party may make written application to the Board for a hearing in regard to the matter at issue and for a ruling thereon. Such application must be filed within the time set forth in Section 11 herein, or within one (1) year after the cessation of voluntary payments, if any have been made.

(2) As soon as possible after the application has been received, the Board will set the date for a hearing, to be held as soon as practicable, in view of the matter involved, and shall notify the parties at issue of the time and place of such hearing.

(3) Unless otherwise agreed to by the parties and authorized by the panel, the hearing shall be held at or convenient to the place where the injury was sustained or the ground for disagreement occurred. Before directing a hearing, the board, a member thereof, the director or a hearing officer authorized by the board, may confer informally with the parties at issue in an attempt to assist in adjusting their differences, but may not delay the granting of a hearing, over the objection of either party for such purpose.

(4) If the parties have previously filed an agreement which has been approved by the board and compensation has been paid or is due in accordance therewith, and the parties thereafter disagree, either party may invoke the provisions of Section 41 which remedy shall be exclusive.

SECTION 14. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The board, a panel or any of its members, the director or any hearing officer directed by the Board,

shall hear the parties at issue and their representatives and witnesses, and the panel shall determine the dispute, in a summary manner. The award, order or decision shall be made within thirty (30) days after final submission, except in cases involving large or complicated records or unusual questions of law, and shall be made within sixty (60) days after final submission in any event. However, if the award, order or decision is not rendered within thirty (30) days, the board shall notify the parties in dispute setting out the reasons for such delay. The award, order or decision, together with a statement of the findings of fact, rulings of law and any other matters pertinent to the question at issue, shall be filed with the record of proceedings, and a copy of the award, order or decision shall immediately be sent to the parties in dispute.

SECTION 15. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Within fourteen (14) days from the date of the award or decision, any party may file a petition for reconsideration of the award, order or decision of the panel. The petition for reconsideration shall be made to the whole board and shall clearly set out the errors relied upon with the reasons and arguments for reconsideration of impending award, order or decision. All other parties shall have ten (10) days thereafter to

file a response to the petition. The Board shall make the final decision and shall report its decision within ten (10) days after submission.

SECTION 16. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) An award or order of the board as provided in Section 14, if petition for reconsideration is not filed as provided for in Section 15, shall be conclusive and binding as to all questions of fact, but either party may within twenty (20) days after the rendition of such final award or order of the board, by petition appeal to the circuit court that would have jurisdiction to try an action for damages for the injuries if this Act did not exist, for the review of such order or award, the board and the adverse party being made respondents. The board shall be named respondent as the patients' compensation board, and service shall be made on the director.

(2) The petition shall state fully the grounds upon which a review is sought, and assign all errors relied on. Summons shall issue upon the petition directing the adverse party to file an answer and cross-appeal, if appropriate, within twenty (20) days after service thereof and directing the board to send its entire original record, properly bound, to the clerk of the circuit court, after certifying that such record is its entire original

record, which shall be filed by the clerk of the circuit court and such record shall then become and be considered by the circuit court on the review.

(3) No new or additional evidence may be introduced in the circuit court except as to the fraud or misconduct of some person engaged in the administration of this Act and affecting the order, ruling or award, but the court shall otherwise hear the cause upon the record as certified by the board and shall dispose of the cause in summary manner. The court shall not substitute its judgment for that of the board as to the weight of evidence on questions of fact, its review being limited to determining whether or not:

(a) The board acted without or in excess of its powers;

(b) The order, decision, or award was procured by fraud;

(c) The order, decision, or award is not in conformity to the provisions of this Act;

(d) The order, decision, or award is clearly erroneous on the basis of the reliable, probative, and material evidence contained in the whole record; or

(e) The order, decision, or award is arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(4) The board and each party may appear in such review proceedings; the court shall enter judgment affirming, modifying or setting aside the order, decision or award, or in its discretion remanding the cause to the board for further proceedings in conformity with the direction of the court. The court may, before judgment and upon a sufficient showing of fact, remand the cause to the board.

(5) The appeal shall be advanced on the circuit court docket without motion or notice.

SECTION 17. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The judgment of the circuit court shall be subject to appeal to the Court of Appeals. The scope of review by the Court of Appeals shall include all matters subject to review by the circuit court and also errors of law arising in the circuit court and upon appeal made reviewable by the Rules of Civil Procedure where not in conflict with this Act.

(2) The procedure as to appeal to the Court of Appeals shall be the same as in civil actions, so far as it is applicable to and not in conflict with this Act.

(3) The appeal shall be advanced on the Court of Appeals docket without motion or notice.

SECTION 18. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Any party in interest may file in the circuit court of the county in which the injury occurred a certified copy of a memorandum of agreement approved by the board or of an order or decision of the board, or of an award of the board on appeal from, or an award of the board rendered upon an appeal whether or not there is a motion to reopen or review pending under Section 41. The court shall render judgment in accordance therewith and notify the parties. Such judgment shall have the same effect, and all proceedings in relation thereto shall thereafter be the same as though it had been rendered in a suit duly heard and determined by that court. Any such judgment, unappealed from or affirmed on appeal or modified in obedience to the mandate of the Court of Appeals shall be modified to conform to any decision of the board ending, diminishing or increasing any weekly payment under the provisions of Section 41 upon a presentation to it of a certified copy of such decision.

SECTION 19. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The board, or any member thereof, may, upon the application of either party or upon its own motion, appoint not more than three (3) disinterested and duly

qualified physicians or surgeons to make any necessary medical examination of the patient and to testify in respect thereto. Such physicians or surgeons shall file with the board within fifteen (15) days after such examination their joint report in writing. The physicians or surgeons shall be allowed a reasonable fee to be fixed by the board and paid out of the maintenance fund, not exceeding seventy-five dollars ($75.00) for each examination and report, except that the board may allow additional reasonable amounts in extraordinary cases and the reasonable cost of X-rays, if any; the board may in its discretion allow a fee not in excess of twenty-five dollars ($25.00) for any deposition given by such physicians or surgeons.

(2) The party filing the motion for an examination shall pay the necessary and reasonable traveling expenses incurred by the employe in submitting to such examination. If the examination is ordered on the board's own motion, then such traveling expenses shall be paid out of the budget of the board.

SECTION 20. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) In addition to all other compensation provided in this Act, the health care professional or institution shall pay for the cure and relief from the effects of an

incident such medical, surgical and hospital treatment, including nursing, medical and surgical supplies and appliances, as may reasonably be required at the time of the injury and thereafter during disability. The patient may select the physician to treat his injury, and the hospital in which he shall be treated.

(2) When a compensable incident results in the amputation of an arm, leg or foot, or the loss of hearing, or the enucleation of an eye or loss of teeth, the health care professional or institution shall initially pay for, in addition to the other medical, surgical and hospital treatment enumerated in this Section, a modern artificial member and where required, proper braces.

(3) For all such payments for treatments, artificial members and braces provided for in Subsection (1) and (2), the health care professional or institution shall be entitled to a set off in the amount of all other benefits otherwise recoverable by or on behalf of the patient for such treatments, artificial members and braces less the direct premium costs, over the twenty-four (24) months prior to the occurrence of the incident, to the patient for the right of such benefits.

(4) Upon motion of the health care professional or institution, with sufficient notice to the employee for a response to be filed, if it is shown to the satisfaction

of the board by affidavits or testimony that because of the physician selected by the employee to treat his injury, or because of the hospital selected by the patient in which he is being treated, that the patient is not receiving proper medical treatment and his recovery is being substantially affected or delayed; or that the funds for his medical expenses are being spent without reasonable benefit to the patient; or that because of the physician selected by the patient or because of the type of medical treatment being received by the patient that the health care professional or institution will substantially be prejudiced in any compensation proceedings resulting from the patient's injury or disease; then the board may allow the health care professional or institution to select a physician to treat the patient and the hospital or hospitals in which the patient is treated for his injury or disease.

(5) All fees and charges under this Section shall be fair and reasonable, shall be subject to regulation by the board and shall be limited to such charges as are reasonable for similar treatment of injured persons of a like standard of living in the same community and where such treatment is paid for by the injured person himself. In determining what fees are reasonable, the board may

also consider the increased security of payment afforded by this Act.

(6) Where such requirements are furnished by a public hospital or other institution, payment thereof shall be made to the proper authorities conducting it. No compensation shall be payable for the death or disability of a patient if his death is caused, or if and insofar as his disability is aggravated, caused or continued, by an unreasonable failure to submit to or follow any competent surgical treatment or medical aid or advice.

SECTION 21. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Income benefits for disability shall be paid to the employe as follows:

(a) For total disability, sixty-six and two-thirds percent (66 2/3%) of the patient's average weekly wage but not more than one hundred percent (100%) of the state average weekly wage and not less than twenty percent (20%) of the state average weekly wage as determined in Section 22 during such disability.

(b) For permanent, partial disability, sixty-six and two-thirds percent (66 2/3%) of the patient's average weekly wage but not more than seventy-five percent (75%) of the state average weekly wage as determined by Section 22, multiplied by his percentage of disability caused by

the injury as determined by "guides to the evaluation of permanent impairment," American medical association, 1977 edition, or by his percentage of disability as determined under Section 1 (8) herein, whichever is greater, for a maximum period, from the date the disability arises, of four hundred twenty-five (425) weeks. Any temporary total disability period within the maximum period for permanent, partial disability benefits shall extend the maximum period but shall not make payable a weekly benefit exceeding that determined in subsection (1)(a) of this section. Notwithstanding any section of this Act to the contrary, there shall be no minimum weekly income benefit for permanent partial disability and medical benefits shall be paid for the duration of the disability.

(2) The period of any income benefits payable under this section on account of any injury shall be reduced by the period of income benefits paid or payable under this Act on account of a prior injury if income benefits in both cases are for disability of the same member or function, or different parts of the same member or function, and the income benefits payable on account of the subsequent disability in whole or in part would duplicate the income benefits payable on account of the pre-existing disability.

(3) When a patient, who has sustained disability compensable under this section, and who has filed, or could have timely filed, a valid claim in his lifetime, dies from causes other than the injury before the expiration of the compensable period specified, the income benefits specified and unpaid at the individual's death, whether or not accrued or due at his death, shall be paid, under an award made before or after such death, for the period specified in this section, to and for the benefit of the persons within the classes at the time of death and in the proportions and upon the conditions specified in this section and in the order named:

(a) To the widow or widower, if there is no child under the age of eighteen (18) or incapable of self-support; or

(b) If there are both such a widow or widower and such a child or children, one-half to such widow or widower and the other half to such child or children; or

(c) If there is no such widow or widower but such a child or children, then to such child or children; or

(d) If there is no survivor in the above classes, then the parent or parents wholly or partly actually dependent for support upon the decedent, or to other wholly or partly actually dependent relatives listed in paragraph (g) of subsection (1) of Section 22 herein or to

both, in such proportions as the board may provide by regulation.

SECTION 22. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) If the incident causes death, income benefits shall be payable in the amount and to or for the benefit of the persons following, subject to the maximum limits specified in Subsections 3 and 4 of this section:

(a) If there is a widow or widower and no children of the deceased, to such widow or widower fifty percent (50%) of the average weekly wage of the deceased, during widowhood or widowerhood.

(b) To the widow or widower, if there is a child or children living with the widow or widower, forty-five percent (45%) of the average weekly wage of the deceased, or forty percent (40%), if such child is not or such children are not living with a widow or widower, and in addition thereto, fifteen percent (15%) for each child. Where there are more than two (2) such children, the indemnity benefits payable on account of such children shall be divided among such children, share and share alike.

(c) Two (2) years' indemnity benefits in one (1) lump sum shall be payable to a widow or widower upon remarriage.

(d) To the children, if there is no widow or widower, fifty percent (50%) of such wage for one (1) child, and fifteen percent (15%) for each additional child, divided among such children share and share alike.

(e) The income benefits payable on account of any child under this section shall cease when he dies, marries, or reaches the age of eighteen (18), or when a child over such age ceases to be physically or mentally incapable of self-support, or if actually dependent ceases to be actually dependent, or, if enrolled as a full-time student in any accredited educational institution, ceases to be so enrolled or reaches the age of twenty-two (22). A child who originally qualified as a dependent by virtue of being less than eighteen (18) years of age may, upon reaching age eighteen (18), continue to qualify if he satisfies the tests of being physically or mentally incapable of self-support, actual dependency, or enrollment in an educational institution.

(f) To each parent, if actually dependent, twenty-five percent (25%).

(g) To the brothers, sisters, grandparents, and grandchildren, if actually dependent, twenty-five percent (25%) to each such dependent. If there should be more than one (1) of such dependents, the total income benefits

payable on account of such dependents shall be divided share and share alike.

(h) The income benefits of each beneficiary under paragraphs (f) and (g) above shall be paid until he, if a parent or grandparent, dies, marries, or ceases to be actually dependent, or, if a brother, sister, or grandchild, dies, marries, or reaches the age of eighteen (18) or if over that age ceases to be physically or mentally incapable of self-support, or ceases to be actually dependent.

(i) A person ceases to be actually dependent when his income from all sources exclusive of patients' compensation income benefits is such that, if it had existed at the time as of which the original determination of actual dependency was made, it would not have supported a finding of dependency. In any event, if the present annual income of an actual dependent person including patients' compensation income benefits at any time exceeds the total annual support received by the person from the deceased patient, the patients' compensation benefits shall be reduced so that the total annual income is no greater than such amount of annual support received from the deceased patient. In all cases, a person found to be actually dependent shall be presumed to be no longer actually dependent three (3) years after each time as of

which the person was found to be actually dependent. This presumption may be overcome by proof of continued actual dependency as defined in this subsection, but full payment shall not be suspended during the pendency of any proceeding to determine dependency.

(2) Upon the cessation of income benefits under this section to or on account of any person, the income benefits of the remaining persons entitled to income benefits for the unexpired part of the period during which their income benefits are payable shall be that which such persons would have received if they had been the only persons entitled to income benefits at the time of the decedent's death.

(3) For the purposes of this section, the average weekly wage of the patient shall be taken as not more than the average weekly wage of the state as determined in KRS 342.740. In no cases shall the aggregate weekly income benefits payable to all beneficiaries under this section exceed the maximum income benefit that was or would have been payable for total disability to the deceased, including benefits to his dependents.

(4) The maximum weekly income benefits payable for all beneficiaries in case of death shall not exceed seventy-five percent (75%) of the average weekly wage of the deceased as calculated under KRS 342.140, subject to

the maximum limits in subsection (3) above. The maximum aggregate limitation shall not operate in case of payment of two (2) years' income benefits to the widow or widower upon remarriage as provided under paragraph (c) of subsection (1) of this section, to prevent the immediate recalculation and payments of benefits to the remaining beneficiaries as provided under subsection (2) of this section, but the weekly income benefits as to such remaining beneficiaries shall not exceed the weekly income benefit that was or would have been payable for total disability to the deceased. The classes of beneficiaries specified in paragraphs (a), (b) and (d) of subsection (1) shall have priority over all other beneficiaries in the apportionment of income benefits. If the provisions of this subsection should prevent payment to other beneficiaries of the income benefits to the full extent otherwise provided for by this section, the gross remaining amount of income benefits payable to such other beneficiaries shall be apportioned by class, proportionate to the interest of each class in the remaining amount. Parents shall be considered to be in one class and those specified in paragraph (f) of subsection (1) in another class.

(5) All relations of the dependency referred to in this section shall mean dependency existing at the time of the incident to the patient.

(6) If death occurs as a direct result of the incident, and the deceased had no statutory dependents as determined by this section, a lump sum payment of $10,000 shall be paid to his estate, in addition to the amount provided for in Section 32 provided, however,
that the lump sum payment shall be reduced by any income benefits previously paid on account of that incident.

SECTION 23. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

The average weekly wage of the patient at the time of the incident shall be determined as follows:

(1) If at the time of the incident, which resulted in harmful change:

(a) The wages were fixed by the week, the amount so fixed shall be the average weekly wage;

(b) The wages were fixed by the month, the average weekly wage shall be the monthly wage multiplied by 12 and divided by 52;

(c) The wages were fixed by the year, the average weekly wage shall be the yearly wage divided by 52;

(d) The hourly wage had not been fixed or cannot be ascertained, the wage for the purpose of calculating, shall be taken to be the usual wage for similar services.

(2) In seasonal occupations, the average weekly wage shall be taken to be 1/50th of the total wages which the employee has earned from all occupations during the twelve (12) calendar months immediately preceding the incident.

(3) In the case of volunteer firemen, police and civil defense members, compensation shall be based on average weekly wage in regular employment.

(4) If the patient was a minor, or unemployed at the time the incident occurred, and it is established under normal conditions, he would have received wages or his wages should be expected to increase during the period of disability, that fact may be considered in computing average weekly wage.

(5) If the patient is working under agreement with two (2) or more employers, his wages from all such sources shall be considered as if earned from one employer.

(6) Wages as used in this section means, in addition to money, payments for services rendered, the reasonable value of board, rent, housing, lodging and fuel or similar advantage received from an employer or employers and gratuities received in the course of

employment from others than the employer to the extent that such gratuities are reported for income tax purposes.

(7) When the patient, prior to the incident, performs services such as child care or home management for which there was no direct monetary compensation, and which services can no longer be performed, wholly or partially, the Board shall consider the replacement cost for such services and apply the formula set forth in Section 21 in determining an award for lost earnings.

SECTION 24. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

Where the patient has a pre-existing disease or disability which effects the degree of disability or length of disability resulting from an incident, the Board shall pro-rate the award for medical and income benefits allowing that percent reasonably attributable to the incident and excluding that percent reasonably attributable to the pre-existing condition.

SECTION 25. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

Where more than one health care professional and/or health care institution has responsibility for an incident, the Board shall apportion the award among those responsible in a fair proportion to their individual degree of responsibility.

SECTION 26. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1)Whenever compensation has been paid for not less than six (6) months, thereafter on the application of all parties in any case where the board determines it will be for the best interest of all parties and will not subject the payor to an undue risk of overpayment, future payments of compensation or any part thereof may be computed to a lump sum of an amount which will equal the total sum of the comparable future payments so computed, discounted at four percent (4%) compounded annually on each payment. Upon payment of such lump sum, all liability for the payments therein commuted shall cease.

(2) Whenever the Board considers it necessary, any lump sum which is paid as provided herein above, shall be paid to any suitable person appointed by the proper court of the county of the residence of the patient as trustee, to administer or apply the same for the benefit of the patient or persons entitled to compensation. The receipt of such trustee for the amount so paid shall discharge the health care professional or institution and his insurer.

SECTION 27. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

If the incident is caused in any degree by the intentional failure of the health care professional or

institution to comply with any specific stature or lawful regulation relative to care or treatment, the compensation for which the institution or professional would otherwise have been liable under this Act, shall be increased fifteen percent (15%) in the amount of each payment period. If the incident is caused in any degree by the intentional failure of the patient to obey any lawful and reasonable rule, order or regulation relative to his care, treatment and safety, the compensation for which the professional or institution would otherwise have been liable under this Act shall be decreased fifteen percent (15%) in the amount of each payment period.

SECTION 28. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) After an incident for so long as compensation is claimed, the patient, if requested by a party or the Board, shall submit himself to examination at a reasonable time and place, to a duly qualified physician or surgeon, designated and paid by the requesting party. The patient shall have the right to have a duly qualified physician or surgeon designated and paid by himself present at such examination. The requesting party's right to the examination hereunder shall be absolute at all reasonable times and under all reasonable conditions.

(2) If a patient refuses to submit himself or in any way obstructs such examination, his right to take or prosecute any proceedings thereafter shall be suspended until such refusal or obstruction ceases. No compensation shall be payable for the period during which the refusal or obstruction continues.

SECTION 29. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

Any patient receiving benefits under this Act may be required, upon request of any party, to furnish a sworn or affirmed statement of earnings and such other supporting information as the Board may require.

SECTION 30. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The primary purpose of this Act shall be restoration of the patient to gainful employment. To this end there is created a rehabilitation panel which shall be composed of the director of the Board and specialists in medical and vocational rehabilitation to be appointed by the Board.

(2) A patient who has suffered an injury covered by this Act shall be entitled to prompt rehabilitation services for whatever period of time necessary to accomplish physical rehabilitation goals which are feasible, practical and justifiable. If the patient, as a

result of the injury, is unable to perform work for which he has previous training or experience, he shall be entitled to vocational rehabilitation services, including re-training in job placement as may be reasonably necessary to restore him to suitable employment. The Board shall inquire whether such services have been voluntarily offered and accepted.

(3) Where rehabilitation requires travel and expenses incident thereto, the reasonable costs of such expenses shall be paid by the health care institution or health care professional. Refusal to accept rehabilitation shall result in a fifty percent (50%) loss of compensation for each week of the period of refusal.

SECTION 31. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

During the period the patient is eligible for permanent total disability benefits and is actively participating in a vocational or physical rehabilitation program, under Board order, the patient's benefit shall be calculated by taking eighty percent (80%) of his average weekly wage, but not more than one hundred percent (100%) of his average weekly wage times the percentage of disability as determined in this Act.

SECTION 32. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

If death results from the incident, the health care professional, or institution shall pay the cost of burying in an amount not to exceed $2,500 to any person who performs such service or incurred the liability for the service, whether or not the patient leaves dependents within the meaning of this Act.

SECTION 33. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

There shall be established an Advisory Board to the Patients' Compensation Board which shall have the following responsibilities, as well as such additional responsibilities as may be assigned to it by the Board:

(1) To review and make recommendations to the Board on any cases or requests for advice submitted by the Board in regard to the appropriateness and validity of an "inherent risk" defense.

(2) To consult with any health care professional or health care institution requesting advice concerning the identification and defining of inherent risks in a health care procedure.

(3) To review and make recommendations on cases submitted by the Board as to whether or not a health care professional should be reported to his licensing authority for its consideration of remedial or disciplinary action, or as to whether or not a health care institution should

be reported to its licensing or review authority for review and consideration of remedial or disciplinary action.

(4) To provide to the Board medical or other health care specialty consultative advice as requested.

SECTION 34. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

The Advisory Board shall be made up of five (5) members, who will be appointed by the governor from a list of nominees submitted by representatives of the health care system. The Advisory Board shall establish ad hoc committees of expert consultants from each health care specialty to consider and advise on questions within their specialty.

SECTION 35. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) All fees of attorneys and physicians, and all charges of hospitals under this Act, shall be subject to the approval of the Board. No attorney fee shall be allowed or approved against any party not represented by said attorney, nor shall any attorney fee be allowed or approved exceeding an amount equal to twenty percent (20%) of the first $25,000, and fifteen percent (15%) of the next $10,000 of the remainder of the amount recovered as actuality determined on past and future benefits. In no

case shall the fee exceed $6,500. Provided, however, the Board in making an allowance of attorneys fees, shall in each case examine the record to ascertain the extent of the services rendered, and fix a reasonable fee for the services rendered, not to exceed the maximum authorized by this section. The Board may reduce the attorneys fee to an amount commensurate with the services performed, or may deny or reduce an attorneys fee upon proof of solicitation of employment.

(2) No attorneys fee in any case involving benefits under this Act shall be paid until the fee is approved by the Board, and any contract for the payment of the attorneys fees otherwise than as provided in this section shall be void. The entire attorneys fee in a lump sum shall be paid directly to the attorney of record, and the Board in allowing or approving an attorneys fee as provided in this section shall order the payment of same directly to the attorney, commuting sufficient of the final payments of compensation payable under the award to a lump sum for that purpose.

(3) The General Assembly declares that by the Bill enactment of subsections (1) and (2), it is the legislative intent to encourage settlement and prompt administrative handling of such claims, and thereby reduce expenses to claimants, and the Board shall give due regard

to such legislative intent in the handling of uncontested claims and the allowance of attorneys fees therein.

SECTION 36. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

No person shall knowingly file, or permit to be filed any false or fraudulent claim on his behalf to compensation or other benefits under this Act, or by fraud, deceit or misrepresentation procure or cause to be made or receive any payments of compensation or other benefits under this Act to which the recipient is not lawfully entitled, or conspire with, aid or abet another so to do. No person shall by deceit or misrepresentation or with intent to defraud cause or procure or conspire with, aid or abet another in so causing or procuring any person entitled to compensation or other benefits under this Act to omit to claim title hereto or to accept the payment of a less sum than that to which he may be lawfully entitled thereunder.

SECTION 37. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Every health care professional or institution under this Act shall either insure and keep insured his liability for compensation hereunder in some corporation, association or organization authorized to transact the business of patients compensation insurance in this state

or shall furnish to the Board satisfactory proof of his financial ability to pay directly the compensation in the amount and manner and when due is provided for in this Act. In the latter case, the Board shall require the deposit of an acceptable security, indemnity or bond to secure to such an extent as the Board directs the payment of compensation liabilities as they are incurred.

(2) Every health care professional or institution subject to this Act shall file, or have filed on its behalf, with the Patient's Compensation Board, as often as may be necessary, evidence of its compliance with the provisions of this section and all others relating thereto.

SECTION 38. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) In order to comply with Section 37 groups of health care professionals and institutions may form among themselves mutual insurance associations or reciprocal or inter insurance exchanges subject to the insurance laws of this state and such reasonable conditions and restrictions not inconsistent therewith as may be fixed by the board. Membership in such mutual insurance associations or reciprocal or inter insurance exchanges so approved, together with evidence of the payment of premiums due, shall be evidence of compliance with Section 37.

(2) The board may, except as provided in subsection (3), require any mutual insurance association or reciprocal or inter insurance exchange to purchase an annuity or to effect reinsurance with a company authorized to transact insurance in this state or to make such deposit with a bank or trust company of this state as shall in either case be approved by the board for the purpose of fully securing the payment of all deferred installments upon any claim for compensation.

(3) Any mutual insurance association or reciprocal or inter insurance exchange possessing a surplus of not less in amount than the capital required of a domestic stock insurance company transacting the same kind of insurance, shall not be required to purchase an annuity or effect reinsurance with a company authorized to transact insurance in this state or to make such a deposit with a bank or trust company of this state for the purpose of fully securing the payment of all deferred installments upon any claim for compensation.

(4) In addition, the board, under rules and regulations as it shall prescribe, may permit any two (2) or more health care professionals and institutions to enter into agreements to pool their liabilities under this Act for the purpose of qualifying as self-insurers. Health care professionals and institutions securing

certification as group self-insurers are regulated by rules and regulations drawn by the patients' compensation board and are not to be in any way subject to the provisions of subsections (1), (2), and (3) of this section.

SECTION 39. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

Upon the request of the board, the attorney general, or, under his direction, the Commonwealth's attorney or county attorney of any county, shall institute and prosecute the necessary actions or proceedings for the enforcement of any of the provisions of this Act arising within his jurisdiction, and shall defend in like manner all actions or proceedings brought against the board or the members thereof in their official capacity.

SECTION 40. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) No claim for compensation under this Act shall be assignable; and all compensation and claims, therefore, shall be exempt from all claims of creditors.

SECTION 41. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Upon its own motion or upon the application of any party interested in a showing of change of conditions, mistake or fraud or newly discovered evidence, the Board

may at any time review any award of order, ending, diminishing or increasing the compensation previously awarded, within the maximum and minimum provided in this Act, or change or revoke its previous order, sending immediately to the parties a copy of its subsequent order or award. Review under this section shall be had upon notice to the parties interested and in the same manner as provided for an initial proceeding hereunder but shall not affect the previous order or award as to any sums already paid thereunder, however, the health care professional or institution shall not suspend the payment of benefits during the pendency of any reopening procedures.

(2) Where an agreement has become an award by approval of the Board, and a review of such an award is initiated, no statement contained in the agreement, whether as to jurisdiction, liability of the health care professional or institution, nature and extent of disability, or as to any other matter, shall be considered by the Board as an admission against the interests of any party. The parties may raise any issues upon review of this type of award which could have been considered upon an original application for benefits.

SECTION 42. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

No patient shall be harrassed, coerced, discharged or discriminated against in any manner whatsoever for filing and pursuing a lawful claim under this Act, or for electing not to come under the provisions of this Act.

SECTION 43. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

If the Board or any court before whom any proceedings are brought under this Act determines that such proceedings have been brought, prosecuted or defended without reasonable ground, it may assess the whole cost of the proceedings, which shall include actual expenses, but not be limited to the following: court costs, travel expenses, deposition costs, physician expenses for attendance fees at depositions, attorneys fees and all other out-of-pocket expenses upon the party who has so brought, prosecuted or defended them.

SECTION 44. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

Commencing January 1, 1990, the state auditor shall report annually to the Governor and to the General Assembly a cost and benefit analysis of the operations of the Patient Compensation Plan and may recommend any amendments to this Act or administrative changes that should be made to improve the operation of the plan.

SECTION 45. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) For the purpose of paying the salaries and necessary expenses of the Board and its assistants and employees in administering and carrying out this Act, an administrative fund shall be created and maintained in the manner provided in this Section.

(2) Every insurance carrier including the parties into any interindemnity contract or reciprocal plan or scheme, insuring health care professionals or institutions in this state aginst liability or personal injuries to their patients under this Act, shall pay a tax upon the premium received, whether in cash or notes, in this state or on account of business done in this state, for such insurance in this state, at the rate of two percent (2%) of the amount of the premium. It shall be assessed and collected as provided in subsection (3). Such insurance carriers shall be credited with all cancelled or returned premiums, including dividends paid or credited to policyholders, and with premiums received for reinsurance assumed from companies authorized and licensed to transact business in this state.

(3) If the Secretary of Finance and Administration and the Secretary of Human Resources find that the tax on the premiums levelled pursuant to subsection (1) of this

Section are insufficient to meet the maintenance level of appropriations and expenditures for maintenance of the Patients' Compensation System, they shall advise the Secretary of Revenue in writing of such fact prior to the end of each fiscal year. The Secretary of Revenue may then levy one additional assessment per fiscal year against all insurance companies writing Patients' Compensation insurance in Kentucky, all self-insurance groups operating under this Act, and every health care professional and institution carrying his own risk. The amount of each assessment shall be in proporion that each assessment payer's "adjusted cost" bears to the total "adjusted cost" of all assessment payers.

(4) Every such insurance carrier shall make an annual return to the Revenue Cabinet, stating the amount of all such premiums and credits during the period covreed by that return. Every insurance carrier required to make such return shall file it by March 1 and shall at the same time pay the tax of two dollars ($2.00) on each one hundred dollars ($100) of such premiums ascertained as provided in subsection 2 of this Section, less return premiums, including dividends paid or credited to policyholders, and reinsurance received from other insurance companies licensed to transact business in this state, and shall thereafter pay any additional assessment

made pursuant to subsection (3) of this Section at the time and in the manner prescribed by the Secretary of Revenue.

(5) Every health care professional or institution carrying his own risk shall report to the Revenue Cabinet his "adjusted cost" of operating under the provisions of this chapter during the period covered by such report. Such report shall be made in form prescribed by the Revenue Cabinet and at the time provided for premium reports by the insurance carriers. The Revenue Cabinet shall assess against such "adjusted cost" so reported a maintenance fund tax of 2 percent (2%) and shall make an additional assessment if required by subsection 3 of this Section. Such amount shallk not exceed the maintenance fund level of appropriations and expenditures for all programs under the Patients' Compensation Program.

SECTION 46. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Any health care professional or institution subject to this Act who refuses or willfully neglects to make the report required by Section 5 shall be fined not more than Twenty-five dollars ($25) for each offense.

(2) Any person who violates Section 36, shall be fined not less than Fifty Dollars ($50.00) nor more than Five Hundred Dollars ($500.00) or imprisoned for not less than ten (10) days nor more than ninety (90) days.

SECTION 47. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

The provisions of this Act shall be effective as to patients, health care professionals, and institutions ninety (90) days after the Secretary for the Cabinet of Human Resources has certified to the Secretary of State of the Commonwealth that the Patients' Compensation Board and its Advisory Board have been appointed, that regulations for the operation of the system have been adopted, and that the administrative system is prepared to be operational; and further that the Commissioner of Insurance has certified to the Secretary of State of the Commonwealth that there is available to the health care professionals and institutions, on either a self-insured, pool, or commercial basis, patients compensation insurance to insure risks incurred under this Act. Certifications will be made no later than eighteen (18) months following the effective date of this Act and in the event either cannot be made the Secretary or the Commissioner shall file in writing the reasons therefor and the effective date shall not occur until both such certificates have been filed.

Bill Draft #14

TWO YEAR STATUTE OF LIMITATION

Property Damage

SECTION 1. A NEW SECTION OF KRS CHAPTER 413 IS CREATED TO READ AS FOLLOWS:

An action for the taking, detaining or injuring personal property, including an action for specific recovery shall be commenced within two (2) years from the time the cause of action accrued.

Section 2. KRS Chapter 413.120 is amended to read as follows:

The following actions shall be commenced within five years after the cause of action accrued:

(1) An action upon a contract not in writing, express or implied.

(2) An action upon a liability created by statute, when no other time is fixed by the statute creating the liability.

(3) An action for a penalty or forfeiture when no time is fixed by the statute prescribing it.

(4) An action for trespass on real or personal property.

(5) An action for the profits of or damages for withholding real or personal property.

[~~(6) An action for the taking, detaining or injuring personal property, including an action for specific recovery.~~]

(6) [~~(7)~~] An action for an injury to the rights of the plaintiff, not arising on contract and not otherwise enumerated.

(7) [~~(8)~~] An action upon a bill of exchange, check, draft or order, or any endorsement thereof, or upon a promissory note, placed upon the footing of a bill of exchange.

(8) [~~(9)~~] An action to enforce the liability of a steamboat or other vessel.

(9) [~~(10)~~] An action upon a merchant's account for goods sold and delivered, or any article charged in such store account.

(10) [~~(11)~~] An action upon an account concerning the trade of merchandise, between merchant and merchant or their agents.

(11) [~~(12)~~] An action for relief or damages on the ground of fraud or mistake.

(12) [~~(13)~~] An action to enforce the liability of bail.

(13) [~~(14)~~] An action for personal injuries suffered by any person against the builder of a home or other improvements. This cause of action shall be deemed to accrue at the time of original occupancy of the improvements which the builder caused to be erected.

Bill Draft #15

STANDARD OF CONDUCT FOR DIRECTORS AND OFFICERS

OF FOR-PROFIT CORPORATIONS

The Task Forced endorses and urges the General Assembly to enact the following Sections from the KBA/MCBA proposed Revision to Kentucky's Corporation Law:

2.02 Articles of Incorporation

(b) The articles of incorporation may set forth:

(4) A provision eliminating or limiting the personal liability of a director to the corporation or its shareholders for monetary damages for breach of his duties as a director, provided that such provision shall not eliminate or limit the liability of a director;

(i) for any transaction in which the director's personal financial interest is in conflict with the financial interests of the corporation or its shareholders,

(ii) for acts or omissions not in good faith or which involve intentional misconduct or are known to the director to be a violation of law,

(iii) under section 8.33 of this Act, or

(iv) for any transaction from which the director derived an improper personal benefit.

(5) No such provision shall eliminate or limit the liability of any director for any act or omissions

occurring prior to the date when such provision becomes effective. In no case shall this subsection or any such provision be construed to expand the liability of any director as determined pursuant to Section 8.30 of this Act.

8.30 General Standards for Directors

(a) A director shall discharge his duties as a director, including his duties as a member of a committee:

(1) in good faith;

(2) on an informed basis; and

(3) in a manner he honestly believes to be in the best interests of the corporation.

(b) A director discharges his duties on an informed basis if he makes, with the care an ordinarily prudent person in a like position would exercise under similar circumstances, inquiry into the business and affairs of the corporations, or into a particular actions to be taken or decision to be made.

(c) In discharging his duties a director is entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, if prepared or presented by:

(1) one or more officers or employees of the corporation whom the director honestly believes to be reliable and competent in the matters presented;

(2) legal counsel, public accountants, or other persons as to matters the director honestly believes are within the person's professional or expert competence; or

(3) a committee of the board of directors of which he is not a member if the director honestly believes the committee merits confidence.

(d) A director is not acting in good faith if he has knowledge concerning the matter in question that makes reliance otherwise permitted by subsection (c) unwarranted.

(e) In addition to any other limitation on a director's liability for monetary damages contained in any provision of the corporation's articles of incorporation adopted in accordance with subsection 2.02 (b) (4), any action taken as a director, or any failure to take any action as a director, shall not be the basis for monetary damages or injunctive relief unless:

(1) the director has breached or failed to perform the duties of the director's office in compliance with this section; and

(2) in the case of an action for monetary damages, the breach or failure to perform constitutes willful misconduct or wanton or reckless disregard for the best interests of the corporation and its shareholders.

(f) A person bringing an action for monetary damages under this section has the burden of proving by clear and

convincing evidence the provisions of subsections (e) (1) and (2), and the burden of proving that the breach or failure to perform was the legal cause of damages suffered by the corporation.

(g) Nothing in this section shall eliminate or limit the liability of any director for any act or omission occurring prior to the date when this section becomes effective.

8.31 Director Conflict of Interest

(a) A conflict of interest transaction is a transaction with the corporation in which a director of the corporation has a direct or indirect interest. A conflict of interest transaction is not voidable by the corporation solely because of the director's interest in the transaction if any one of the following is true:

(1) the material facts of the transaction and the director's interest were disclosed or known to he board of directors or a committee of the board of directors and the board of directors or committee authorized, approved, or ratified the transaction;

(2) the material facts of the transaction and the director's interest were disclosed or known to the shareholders entitled to vote and they authorized, approved, or ratified the transaction; or

(3) the transaction was fair to the corporation.

(b) For purposes of this section, a director of the corporation has an indirect interest in a transaction if (a) another entity in which he has a material financial interest or in which he is a general partner is a party to the transaction or (b) another entity of which he is a director, officer, or trustee is a party to the transaction and the transaction is or should be considered by the board of directors of the corporation.

8.32 Standard of Conduct for Officers

(a) An officer with discretionary authority shall discharge his duties under that authority:

(1) in good faith;

(2) on an informed basis; and

(3) in a manner he honestly believes to be in the best interests of the corporation.

(b) An officer discharges his duties on an informed basis if he makes, with the care an ordinarily prudent person in a like position would exercise under similar circumstances, inquiry into the business and affairs of the corporation, or into a particular action to be taken or decision to be made.

(c) In discharging his duties an officer is entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, if prepared or presented by:

(1) one or more officers or employees of the corporation whom the officer honestly believes to e reliable and competent in the matters presented; or

(2) legal counsel, public accountants, or other persons as to matters the officer honestly believes are within the person's professional or expert competence.

(d) An officer is not acting in good faith if he has knowledge concerning the matter in question that makes reliance otherwise permitted by subsection (c) unwarranted.

(e) Any action taken as an officer, or any failure to take any action as an officer, shall not be the basis for monetary damages or injunctive relief unless:

(1) the officer has breached or failed to perform his duties in compliance with this section; and

(2) in the case of an action for monetary damages, the breach or failure to perform constitutes willful misconduct or wanton or reckless disregard for the best interests of the corporation or its shareholders.

(f) A person bringing an action for monetary damages under this section has the burden of proving by clear and convincing evidence the provisions of subsections (e) (1) and (2), and the burden of proving that the breach or failure to perform was the legal cause of damages suffered by the corporation.

(g) Nothing in this section shall eliminate or limit the liability of any officer for any act or omission occurring prior to the date when this section becomes effective.

Bill Draft 16a

STANDARD OF CONDUCT FOR DIRECTORS AND OFFICERS OF NON-PROFIT CORPORATIONS

SECTION 1. A NEW SECTION OF KRS CHAPTER 273 IS CREATED TO READ AS FOLLOWS:

The articles of incorporation of a non-profit corporation subject to the provisions of KRS 273.161 to 273.387 may set forth:

(1) A provision eliminating or limiting the personal liability of a director to the corporation for monetary damages for breach of his duties as a director, provided that such provision shall not eliminate or limit the liability of a director

(a) for any transaction in which the director's personal financial interest is in conflict with the financial interests of the corporation,

(b) for acts or omissions not in good faith or which involve intentional misconduct or are known to the director to be a violation of law,

(c) for any transaction from which the director derived an improper personal benefit.

(2) No such provision shall eliminate or limit the liability of any director for any act or omissions

occurring prior to the date when such provision becomes effective. In no case shall this subsection or any such provision be construed to expand the liability of any director as determined pursuant to Section 2 of this Act.

SECTION 2. A NEW SECTION OF KRS CHAPTER 273 IS CREATED TO READ AS FOLLOWS:

(1) A director of a non-profit corporation subject to the provisions of KRS 273.161 to 273.387 shall discharge his duties as a director, including his duties as a member of a committee:

(a) in good faith;

(b) on an informed basis; and

(c) in a manner he honestly believes to be in the best interests of the corporation.

(2) Such director discharges his duties on an informed basis if he makes, with the care an ordinarily prudent person in a like position would exercise under similar circumstances, inquiry into the business and affairs of the corporations, or into a particular actions to be taken or decision to be made.

(3) In discharging his duties such director is entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, if prepared or presented by:

(a) one or more officers or employees of the corporation whom the director honestly believes to be reliable and competent in the matters presented;

(b) legal counsel, public accountants, or other persons as to matters the director honestly believes are within the person's professional or expert competence; or

(c) a committee of the board of directors of which he is not a member if the director honestly believes the committee merits confidence.

(4) A director of a non-profit corporation is not acting in good faith if he has knowledge concerning the matter in question that makes reliance otherwise permitted by subsection (3) unwarranted.

(5) In addition to any other limitation on such director's liability for monetary damages contained in any provision of the corporation's articles of incorporation adopted in accordance with the provisions of Section 1, any action taken as a director, or any failure to take any action as a director, shall not be the basis for monetary damages or injunctive relief unless:

(a) the director has breached or failed to perform the duties of the director's office in compliance with this section; and

(b) in the case of an action for monetary damages, the breach or failure to perform constitutes

willful misconduct or wanton or reckless disregard for the best interests of the non-profit corporation.

(6) A person bringing an action for monetary damages under this section has the burden of proving by clear and convincing evidence the provisions of subsections (5) (a) and (b), and the burden of proving that the breach or failure to perform was the legal cause of damages suffered by the non-profit corporation.

(7) Nothing in this section shall eliminate or limit the liability of any director for any act or omission occurring prior to the date when this section becomes effective.

SECTION 3. A NEW SECTION OF KRS CHAPTER 273 IS CREATED TO READ AS FOLLOWS:

(1) A conflict of interest transaction is a transaction with the non-profit corporation in which a director of such corporation has a direct or indirect interest. A conflict of interest transaction is not voidable by the corporation solely because of the director's interest in the transaction if any one of the following is true:

(a) the material facts of the transaction and the director's interest were disclosed or known to the board of directors or a committee of the board of directors and the board of directors or committee authorized, approved, or ratified the transaction;

(b) the transaction was fair to the corporation.

(2) For purposes of this section, a director of a non-profit corporation has an indirect interest in a transaction if (a) another entity in which he has a material financial interest or in which he is a general partner is a party to the transaction or (b) another entity of which he is a director, officer, or trustee is a party to the transaction and the transaction is or should be considered by the board of directors of the corporation.

SECTION 4. A NEW SECTION OF KRS CHAPTER 273 IS CREATED TO READ AS FOLLOWS:

(1) An officer of a non-profit corporation subject to the provisions of KRS 273.161 to 273.387, with discretionary authority, shall discharge his duties under that authority:

(a) in good faith;

(b) on an informed basis; and

(c) in a manner he honestly believes to be in the best interests of the corporation.

(2) Such officer discharges his duties on an informed basis if he makes, with the care an ordinarily prudent person in a like position would exercise under similar circumstances, inquiry into the business and affairs of the corporation, or into a particular action to be taken or decision to be made.

(3) In discharging his duties such officer is entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, if prepared or presented by:

(a) one or more officers or employees of the corporation whom the officer honestly believes to be reliable and competent in the matters presented; or

(b) legal counsel, public accountants, or other persons as to matters the officer honestly believes are within the person's professional or expert competence.

(4) An officer is not acting in good faith if he has knowledge concerning the matter in question that makes reliance otherwise permitted by subsection (3) unwarranted.

(5) Any action taken as an officer, or any failure to take any action as an officer, shall not be the basis for monetary damages or injunctive relief unless:

(a) the officer has breached or failed to perform his duties in compliance with this section; and

(b) in the case of an action for monetary damages, the breach or failure to perform constitutes willful misconduct or wanton or reckless disregard for the best interests of the corporation.

(6) A person bringing an action for monetary damages under this section has the burden of proving by clear and

convincing evidence the provisions of subsections (5) (a) and (b), and the burden of proving that the breach or failure to perform was the legal cause of damages suffered by the corporation.

(7) Nothing in this section shall eliminate or limit the liability of any officer for any act or omission occurring prior to the date when this section becomes effective.

Bill Draft #18: Municipal Tort Claims Act

SECTION 1. KRS CHAPTER 65A IS ESTABLISHED AND A NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

As used in this Act unless the context otherwise requires:

(1) "Action in tort" means any claim for money damages based upon negligence, medical malpractice, intentional tort, nuisance, products liability and strict liability, and also includes any wrongful death or survival-type action; and

(2) "Employee" means any elected or appointed officer of a local government, or any paid or unpaid employee or agent of a local government, provided that no independent contractor nor employe nor agent of an independent contractor shall be deemed to be an employee of a local government; and

(3) "local government" means any city incorporated under the law of this Commonwealth, the offices and agencies thereof, any county government or fiscal court, any special district or special taxing district created or controlled by a local government.

SECTION 2. A NEW SECTION OF KRS CHAPTER 65A IS CREATED TO READ AS FOLLOWS:

Every action in tort against any local government in this Commonwealth for death, personal injury or property damages proximately caused by:

(1) Any defect or hazardous condition in public lands, buildings or other public property, including personalty;

(2) Any act or omission of any employee, while acting within the scope of his employment or duties; or

(3) Any act or omission of a person other than an employee for which the local government is or may be liable, shall e subject to the provisions of this Act. Except as otherwise specifically provided herein, all enacted and case-made law, substantive or procedural, concerning actions in tort against local governments shall continue in force. No provision of this Act shall in any way be construed to expand the existing common law concerning municipal tort liability as of the effective date of this Act nor eliminate or abrogate the defense of governmental immunity for county governments.

SECTION 3. A NEW SECTION OF KRS CHAPTER 65A IS CREATED TO READ AS FOLLOWS:

(1) The amount of damages recoverable against a local government for death, personal injury or property damages arising out of a single accident or occurrence, or sequence of accidents or occurrences, shall not exceed the total damages recoverable by plaintiff, reduced by the

percentage of fault including contributory fault, attributed by the trier of fact to other parties, if any.

SECTION 4. A NEW SECTION OF KRS CHAPTER 65A IS CREATED TO READ AS FOLLOWS:

Notwithstanding Section 2 of this Act, a local government shall not be liable for injuries or losses resulting from:

(1) Any claim by an employee of the local government which is covered by the Kentucky worker's compensation law;

(2) Any claim in connection with the assessment or collection of taxes;

(3) Any claim arising from the exercise of judicial, quasi-judicial, legislative or quasi-legislative authority or others, exercise of judgment or discretion vested in the local government, which shall include by example, but not be limited to:

(a) The adoption or failure to adopt any ordinance, resolution, order, regulation, or rule;

(b) The failure to enforce any law;

(c) The issuance, denial, suspension, revocation of, or failure or refusal to issue, deny, suspend or revoke any permit, license, certificate, approval, order or similar authorization.

(d) The exercise of discretion when in the fact of competing demands, the local government determines whether and how to utilize or apply existing resources; or

(e) Failure to make an inspection.

Nothing contained in this subsection shall be construed to exempt a local government from liability for negligence arising out of acts or omissions of its employees in carrying out their ministerial duties.

SECTION 6. A NEW SECTION OF KRS CHAPTER 65A IS CREATED TO READ AS FOLLOWS:

(1) Upon motion of a local government against which final judgment has been rendered for a claim within the scope of this act, the court in accordance with subsection (2) of this section, may include in such judgment a requirement that the judgment be paid in whole or in part by periodic payments. Periodic payments may be ordered paid over a period of time not exceeding ten (10) years. Any periodic payment , upon becoming due under the terms of the judgment, shall constitute a separate judgment. Any judgment ordering any such payments shall specify the total amount awarded, the amount of each payment, the interval between payments and the number of payments to be paid under the judgment. Judgments paid pursuant tot his section shall bear interest accruing from the date final judgment is entered, at the interest rate as specified in KRS 360.040. For good cause shown, the court may modify such judgment with respect to the amount of such payments and the number of payments, but the total amount of damages awarded by such judgment shall not be subject to

modification in any event and periodic payments shall not be ordered paid over a period in excess of ten (10) years.

(2) A court may order periodic payment only upon finding that:

(a) Payment of the judgment is not totally covered by insurance; and

(b) Funds for the current budget year and other funds of the local government which lawfully may be utilized to pay judgments are insufficient to finance both the adopted budget of expenditures for the year and the payment of that portion of the judgment not covered by insurance.

SECTION 7. A NEW SECTION OF KRS CHAPTER 65A IS CREATED TO READ AS FOLLOWS:

If the legislative body of a local government against whom a judgment has been entered or a settlement made for a tort claim covered by this Act determines that current revenues of the local government are insufficient to pay the judgment or settlement, or the installment due pursuant to Section 6 of this Act, it may levy a special tax for the purpose of paying such judgment or settlement. Such levy may include any tax permitted by Section 181 of the Kentucky constitution. An ad valorem tax levied pursuant to this section shall not be considered for purposes of calculating either the maximum tax rate or the compensating tax rate in accordance with

KRS 132.027. Any tax levied for the purpose of paying a judgment or settlement shall be used solely for such purpose.

SECTION 8. A NEW SECTION OF KRS CHAPTER 65A IS CREATED TO READ AS FOLLOWS:

(1) A local government shall provide for the defense of any employe in any action in tort arising out of an act or omission occurring within the scope of his employment of which it has been given notice pursuant to subsection (2) of this section. The local government shall pay any judgment based thereon or any compromise or settlement of the action except as provided in subsection (3) of this section and except that a local government's responsibility under this section to indemnify an employe shall be subject to the limitations contained in Section 3 of this Act.

(2) Upon receiving service of a summons and complaint in any action in tort brought against him, an employe shall, within ten (1) days of receipt of service, give written notice of such action in tort to the executive authority of the local government.

(3) A local government may refuse to pay a judgment or settlement in any action against an employe, or if a local government pays any claim or judgment against any employe pursuant to subsection (1) of this section, it may recover from such employe the amount of such payment and the costs to defend if:

(a) The employe acted or failed to act because of fraud, malice or corruption;

(b) The action was outside the actual or apparent scope of his employment;

(c) The employe willfully failed or refused to assist the defense of the cause of action, including the failure to give notice to the executive authority of the local government pursuant to section (2) of this section; or

(d) The employe compromised or settled the claim without the approval of the governing body of the local governmental.

SECTION 9. A NEW SECTION OF KRS CHAPTER 65A IS CREATED TO READ AS FOLLOWS:

This Act shall apply to all actions in tort in which money damages have not be adjudged as of the effective date of this Act.

Bill Draft #19

EXPANDED FAIR PLAN

Section 1. KRS 304.35-010 is amended to read as follows:

(1) As used in this subtitle:

(a) "Casualty insurance" [~~means only those coverages for bodily injury or property damage legal liability which are combined with property insurance in a homeowner or farmowner insurance policy form approved by the commissioner;~~] has the meaning set forth in KRS 304.5-070; and

(b) "Property insurance" has the meaning set forth in KRS 304.5-050.

(2) All insurers licensed to write and writing property and casualty insurance in this Commonwealth on a direct basis shall, subject to approval and regulation by the commissioner of insurance, establish and maintain a "FAIR" (Fair access to insurance requirements) plan and establish and maintain a reinsurance association and formulate and from time to time amend the plan and articles of association and rules and regulations in connection therewith, and assess and share on a fair and equitable basis all expenses, income, and losses incident

to such "FAIR" plan and reinsurance association in a manner consistent with the provisions of this subtitle.

Section 2. KRS 304.35-020 is amended to read as follows:

Each insurer authorized to write and writing property and casualty insurance on a direct basis in this Commonwealth shall be required to become and remain a member of the plan and the reinsurance association, and comply with the requirements thereof as a condition of its authority to transact property or casualty insurance business in Kentucky.

Section 3. KRS 304.35-030 is amended to read as follows:

(1) The "FAIR" plan and articles of association shall make provision for a reinsurance association having authority on behalf of its members as their agent to cause to be issued property and casualty insurance policies, to reinsure in whole or in part any such policies, and to cede any such reinsurance. The plan and articles of association shall provide, among other things, for the lines of business to be written, policy forms to be used, perils to be covered, geographical area of coverage, compensation and commissions, assessments of members (which assessments annually shall not exceed one fourth of one percent (1/4 of 1%) of any such member's net direct

premium written on a voluntary basis in this state during the preceding year), participation in the writings, expenses, income and losses in the proportion each member's property and casualty premiums written bear to the aggregate property and casualty premiums voluntarily written by all members, the administration of the plan and association, and any other matter necessary or convenient for the purpose of assuring fair access to insurance requirements.

(2) [~~The reinsurance association shall administer the mine subsidence insurance fund if directed to do so by the commissioner.~~] If the commissioner, in the fulfillment of the duties imposed upon him by KRS 304.13-041, determines that a reasonable degree of competition does not exist in the market for any lines of insurance, within the definitions of KRS 304.5-050 (property insurance) and KRS 304.5-070 (casualty insurance), or either of them, and issues an order to that effect, the commissioner shall order the governing committee to promptly amend the plan to include such line or lines of business unless, in the commissioner's opinion, an effective residual market mechanism as defined in KRS 304.13-011(8) is already then functioning to provide basic insurance requirements to worthy applicants for reasonable amounts of coverage under such line or

lines of insurance with insurers licensed to do business in this state. For accounting and rate making purposes, the commissioner may require the plan provide for the establishment and maintenance of separate accounts for any line included in the plan pursuant to this section.

Section 4. KRS 304.35-040 is amended to read as follows:

(1) The reinsurance association shall be governed by a committee consisting of seven (7) persons to be appointed by the commissioner of insurance within five (5) days from July 15, 1980. The governing committee shall be composed of two (2) persons representing insurers chartered under the laws of the Commonwealth of Kentucky, one (1) person representing an insurer that is neither chartered under the laws of the Commonwealth of Kentucky nor affiliated with one (1) of the national insurance trade associations, one (1) person representing an insurer from each of the following three (3) associations: American Insurance Association, Alliance of American Insurers, National Association of Independent Insurers, and one (1) licensed insurance agent.

(2) Within thirty (30) days following July 15, 1980, the governing committee of the association shall submit to the commissioner of insurance, for his review, a proposed

"FAIR" plan and articles of association consistent with the provisions of this subtitle.

(3) The "FAIR" plan and articles of association shall be subject to approval by the commissioner of insurance and shall take effect five (5) days after having been approved by him. If the commissioner disapproves all or any part of the proposed plan and articles, the governing committee of the association shall within fifteen (15) days submit for review an appropriately revised plan and articles; and, if the governing committee fails to do so, the commissioner shall thereafter promulgate such plan and articles consistent with the provisions of this subtitle.

(4) The governing committee of the association may, on its own initiative or shall at the request of the commissioner, amend the plan and articles, subject to approval by the commissioner.

(5) The governing committee of the association shall, on or before April 1 of each year, file with the commissioner, on such forms as the commissioner requires, an accounting of the plan's operations during the preceding calendar year together with its financial condition, and its underwriting experience as to each separate account maintained therein, as of the end of such year. The commissioner may require interim accountings on

a quarterly basis or examine the affairs of the association when, in his opinion, such action is necessary to determine the continued solvency of the reinsurance association.

(6) If at any time the commissioner determines that the reinsurance association is or may become unable to meet its financial obligations during the current year, the commissioner shall order the governing committee to levy appropriate assessments within the limitations of KRS 304.35-030(1) against all members. If the commissioner further determines that such assessment, when levied at the maximum rate for any account during any calendar year, is or may be insufficient to maintain the solvency of the reinsurance association for at least one year, the commissioner shall order each member to collect a premium surcharge for the benefit of the reinsurance association of one dollar ($1.00) from the holder of each individual policy or certificate written or renewed either voluntarily by such member or as a residual market mechanism assignment during the subsequent twelve (12) month period. Such policy or certificate surcharge shall be remitted monthly to the association by each member and shall be in addition to any assessments levied against the member pursuant to KRS 304.35-030(1) by the governing committee.

Section 5. A new section of KRS Chapter 304, Subtitle 35, is created to read as follows:

There shall be no liability on the part of, and no cause of action of any nature shall arise against any member insurer, servicing insurer, insurance agent, inspector or inspection bureau, adjustor or adjusting firm, placement facility, or reinsurance association, or the governing committee, or the agents or employees of any of them, or the commissioner of insurance or his authorized representatives, for any inspections undertaken or statements made by any of them concerning the risk to be insured, or any person having a legal interest therein, and any reports and communications in connection therewith shall not be considered public documents.

Bill Draft #20a: Liability Insurance for Local Governments

KRS 65.150 is amended to read as follows:

(1) A county, city or urban-county government and any board, commission, agency or authority of a county, city or urban-county government may expend funds necessary to insure any of its employees [and], officials and property against any liability or property damage arising out of an act or omission committed in the scope and course of legal duties.

(2) A county fee officer and his deputies and assistants may be insured pursuant to subsection (1) of this section, or the officer may expend excess fees to insure himself and his deputies and assistants against any liability arising out of an act or omission committed in the scope and course of performing legal duties.

(3) Any parties eligible to expend funds for insurance pursuant to this section may associate, pursuant to KRS 65.210 to 65.300, for the purpose of insuring themselves against any liability or property damage.

(4) An association of governmental units formed for the purpose of providing insurance to the participating members may act on behalf of and with the approval of the

participating governmental units to borrow money and issue revenue bonds to fund the costs of providing the insurance. Revenue bonds issued pursuant to the authority granted in this subsection shall be issued in accordance with KRS 65.270.

Bill Draft #20b

REPEAL OF FICTITIOUS GROUP STATUTE

Section 1. KRS 304.12-210 is hereby repealed.

[KRS 304.12-210

(1) No insurer or any person on behalf of any insurer shall make, offer to make, or permit any preference or distinction in property, marine, casualty or surety insurance as to form of policy, certificate, premium rate, benefits, preferred distribution of profits or dividends, or conditions of insurance, on a group basis, based upon membership, nonmembership, employment, or of any person or persons by or in any particular group, association, corporation, or organization, or employes of any particular employer, and shall not make the foregoing preference or distinction available in any event based upon any fictitious grouping of persons as defined in this code, such fictitious grouping being hereby defined and declared to be any grouping by way of membership, nonmembership, license, franchise, employment, contract agreement or any other method or means, except, where under common majority ownership and the same direct operating management,]

[(2) The restrictions and limitations of this section shall not extend or apply to automobile, life, health, accident or disability insurance, or where those grouped are engaged in a joint venture or a common construction or demolition project or to liability, property and surety insurance for public housing authorities created pursuant to KRS Chapter 80.

(3) Nothing in this section shall apply to any company which confines its direct insurance business to this state and to the providing of insurance for the benefit of its members, or members of its parent or sponsoring organization, providing such company was in existence and confining its insurance business and operations in such manner prior to January 1, 1968.]

Bill Draft #21

EXTENDED NOTIFICATION OF CANCELLATION AND NON RENEWAL

Section 1. KRS 304.20-040 is amended to read as follows:

(1) As used in this section:

(a) "Policy" means an automobile liability insurance policy, delivered or issued for delivery in this state, assuring a single individual or husband and wife resident of the same household, as named insured, and under which the insured vehicles therein designated are of the following types only:

1. A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others;

2. Any other four-wheel vehicle with a load capacity of fifteen hundred (1500) pounds or less which is not used in the occupation, profession or business of the insured; provided, however, that this section shall not apply:

a. To any policy issued under an automobile assigned risk plan;

b. To any policy insuring more than four (4) automobiles; or

c. To any policy covering garage, automobile sales agency, repair shop, service station or public parking place operation hazards;

(b) "Automobile liability insurance policy" includes only coverage for bodily injury and property damage liability, basic reparations benefits and the provisions therein, if any, relating to medical payments, uninsured motorists coverage, and automobile physical damage coverage;

(c) "Renewal" or "to renew" means the issuance and delivery by an insurer of a policy replacing at the end of the policy period a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term; provided, however, that any policy with a policy period or term of less than three (3) [~~six (6)~~] months shall for the purpose of this section be considered as if written for a policy period or term of three (3) [~~six (6)~~] months. Provided, further, that any policy written for a term longer than one (1) year or any policy with no fixed expiration date, shall for the purpose of this section, be considered as if written for successive policy periods or terms of one (1) year, and such policy may be terminated at the expiration of any annual period upon giving seventy five (75) [~~twenty (20)~~] days' notice of cancellation prior to such

anniversary date, and such cancellation shall not be subject to any other provisions of this section; and

(d) "Nonpayment of premium" means failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums on a policy, or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

(2) (a) A notice of cancellation of a policy shall be effective only if it is based on one (1) or more of the following reasons:

1. Nonpayment of premium; or

2. The driver's license or motor vehicle registration of the named insured or of any other operator who either resides in the same household or customarily operates an automobile insured under the policy has been under suspension or revocation during the policy period or, if the policy is a renewal, during its policy period or the one hundred eighty (180) days immediately preceding its effective date;

(b) This subsection shall not apply to any policy or coverage which has been in effect less than sixty (60) days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy;

(c) Modification of automobile physical damage coverage by the inclusion of a deductible not exceeding

one hundred dollars ($100) shall not be deemed a cancellation of the coverage or of the policy; and

(d) This subsection shall not apply to nonrenewal.

(3) No notice of cancellation of a policy to which subsection (2) of this section applies shall be effective unless mailed or delivered by the insurer to the named insured at least twenty (20) days prior to the effective date of cancellation; provided, however, that where cancellation is for nonpayment of premium at least fourteen (14) days' notice of cancellation accompanied by the reason therefor shall be given. This subsection shall not apply to renewals.

(4) No insurer shall refuse to renew a policy of automobile insurance solely because of the age of the insured.

(5) No insurer shall fail to renew a policy unless it shall mail or deliver to the named insured, at the address shown in the policy, at least seventy five (75) [twenty (20)] days' advance notice of its intention not to renew. [This subsection shall not apply:

(a) If the insurer has manifested its willingness to renew; or]

[(b) In case of nonpayment of premium; Provided that, notwithstanding the failure of an insurer to comply with this subsection, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies;]

(6) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

(7) If the insurer has manifested its willingness to renew by mailing or delivering of a renewal notice, bill, certificate, or policy to the first named insured at his last known address at least thirty (30) days before the end of the current policy period with the amount of the renewal premium charge and its due date clearly set forth therein; then the policy shall expire and terminate without further notice to the insured on the due date unless the renewal premium is received by the insurer or its authorized agent on or before that date. When any policy terminates pursuant to this subsection because the renewal premium was not received on or before the due date, the insurer shall, within fifteen (15) days, deliver or mail to the first named insured at his last known address a notice that the policy was not renewed and the date on which the coverage under it ceased to exist.

(8) (a) Proof of mailing of renewal premium to the insurer or its agent, when authorized, on or before the due date, shall constitute a presumption of receipt pursuant to Subsection (7).

(b) Proof of mailing of notice of cancellation or of intention not to renew or of reasons for cancellation or nonrenewal to the named insured at the address shown in the policy, shall be sufficient proof of notice.

(9)[(7)] No insurer shall impose or request an additional premium higher than its standard premium for automobile insurance, cancel or refuse to issue a policy, or refuse to renew a policy solely because the insured or the applicant is handicapped or a physically disabled person, so long as the handicap or physical disability does not substantially impair the person's mechanically assisted driving ability.

(10)[(8)] When an automobile liability insurance policy is canceled other than for nonpayment of premium, or in the event of failure to renew a policy of automobile liability insurance to which subsection (5) of this section applies, the insurer shall notify the named insured of his possible eligibility for automobile liability insurance coverage through the Kentucky automobile assigned risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew. Such notice shall also inform the insured that he may, within four (4) days, request the commissioner in writing to determine whether there is sufficient reason to cancel or not to renew the policy. Within fourteen (14) days of receiving such a written request, the commissioner shall send his findings to the insurer and to the insured. When he sends his findings, the commissioner shall notify both parties of their right to request a hearing under KRS 304.2-310(2)(b).

(10)[(9)] The reason for nonrenewal or cancellation shall accompany or be included in the notice of nonrenewal or cancellation.

(11)[(10)] There shall be no liability on the part of and no cause of action of any nature shall arise against the commissioner or against any insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal, for any statement made by any of them in any written notice of cancellation or nonrenewal, or in any other communication, oral or written specifying the reasons for cancellation or nonrenewal, or the providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

Section 2. KRS 304.20-310 is amended to read as follows:

As used in KRS 304.20-320 to 304.20-350:

(1) "Renewal" or "to renew" means the issuance and delivery by an insurer at the end of a policy period or term of a policy superseding a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term. For the purpose of KRS 304.20-320 to 304.20-350, any policy

period or term of less than six (6) months shall be considered to be a policy period or term of six (6) months and any policy period or term of more than one (1) year or any policy with no fixed expiration date shall be considered a policy period or term of one (1) year;

(2) "Nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on property or casualty insurance subject to KRS 304.20-320 to 304.20-350, whether such payments are directly payable to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. "Nonpayment of premium" shall include failure to pay dues or fees where payment of such dues or fees is a prerequisite to obtaining or continuing property or casualty insurance coverage;

(3) "Termination" means either a cancellation or nonrenewal of property or casualty insurance coverage in whole or in part. A cancellation occurs during the policy period or term as set forth in subsection (1) of this section. A nonrenewal occurs at the end of the policy period [~~year~~] or term as set forth in subsection (1) of this section. For the purpose of KRS 304.20-320 to 304.20-350, the transfer of a policyholder between companies within the same insurance group shall be considered a termination, but requiring a reasonable deductible, reasonable changes in the amount of insurance,

intention not to renew the policy upon expiration of the current policy period with [~~/ The insured may request in writing an explanation of the insurer/s reason for a nonrenewal/ Upon receipt of such request/ the insurer shall provide~~] a written explanation of the specific reason or reasons for the nonrenewal;

[~~(b) No notice of intention not to renew shall be required where the named insured is given notice of the insurer/s willingness to renew the policy by mailing or delivering of a renewal notice/ bill/ certificate/ or policy/ and~~]

(b)[~~¢~~] If notice is not provided pursuant to paragraph (a) of this subsection, coverage shall be deemed to be renewed for the ensuing policy period upon payment of the appropriate premium under the same terms and conditions, and subject to the provisions of KRS 304.20-330, until the named insured has accepted replacement coverage with another insurer, or until the named insured has agreed to the nonrenewal.

(c) If the insurer has manifested its willingness to renew by mailing or delivering of a renewal notice, bill, certificate, or policy to the first named insured at his last known address at least thirty (30) days before the end of the current policy period with the amount of the renewal premium charge and its due date clearly set forth therein; then the policy shall expire and terminate without further notice to the insured on the due date

(a) A notice of cancellation of insurance subject to KRS 304.20-300 to 304.20-350 by an insurer shall be in writing, shall be delivered to the named insured or mailed to the named insured at the last known address of the named insured, shall state the effective date of the cancellation, and shall be accompanied by a written explanation of the specific reason or reasons for the cancellation; and

(b) The notice of cancellation referred to in paragraph (a) of this subsection shall be mailed or delivered by the insurer to the named insured at least fourteen (14) days prior to the effective date of the cancellation if the cancellation occurs within sixty (60) days of the date of issuance of the policy. Such notice of cancellation shall be mailed or delivered by the insurer to the named insured at least seventy five (75) [~~thirty (30)~~] days prior to the effective date of the cancellation if the policy has been in effect more than sixty (60) days.

(3) Nonrenewals.

(a) No insurer shall refuse to renew a property or casualty insurance policy subject to KRS 304.20-300 to 304.20-350 unless at least seventy five (75) [~~thirty (30)~~] days before the end of the policy period as described in KRS 304.20-310(1), the insurer shall mail or deliver to the named insured, at the last known address of the named insured, written notice of the insurer's

unless the renewal premium is received by the insurer or its authorized agent on or before that date. When any policy terminates pursuant to this subsection because the renewal premium was not received on or before the due date, the insurer shall, within fifteen (15) days, deliver or mail to the first named insured at his last known address a notice that the policy was not renewed and the date on which the coverage under it ceased to exist.

(d) Proof of mailing of renewal premium to the insurer or its agent, when authorized, on or before the due date shall constitute a presumption of receipt pursuant to Subsection (c).

(4) No insurer shall increase the premium for a property or casualty insurance policy subject to KRS 304.20-300 to 304.20-350 more than twenty-five percent (25%) of the premium for the preceding policy term for like coverage and like risks unless at least seventy five (75) [~~thirty (30)~~] days before the end of the policy period as described in KRS 304.20-310(1), the insurer shall mail or deliver to the named insured, at the last known address of the named insured, notice of such premium increase or a notice [~~bill~~]for the renewal premium amount and the insurer shall mail or deliver to its agent, if any, a duplicate notice of the premium amount [~~increase~~]. In order to comply with this requirement, the insurer may extend the period of coverage of the current policy at the expiring premium.

Bill Draft #22

CONFIDENTIALITY OF PEER REVIEW RECORDS

Section 1. KRS 311.377 is amended to read as follows:

(1) Any person who applies for, or is granted staff privileges after June 17, 1978, by any health services organization subject to licensing under the certificate of need and licensure provisions of KRS Chapter 216B, shall be deemed to have waived as a condition of such application or grant, any claim for damages for any good faith action taken by any person who is a member, participant in or employee of or who furnishes information, professional counsel or services to any committee, board, commission, or other entity which is duly constituted by any licensed hospital, organized medical staff, medical society, or association affiliated with the American Medical Association, American Podiatry Association, American Dental Association, American Osteopathic Association or the American Hospital Association, or a medical care foundation affiliated with such a medical society or association, or governmental or quasi-governmental agency when such entity is performing the designated function of review of credentials or

retrospective [~~designated to~~] review and [~~evaluate the health care acts~~] evaluation of the competency of professional acts or conduct of other health care personnel. This subsection shall have equal application to, and the waiver be effective for, those persons who, subsequent to June 17, 1978, continue to exercise staff privileges previously granted by any such health services organization.

(2) At all times in performing a designated professional review function, the [~~The~~] proceedings, records, opinions, conclusions and recommendations of any committee, board, commission, medical staff, professional standards review organization, or other entity, as referred to in subsection (1) of this section shall be confidential and privileged and shall not be subject to discovery, subpoena, or introduction into evidence, in any civil action in any court or in any administrative proceeding before any board, body, or committee, whether federal, state, county, or city, except as specifically provided with regard to the board in KRS 311.605(2). This subsection shall not apply to any proceedings or matters governed exclusively by federal law or federal regulation.

(3) Nothing in subsection (2) of this section shall be construed to restrict or limit the right to discover or use in any civil action or other administrative proceedings

any evidence, document or record which is subject to discovery independently of the proceedings of the [~~committee, board, commission, professional standard review organization or other~~] entity to which subsection (1) of this section refers.

(4) No person who presents or offers evidence in proceedings described in subsection (2) of this section or who is a member of any [~~committee, board, commission, professional standards review organization~~] entity before which such evidence is presented or offered may refuse to testify in discovery or upon a trial of any civil action as to any evidence, document or record described in subsection (3) of this section or as to any information within his own knowledge except as provided in subsection (5) of this section.

(5) No person shall be permitted or compelled to testify concerning his testimony or the testimony of others except that of a defendant given in any proceeding referred to in subsection (2) of this section, or as to any of his opinions formed as a result of such proceeding.

(6) In any action in which the denial, termination or restriction of staff membership or privileges by any health care facility [~~entity~~] shall be in issue, agents, employees or other representatives of a health care entity may with the consent of such health care entity testify

concerning any evidence presented in proceedings related to the facility's [~~entity's~~] denial of such staff membership of privileges.

(7) Nothing in this section shall be construed to restrict or prevent the presentation of testimony, records, findings, recommendations, evaluations, opinions, or other actions of any [~~committee, board, commission, professional standards review organization, or other~~] entity described in subsection (1) of this section, in any statutory or administrative proceeding related to the functions or duties of such [~~any committee, board, commission, professional standards review organization, or other~~] entity.

(8) In addition to the foregoing, the immunity provisions of the federal Health Care Quality Improvement Act of 1986, P.L. 99-660, shall be effective arising under state laws as of the effective date hereof.

Section 2. KRS 311.605 is amended to read as follows:

(1) Every county board of health shall, at such times as are fixed by the board, report to the board the name and address of each person believed to be engaged in the practice of medicine or osteopathy, as defined by KRS 311.550, within their respective jurisdictions. The county boards of health shall also report to the board and to the county and Commonwealth's attorneys of their respective

counties all violations of KRS 311.550 to 311.620 and shall assist in the enforcement thereof.

(2) For the purpose of enforcing the provisions of KRS 311.550 to 311.620, agents of the board shall have the power and authority to administer oaths, to enter upon premises at all times for the purpose of making inspections, to seize evidence, to interrogate all persons, and to require the production of books, papers, documents or other evidence. The term "premises" as used in this subsection shall include physician offices, pharmacies and all health care facilities licensed or regulated by the Commonwealth. Agents of the board may only require pharmacies to produce prescription records and health care facilities to produce records of patients or physician peer reviews. Such inspection or seizure of peer review records shall not affect the confidential nature of those records as provided in KRS 311.377, and the board shall maintain such peer review records so as to protect the confidentiality thereof.

(3) The board may institute, in its own name, proceedings to temporarily or permanently restrain and enjoin violations of KRS 311.550 to 311.620, regardless of whether the defendant has been convicted for violation of the penal provisions thereof, and shall not be required to pay any costs or filing fees or furnish any bond in

connection therewith. Violation of injunctions and restraining orders shall be punished as a contempt without the intervention of a jury.

Bill Draft #23a

TRIGGERED RATE FILING

SECTION 1. A NEW SECTION OF SUBTITLE 13 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) All insurers subject to this subtitle shall, for lines of business prescribed by the Commissioner, on or before of each year, file with the Commissioner an experience report. The form of the experience report shall be prescribed by the Commissioner.

(2) The Commissioner shall establish ranges of trigger ratios for the lines of business named in each experience report. The ranges of trigger ratios may vary by line of business, recognizing factors such as the different investment income potential for each line of business. The Commissioner may from time to time change the range of trigger ratios for a line of business to reflect current circumstances such as changes in investment income potential.

(3) When an insurer's trigger ratio for a line of business for a time period specified by the Commissioner falls outside the range of trigger ratios established pursuant to subsection (2) of this section, the insurer shall file with the department at rate filing for that

line of business. Procedures for such rate filings shall be established by the Commissioner.

(a) The commissioner may order a rate filing by an insurer which has a trigger ratio within the range of trigger ratios established pursuant to subsection (2) of this section when the circumstances indicate a rate filing is needed, such as a trend in the insurer's trigger ratio which suggests developing problems.

(4) If the rate filing required by subsection (3) of this section indicates that a rate change is necessary, the Commissioner may order the insurer to make an appropriate rate change. The insurer may appeal this order. Any such appeal shall be made pursuant to subtitle 2 of this chapter.

(5) The Commissioner may exempt an insurer from the experience reporting requirements of this section for a line of business if the Commissioner determines that the insurer's market share of a line of business is not substantial. Such an exemption may at any time be revoked by the Commissioner.

Bill Draft #23b

FLEX RATING

Section 1. KRS 304.13-051 is amended to read as follows:

(1) In a competitive market, every insurer shall file with the Commissioner rates and supplementary information to be used in this state for commercial risks as designated by the Commissioner and for all personal risks. Such rates and supplementary rate information shall be filed not later than fifteen (15) days after the date of first use of the rates, unless the Commissioner finds after a hearing that an insurer's rates require closer supervision because of the insurer's financial condition. On such a finding, rates for both personal and commercial risks, supplementary rate information, and supporting information shall be filed with the Commissioner at least thirty (30) days before the effective date of the rates. Such an order shall expire no later than one (1) year after it is issued.

(2) In a noncompetitive market, every insurer shall file with the Commissioner all rates for that market, supplementary rate information, and supporting information at least thirty (30) days before the proposed effective

date of the rates. On application of the filer, the Commissioner may authorize an earlier effective date.

(3) Any rate filing in effect at the time the Commissioner determines that competition does not exist pursuant to KRS 304.13-041 shall be deemed to be effective until disapproved pursuant to the procedures and rating standards of this chapter.

(4) Every insurer shall file with the Commissioner all rating manuals and underwriting rules that it uses in this state not later than fifteen (15) days after they become effective. Such manuals, rules and guidelines must be adhered to until amended. The Commissioner may exempt an insurer from filing supporting information if it files by reference, with or without deviation, to a filing which is in effect for another insurer or an advisory organization.

(5)(a) No insurer shall place into effect any rates, manuals, or underwriting rules which it proposes to use pursuant to subsection (1) or (4) of this section if such rates, manuals or underwriting rules will result in an increase or decrease of more than twenty-five percent (25%) from such insurer's then existing rates for any classification of risks in any of its rating territories within a twelve (12) month period of time.

(B) Any insurer which proposes to change its then existing rates, manuals or underwriting rules so as to effectively increase or decrease the rates of any classification of risks within any rating territory more than twenty-five percent (25%) within a twelve (12) month period shall file all such rates and supplemental rating information which shall not become effective until approved by the commissioner.

(6)[5] Rates and supplemental rating information for a residual market mechanism shall not become effective until approved by the Commissioner.

(7)[6] The Commissioner shall review filings made in accordance with subsections (2), (5)(b) and (6) [and (5)] of this section as soon as reasonably possible after they have been made in order to determine whether they meet the applicable requirements of this chapter. Each filing shall be on file for a waiting period of thirty (30) days before it becomes effective, which period may be extended by the Commissioner for an additional period not to exceed thirty (30) days if he gives written notice within such waiting period to the insurer which made the filing that additional time is needed for consideration of the filing. The Commissioner may, when he deems it to be in the public interest, hold a public hearing on any filing before said filing becomes effective to determine

whether the filing meets the requirements of this subtitle. In the event that a hearing is held under the provisions of this subsection, the waiting periods specified in this subsection shall not begin to run until thirty (30) days after the close of such hearing. The burden of establishing that the filing under consideration meets the requirements of this subtitle is on the insurer which makes such filing. A filing shall be deemed to meet the requirements of this subtitle unless disapproved by the Commissioner within the waiting period or any extension thereof.

Bill Draft #24

KENTUCKY EXPERIENCE IN RATE MAKING

SECTION 1. A NEW SECTION OF SUBTITLE 13 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

Every insurer shall provide to the Commissioner such information as the Commissioner may require to demonstrate to what extent the insurer's rates are based upon its Kentucky experience.

Bill Draft #26

CLOSED CLAIM INFORMATION

SECTION 1. A NEW SECTION OF KRS CHAPTER 304.3 IS CREATED TO READ AS FOLLOWS:

(1) Every authorized insurer which writes casualty insurance in this state shall develop, maintain and report to the Commissioner of Insurance, as an exhibit to its annual statement, such information as shall be required by the Commissioner with regard to each bodily injury claim made against it or its insured by any person who has sustained bodily injury from an accident occurring within the confines of this Commonwealth. Each such claim shall be reported with the annual statement covering the period during which the claim was closed. The Commissioner may, upon 90 days' notice to any authorized insurer, require information on claims closed during any other period designated by him.

(2) The information to be reported in accordance with the provisions of this Act shall, when applicable, include:

(a) information relating to the identification of the insurer;

(b) information relating to the casualty insurance policy including the type or types of insurance, the

amounts of various policy limits, whether the policy was occurrence or claims-made, the classification of the insured, and reserves for the claim;

(c) details concerning any injury, damage, and other losses that were the subject of the claim, including the types of injuries, damages, and other losses, where and how injuries, damages, and other losses occurred, age of any injured party, and whether an injury was work-related;

(d) details relating to the claims process including whether suit was filed, where suit was filed, whether attorneys were involved, stage at which the claim was closed, court verdict, information relating to appeals, number of defendants, and whether the claim was settled outside of court and, if so, at what stage;

(e) detailed information relating to the amounts paid on the claim including information relating to the total amount of a court award, the amount paid by the insurer, amounts paid by other insurers, amounts paid by other defendants, collateral sources, structured settlements, amount of noneconomic compensatory damages, amount of prejudgment interest, amounts paid for defense costs, amounts paid for punitive damages, and amounts of allocated loss adjustment expenses; and

(f) any other information that the Commissioner determines to be significant in allowing the Department

and the General Assembly to monitor the casualty insurance industry and its workings with the civil justice system and to assure that casualty insurance is available, affordable, and providing adequate protection in Kentucky.

(3) The Commissioner shall adopt, in accordance with the provision of KRS Chapter 13A, administrative regulations setting out the manner and form in which the information required by this Act is to be reported.

(4) The Commissioner shall compile the information reported pursuant to this Act and shall prepare annually a written report on the composite information. The report shall be available to the public except that individual bodily injury claims information shall be kept confidential by the Department. Copies of the report shall be provided to the Governor and the presiding officers of each house of the General Assembly.

Bill Draft #27

INSURANCE POLICY SIMPLIFICATION

SECTION 1. A NEW SECTION OF KRS CHAPTER 304.14 IS CREATED TO READ AS FOLLOWS:

(1) No insurance policy for homeowners, dwelling fire, automobile, accident and health, life or other forms of personal insurance shall be delivered, issued for delivery, amended or renewed in this state after the effective date set out in subsection (2) of this section unless the policy is in compliance with the provisions of this Act.

(2) The Commissioner shall, within one (1) year from the effective date of this Act, promulgate regulations in accordance with the provisions of KRS Chapter 13A to carry out the provisions of this Act and to establish minimum standards for the readability and intelligibility of insurance contracts. Within one (1) year of the effective date of the regulations all insurers licensed to transact business shall comply with the standards set out by this Act and promulgated by the Commissioner.

(3) The Commissioner may, by order, exempt a type of personal lines insurance policy from the provisions of

this Act if the Commissioner finds that type of policy is generally understood by persons to whom it is delivered.

SECTION 2. A NEW SECTION OF KRS CHAPTER 304.14 IS CREATED TO READ AS FOLLOWS:

(1) All insurance policies subject to the provisions of this Act shall contain as the first page or first page of text, if it is preceded by a title page or pages, a cover sheet or sheets as provided in this Section. The cover sheet or sheets shall be printed in legible type and readable language, and shall contain at least the following:

(a) A brief statement that the policy is a legal contract between the policy owner and the company;

(b) The statement "READ YOUR POLICY CAREFULLY. This cover sheet provides only a brief outline of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY."; and

(c) An index of the major provisions of the policy or contract and the pages on which they are found which may include the following items:

1. the person or persons insured by the policy,

2. the applicable events, occurrences, conditions, losses or damages covered by the policy,

3. the limitations or conditions on the coverage of the policy,

4. definitional sections of the policy,

5. provisions governing the procedure for filing a claim under the policy,

6. provisions governing cancellation, renewal, or amendment of the policy by either the insurer or the policyowner,

7. any options under the policy, and

8. provisions governing the insurer's duties and powers in the event that suit is filed against the insured.

(2) The cover sheet may include, either as part of the index or as a separate section, a brief summary of the extent and types of coverage in the policy.

(3) No cover sheet shall be used unless it has been filed with and approved by the Commissioner. The cover sheet shall be deemed approved sixty (60) days after filing unless disapproved by the Commissioner within the sixty (60) day period, subject to a reasonable extension of times as the Commissioner may require by notice given within the sixty (60) day period. The Commissioner shall

disapprove any cover sheet which does not meet the requirements of this Section. Any disapproval shall be delivered to the insurer in writing, stating the grounds therefor.

SECTION 3. A NEW SECTION OF KRS CHAPTER 304.14 IS CREATED TO READ AS FOLLOWS:

(1) All insurance policies subject to the provisions of this Act shall be written in language easily readable and understandable by a person of average intelligence and education.

(2) In determining whether a policy or contract is readable within the meaning of this Section the Commissioner shall consider, at least, the following factors:

(a) the simplicity of the sentence structure and the shortness of the sentences used;

(b) the extent to which commonly used and understood words are employed;

(c) the extent to which legal terms are avoided;

(d) the extent to which references to other sections or provisions of the contract are minimized;

(e) the extent to which definitional provisions are incorporated in the text of the policy or contract; and

(f) any additional factors relevant to the readability or understandability of an insurance policy or

contract which the Commissioner may prescribe by regulation.

SECTION 4. A NEW SECTION OF KRS CHAPTER 304.14 IS CREATED TO READ AS FOLLOWS:

(1) All insurance policies subject to the provisions of this Act shall be printed in legible type and in a type face style approved by the Commissioner. The Commissioner shall by regulation establish a list of type face styles approved as acceptable.

(2) In determine whether a policy is legible the Commissioner shall consider, in addition to the requirements of subsection (1) relating to type face size and style, the following factors:

(a) margin size;

(b) contrast and legibility of the color of the ink and paper;

(c) the amount and use of space to separate sections of the policy;

(d) the use of contrasting titles or headings for sections or similar aids; and

(e) any additional factors relevant to legibility which the Commissioner may prescribe by regulation.

Bill Draft #28

SURPLUS LINES POLICIES

Section 1. KRS 304.10-090 is amended to read as follows:

Every insurance contract procured and delivered as a surplus lines coverage pursuant to this subtitle shall have conspicuously stamped upon the face page in bold type, initialed by or bearing the name of the surplus lines broker who procured it, the following:

"This insurance has been placed with an insurer not licensed to transact business in the Commonwealth of Kentucky, but eligible as a surplus lines insurer. The insurer is not a member of the Kentucky Insurance Guaranty Association. Should the insurer become insolvent the protection and benefits of the Kentucky Insurance Guaranty Association are not available."

Bill Draft #29

INSURANCE SETTLEMENT

A NEW SECTION OF SUBTITLE 12 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) All claims arising under the terms of any contract of insurance, unless there is a proper assignment of benefits, shall be paid to the named insured not more than sixty (60) days from the date upon which notice and proof of claim, in the substance and form required by the terms of the policy, are furnished the insurer.

(2) If an insurer fails to make a good faith attempt to settle a claim within the time prescribed in subsection (1) of this section, the value of the final settlement shall bear interest at the rate of twelve percent (12%) per annum.

(3) If an insurer fails to settle a claim within the time prescribed in subsection (1) of this section and the delay was without reasonable foundation, the insured shall be entitled to be reimbursed for his reasonable attorney's fees incurred. No part of the fee for representing the claimant in connection with this claim shall be charged against benefits otherwise due the claimant.

Bill Draft #30

UNFAIR CLAIMS SETTLEMENT PRACTIES

Section 1. KRS 304.3-200 is amended to read as follows:

(1) The Commissioner may, in his discretion, refuse to continue or may suspend or revoke an insurer's certificate of authority if he finds after a hearing thereon, or upon waiver of hearing by the insurer, that the insurer has:

(a) Willfully violated or willfully failed to comply with any lawful order of the Commissioner; or

(b) Willfully violated or willfully failed to comply with any lawful regulation of the Commissioner; or

(c) Willfully violated any provision of this code other than those for violation of which suspension or revocation is mandatory; or

(d) Failed to pay taxes on its premiums as required by law; or

(e) Has committed any unfair claims settlement practice as defined in subtitle 12 or regulations promulgated thereunder.

In lieu of or in addition to such suspension or revocation, the Commissioner may, in his discretion, reprimand the insurer, which shall be made a part of the

insurers record, or may levy upon the insurer, and the insurer shall pay forthwith, an administrative fine as specified in KRS 304.99-020.

(2) The Commissioner shall suspend or revoke an insurer's certificate of authority on any of the following grounds, if he finds after a hearing thereon that the insurer:

(a) Is in unsound condition, or is being fraudulently conducted, or is in such condition or using such methods and practices in the conduct of its business as to render its further transaction of insurance in this state currently or prospectively hazardous or injurious to policyholders or to the public.

(b) With such frequency as to indicate its general business practice in this state:

1. Has without just cause failed to pay, or delayed payment of, claims arising under its policies, whether the claim is in favor of an insured or is in favor of a third person with respect to the liability of an insured to such third person; or

2. Without just cause compels insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or such an insured to secure full payment or settlement of such claims.

(c) Refuses to be examined, or if its directors, officers, employees or representatives refuse to submit to examination relative to its affairs, or to produce its accounts, records and files for examination by the Commissioner when required, or refuse to perform any legal obligation relative to the examination.

(d) Has failed to pay any final judgment rendered against it in this state upon any policy, bond, recognizance or undertaking as issued or guaranteed by it, within thirty (30) days after the judgment became final or within thirty (30) days after dismissal of an appeal before final determination, whichever date is the later.

(e) Has actual knowledge by the chief executive officer or person in charge of Kentucky operations that an agent employed by the insurer has engaged or is engaging in conduct in violation of this code and the insurer has failed to report such conduct to the department.

(f) No insurer, its agents, servants, or employees shall incur any liability in connection with or as a result of any disclosure made to the Commissioner of insurance pursuant to the provisions of this section.

(3) The Commissioner may, in his discretion and without advance notice or a hearing thereon, immediately suspend the certificate of authority of any insurer as to which proceedings for receivership, conservatorship,

rehabilitation or other delinquency proceedings have been commenced in any state by the public insurance supervisory officer of such state.

Section 2. KRS 304.12-230 is amended to read as follows:

It is an unfair claims settlement practice for any person to commit or perform any of the following acts or omissions [~~with such frequency as to indicate a general business practice~~]

(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(7) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(8) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(10) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made;

(11) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(14) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

Bill Draft #31

LIABILITY INSURANCE CONSUMER'S ADVISORY COUNCIL

OF KENTUCKY

Section 1. A NEW SECTION OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) The Insurance Consumer's Advisory Council of Kentucky is hereby established.

(2) The members of the insurance consumer's advisory council shall be nine (9) in number and shall be appointed by the Governor for a term of four (4) years. To the extent possible, each member shall be appointed from a different geographic region and shall include:

(a) One (1) licensed insurance agent as defined in KRS 304.9-030.

(b) One (1) representative of an insurance company which has certificate of authority and is licensed to do business in Kentucky as defined by KRS 304.1-110.

(c) Two (2) citizens who are consumers of insurance.

(d) One (1) representative of a labor organization as defined by KRS 336.180.

(e) One (1) attorney at law licensed to practice law in the Commonwealth of Kentucky.

(f) One (1) representative who self-funds their risk either on an individual or group basis.

(g) One (1) representative of general business.

(h) One (1) representative who is a health care provider.

(3) The chairman of the council shall be selected by a majority vote of the council. The council shall meet at least four (4) times annually at the call of the chairman. The council shall be attached for administrative purposes to the Kentucky Department of Insurance.

(4) It shall be the function of the council to advise the Commissioner of Insurance on matters of concern to the consumers of insurance and problems relating to the availability and affordability of insurance. The council shall conduct an ongoing study of the operation of all laws, rules, regulations, orders, and state policies affecting consumers and to recommend to the governor, the legislature and the Commissioner legislation, rules, regulations, orders and policies in the interest of consumers of insurance. The council shall maintain records indicating the final disposition by the official of any matter so referred.

Bill Draft #33

FIRE PROTECTION IMPROVEMENT FUND

SECTION 1. A NEW SECTION OF KRS CHAPTER 42 IS CREATED TO READ AS FOLLOWS:

(1) There is hereby established in the state treasury a fund entitled "fire protection improvement fund". The fund may receive state appropriations, gifts, grants, federal funds and tax receipts. The fund shall be disbursed by the state treasurer upon the warrant of the secretary of the finance and administration cabinet.

(2) Monies in the fund shall include insurance premium surcharge proceeds as provided for in KRS 136.392.

(3) Monies in the fund shall be used for the fire protection improvement program established in Section 2 of this Act.

SECTION 2. A NEW SECTION OF KRS CHAPTER 42 IS CREATED TO READ AS FOLLOWS:

(1) There is established within the department for local government a fire protection improvement program to consist of a system of grants to fire protection districts and local governments to improve fire protection and safety for the residents served thereby. Grants made under this program shall be for priority capital expenditures such as purchase of major items of equipment or construction of water lines. Such priority items must

be certified by the state fire marshall as contributing to the upgrading of the protection category pursuant to the fire suppression rating schedule.

(2) The department for local government shall receive grant applications on an annual basis and review them based on estimated costs, local contribution and other criteria specified in regulation promulgated as directed herein. The department shall forward all eligible applications to the state fire marshall for his review. The state fire marshall shall review applications using the protection category as the primary criteria for assigning priorities, starting with the highest (worst) ratings. The prioritized applications will then be returned to the administrator of the fire protection improvement program in the office for local government for a final ranking which shall include additional points in the ranking formula for local contribution to said proposed capital project or purchase. The administrator shall then make awards beginning with the first priority funded in full then proceeding on down the priority scale, as available monies allow. The administrator of the fund shall approve and award all project applications based on available monies in the fund. Disbursal of funds to the beneficiary agency shall follow a schedule of payments based on such rules and regulations promulgated by the department for local government. Rankings shall be made on an annual basis without alteration of previous awards.

Applications received previously but which have not received awards shall be updated, as needed, by the applicant in each year's ranking process.

(3) Grants made under this program may be used as the local share to secure federal funds as long as program expenditures are in the priority area. Interest earned on funds received by fire protection districts or local units of government shall be used by the receiving entity in the priority expenditure categories prescribed by the state department for local government.

(4) The department for local government shall be responsible for the promulgation of rules and regulations necessary to implement the grants program authorized by this section with assistance from the justice cabinet, revenue cabinet and public protection and regulation cabinet, as necessary. The department for local government shall receive reasonable administrative costs from the program's monies.

(5) Any assistance granted under the fire protection improvement program shall be preceded by an agreement that an independent annual audit shall be conducted and that the audit report will include a certification that said funds were expended for the purpose intended. A copy of the audit and certification of compliance shall be forwarded to the department for local government within eighteen (18) months after the end of the fiscal year.

(6) The commissioner of the department for local government may make direct grants in aid of money out of the fund to any beneficiary agency for the construction or acquisition of any approved capital project. When a direct grant in aid has been made to a beneficiary agency, all contracts awarded for the purchase of materials, supplies, equipment or services, except professional and technical services, required for the construction or acquisition of the project shall be awarded to the lowest and best bidder in the discretion of the beneficiary agency after public advertisement as required by KRS Chapter 424 or other applicable law. All contracts awarded under this section for the construction, reconstruction or renovation of a building or other improvement to real estate shall be deemed contracts for public works within the meaning of KRS 341.317 and KRS Chapter 376 and other applicable statutes. All beneficiary agencies receiving a direct grant in aid under this subsection shall keep and maintain complete and accurate records of accounts of all expenditures of the grant moneys which shall be subject to audit by the Commonwealth for a period of five (5) years after completion of the capital project. Beneficiary agencies shall complete approved capital projects within a reasonable period of time as determined by the department for local government. Upon completion of capital projects, beneficiary agencies shall submit project completion reports to the department for local government as

prescribed by the department for local government and containing such documents and information as may be necessary to determine compliance with other applicable statutes and administrative regulations. Beneficiary agencies shall be liable to repay to the fund any granted funds for failure to submit full project completion reports within a reasonable period of time or for expenditure of granted funds in violation of statutes and regulations. No additional funds may be approved until compliance, except at the discretion of the commissioner of the department. Any grant moneys not required after all of the costs of the capital project have been paid by the beneficiary agency shall be promptly returned to the Commonwealth for reallocation for expenditure for other capital projects to which such funds had been originally allocated.

(7) No capital project shall be constructed under this Act except upon land to which (a) the Commonwealth, a political subdivision of the Commonwealth or the beneficiary agency of the capital project has a good and marketable title, free of encumbrances, or (b) the beneficiary agency of the project has the right to the uninterrupted use, occupancy and possession for a period longer than the estimated useful life of the capital project; provided nothing herein shall prohibit the construction or renovation of public buildings on land with an existing encumbrance to secure payment of funds

obtained for the acquisition or improvement of said land. Each beneficiary agency shall execute and deliver to the Commonwealth its written assurances, which shall be binding on such agencies' successors and assigns, guaranteeing that during its estimated useful life, the capital project or equipment purchase shall be operated and maintained for public purposes and pledging that no mortgage or other encumbrances shall be placed against any capital project wholly or equipment purchase financed out of the fund for the breach of which assurances the Commonwealth shall have right of entry to the capital project and the beneficiary agency, or its successors and assigns, shall forthwith convey the title to the capital project or equipment purchase to the Commonwealth. Similar assurances shall be executed and delivered to the Commonwealth by the beneficiary agencies of capital project or equipment purchases financed in part out of the fund and in part from other sources, except that when such additional funding is derived from the issuance and sale of revenue bonds or under other statutorily authorized financing methods, to secure the repayment of which funds a statutory mortgage lien is granted in favor of any person or group of persons, the capital project or equipment purchase may be encumbered to the extent authorized or required by the law under which such financing method was undertaken. The written assurances provided by beneficiary agencies under this section shall

be lodged for recording and recorded in the office of the county clerk of the county in which the proposed project shall be located.

Section 3. KRS 42.190 is amended to read as follows:

(1) On June 1, 1982, and then on or before the first day of each December, March, June and September thereafter, the a cabinet shall request in writing of the administrator of the professional fire fighters foundation program fund, which is established by KRS 95A.220, and of the administrator of the law enforcement foundation program fund, which is established by KRS 15.430, cost projections of their respective funds for the next quarter. The cabinet shall also request in writing on the same schedule revenue estimates of total funds received by the revenue cabinet from insurance premium surcharge proceeds as provided for in KRS 136.392.

Based on the estimate of quarterly receipts and the cost of [~~these~~] projections, the cabinet shall [~~determine the proportionate share of~~] allocate the total insurance premium surcharge proceeds, prescribed in KRS 136.392, [~~to accrue to each fund~~] among the funds, as provided for in subsection (2) of this section.

(2) Monies projected for expenditure by the professional fire fighters foundation program fund and the law enforcement foundation program fund shall be allocated to those funds on a quarterly basis. All monies not required to meet quarterly expenditure projections of the

professional fire fighters foundation program fund and the law enforcement foundation program fund shall be allocated to the fire protection improvement fund.

(3) Any balances in the professional fire fighters foundation program fund and the law enforcement foundation program fund shall be transferred into the fire protection improvement fund. The transfer shall be made as of the effective date of this Act.

(4)[~~(2)~~] On or before the first day of each quarter, the cabinet shall certify to the state treasurer a distribution schedule describing the proportionate share of total insurance premium surcharge proceeds accruing to each fund during such quarter, and the state treasurer shall pay into each fund's trust and agency account its proportionate share of all deposited tax moneys as set forth and in the manner as prescribed in subsections (1) and (3) of KRS 136.392.

(5)[~~(3)~~] Moneys deposited in the fire protection improvement fund's trust and agency account, the professional fire fighters foundation program fund's trust and agency account, shall be invested by the state in accordance with state investment practices, and all earnings from such investments shall accrue to, and be paid into the respective account from which such investments are made. All moneys remaining on deposit at the close of the state's fiscal year in the professional fire fighters foundations program fund's trust and agency

account and all earnings from investments made from moneys in this account, shall not lapse, and shall be used only for the purposes as specified in KRS 95A.200 to 95A.300. All moneys remaining on deposit at the close of the state's fiscal year in the law enforcement foundation program fund's trust and agency account, and all earnings from investments made from moneys in this account, shall not lapse, and shall be used only for the purposes as specified in KRS 15.410 to 15.500. All monies remaining on deposit at the close of the state's fiscal year in the fire protection improvement fund's trust and agency account and all earnings from investments made from monies in this account, shall not lapse, and shall be used only for the purposes specified in Section 2 of this Act.

(6)[(4)] The cabinet shall provide monthly financial reports to the administrator of the fire protection improvement fund, the administrator of the professional fire fighters foundation program fund and the administrator of the law enforcement foundation program fund respecting the amount of funds received and on deposit in each fund and the amount of earnings accruing to each fund from their investment.

(7) All unencumbered fund balances held under KRS 17.250 in the volunteer fire department aid fund shall be transferred to the fire protection improvement fund. The transfer shall be made as of the effective date of this Act.

SECTION 4. KRS 136.392 is amended to read as follows:

(1) Every domestic, foreign or alien insurer, other than life and health insurers, which is either subject to or exempted from Kentucky premium taxes as levied pursuant to the provisions of either KRS 136.340, 136.350, 136.370 or 136.390, shall charge and collect a surcharge of one dollar and fifty cents ($1.50) upon each one hundred dollars ($100) of premium, assessments, or other charges, except for those municipal premium taxes, made by it for insurance coverage provided to its policyholders, on risk located in this state, whether such charges are designated as premiums, assessments or otherwise. The premium surcharge shall be collected by the insurer from its policyholders at the same time and in the same manner that its premium or other charge for the insurance coverage is collected. The premium surcharge shall be disclosed to policyholders pursuant to regulations which shall be promulgated by the commissioner of insurance. However, no insurer or its agent shall be entitled to any portion of any premium surcharge as a fee or commission for its collection. On or before the twentieth (20the) day of each month, each insurer shall report and remit to the revenue cabinet, on such forms as it may require, all premium surcharge moneys collected by it during its preceding monthly accounting period less any such moneys returned to policyholders as applicable to the unearned portion of the premium on policies terminated by either the insured or

the insurer. The funds derived from such premium surcharge[/ *except as provided in subsection (2) of this section*/] shall be deposited in the state treasury, and shall constitute a fund allocated for the uses and purposes of the fire protection improvement fund (Section 1 of this Act), the professional fire fighters foundation program fund (KRS 95A.220) and the law enforcement foundation program fund (KRS 15.430).

[*(2) Insurance premium surcharge funds collected from the policyholders of any domestic mutual company/ cooperative or assessment fire insurance company shall be deposited in the state treasury/ and shall be paid monthly by the state treasurer into the volunteer fire department aid fund as provided in KRS 17.250/ provided however/ that insurance premium surcharge funds collected from the policyholders of any mutual company/ cooperative or assessment fire insurance company which transfers its corporate domicile to this state from another state] [after July 15/ 1986/ shall continue to be paid into the professional fire fighters foundation program fund and the law enforcement foundation program fund as prescribed herein/*]

(2)[*(3)*] Within five (5) days after the end of each month, all insurance premium surcharge proceeds deposited in the state treasury as set forth in subsection (1) of this section shall be paid by the state treasurer into the professional fire fighters foundation program

fund trust and agency account and the law enforcement foundation program fund trust and agency account and the fire protection improvement fund trust and agency account. The amount paid into each account shall be proportionate to each fund's respective share of the total deposits, pursuant to KRS 42.190. Moneys deposited to the law enforcement foundation program fund trust and agency account shall not be disbursed, expended, encumbered or transferred by any state official for uses and purposes other than those prescribed by KRS 15.410 to 15.500. Money deposited to the professional fire fighters foundation program fund trust and agency account shall not be disbursed, expended, encumbered or transferred by any state official for uses and purposes other than those prescribed by KRS 95A.200 to 95A.300. Monies deposited to the fire protection improvement fund trust and agency account shall not be disbursed, expended, encumbered or transferred by any state official for uses and purposes other than those prescribed by Section 2 of this Act.

Other statutory provisioins notwithstanding, no eligible participants in the law enforcement foundation program fund and the professional fire fighters foundation program fund shall be admitted as if the effective date of this Act. All recipients of the two funds specified herein on the effective date of this Act shall constitute as participants in the funds as long as they are deemed eligible participants in either of the two funds, the

funds shall sunset and authorizing statutes shall thereby be repealed. Any and allmonies remaining in either of the funds shall be transferred to the fire proteciton improvement fund's trust and agency account. From that point forward, all proceeds from the insurance premium surcharge as provided for in KRS 136.392 shall be deposited solely in the fire protection improvement fund for purposes set out in this Act.

SECTION 5. KRS 61.316 is amended to read as follows:

(1) "Volunteer fire fighter," as used in this section, means any person who is a member of or employed by a volunteer fire department of any county, city, fire district or other organized volunteer fire department operated and maintained on a nonprofit basis in the interest of health and safety of the inhabitants of the Commonwealth.

(2) The spouse of any volunteer fire fighter whose death occurs as a direct result of an act in the line of duty shall receive a lump sum payment of twenty-five thousand dollars ($25,000), which sum shall be paid by the state treasurer from the fire protection improvement fund trust and agency account as established in Section 1 of this Act [*insurance premium surcharge moneys provided in subsection (2) of KRS 136.392*]. If there is no surviving spouse, the payment shall be made to the surviving children. If there are no surviving children, the payment shall be made to any dependent parent of the deceased.

(3) The commission on fire protection personnel standards and education shall be authorized to promulgate and adopt regulations establishing procedures and criteria applicable to the administration of this section including, but not limited to, defining when a fire fighter dies in line of duty.

SECTION 6. KRS 17.250 is hereby repealed.

Bill Draft #34a

INCREASE IN DEPARTMENT'S CARRYOVER

Section 1. KRS 304.2-400 is amended to read as follows:

(1) There is created in the state treasury a trust fund designated the "insurance regulatory trust fund" to which shall be credited all payments received under KRS 304.4-010.

(2) The moneys so received and deposited in the insurance regulatory trust fund shall be appropriated for use only by the department to defray the expenses of the department in discharge of its administrative and regulatory powers and duties as prescribed by law subject to the applicable laws relating to the appropriation of state funds and to the deposit and expenditure of state moneys. The department shall be responsible for the proper expenditure of these monies as provided by law.

(3) Any cash balance in excess of two million dollars ($2,000,000) [~~five hundred thousand dollars ($500,000)~~] in the insurance regulatory trust fund after all current fiscal year expenditures are met shall lapse to the general fund.

Bill Draft #34b

FUNDING ASSESSMENT

SECTION 1. A NEW SECTION OF SUBTITLE 2 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "insurer" means assessment or cooperative insurers, insurers, fraternal benefit societies, nonprofit hospital, medical-surgical, dental, and health service corporations, health maintenance organizations, and prepaid dental plan organizations.

(2) If the commissioner finds that there are insufficient funds for operations of the department, he may make an assessment on all insurers not to exceed .000235 of net direct written premium from Kentucky as reported in insurers' annual statements for the immediately proceeding calendar year. In making each assessment, the Commissioner may establish a minimum ssessment. Assessments made pursuant to this section shall be in addition to all other taxes, assessments, and fees.

(3) Overdue payment of any assessments shall bear interest at the tax interest rate as set forth in KRS 131.010(6) from the date due until paid. Any unpaid

assessment may be recovered in an action brought thereon in the name of the department in the Franklin Circuit Court or in any other court of appropriate jurisdiction. Such interest penalty is separate from other penalties applicable to violations of KRS Chapter 299 and this chapter and such an action is separate from any other means of collecting an assessment under KRS Chapter 299 or this chapter.

(4) All funds derived from assessments made pursuant to this section shall be deposited in the insurance regulatory trust fund. However, funds derived from assessments made pursuant to this section shall not lapse to the general fund pursuant to KRS 304.2-400(3) or any other law, but shall at all times be available to defray expenses of the department in discharge of its administrative and regulatory powers.

SECTION 2. A NEW SECTION OF KRS CHAPTER 299 IS CREATED TO READ AS FOLLOWS:

(1) Assessment or cooperative insurers may be assessed pursuant to Section 1 of this Act.

SECTION 3. A NEW SECTION OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Fraternal benefits societies may be assessed pursuant to Section 1 of this Act.

Bill Draft #34c

INSURANCE FEES BY REGULATION

Section 1. KRS 304.4-010 is amended to read as follows:

304.4-010 The Commissioner shall by regulation prescribe the fees charged by the Commissioner and the services for which fees shall be charged. All such fees shall be collected in advance. [The Commissioner shall collect in advance fees, licenses and miscellaneous charges as follows:

(1) Annual statement:

(a) Filing each year.....$100.00

(b) Filing additional or supplemental statement in same year..... 100.00

(2) For filing charter documents:

(a) Original charter document, bylaws and records of organization, or certified copies thereof, required to be filed..... 100.00

(b) Amended charter documents, bylaws and records of organization, or certified copies thereof..... 50.00

]

[(3) Certificate of authority/

(a) Issuance of original certificate/////////// 500/00

(b) Amending/ to add a line////////////////////// 50/00

(c) Renewal/ each year/////////////////////////// 100/00

(4) Organization of domestic mutual insurers/

Filing application for solicitation permit and issuance of such permit/////////////////////////// 200/00

(5) Self insurer/

(a) Application to become self-insurer under Subtitle 39/// 200/00

(b) Annual review of status under Subtitle 39// 100/00

(c) Notification of self-insurance program under Subtitle 32/////////////////////////////////////// 50/00

(6) Agent/s licenses/ foreign and alien insurers/

(a) License for life insurer/ whether or not health insurance is included/ biennial/////////////// 40/00

(b) License for industrial life insurer/ only/ biennial/// 40/00

(c) License for other insurance/ each insurer represented/ biennial/////////////////////////////// 40/00

(d) Limited license as travel insurance agent/ biennial/// 40/00

(e) Temporary license as property and casualty agent/// 20/00

]

[(f) Temporary license as life and health agent// 20/00

(g) Nonresident agent/ biennial//////////////// 50/00

(7) Surplus lines broker/ managing general agent/ biennial// 100/00

(8) Solicitor/s license/ biennial////////////// 40/00

(9) Adjuster/s license/ biennial/////////////// 50/00

(a) Temporary license as apprentice adjuster// 25/00

(b) Administrator/s license/ biennial/////////// 50/00

(10) Consultant/s license/ biennial////////////// 50/00

(11) Agent/s licenses/ fraternal benefit societies/ Subtitle 32 corporations/ health maintenance organizations/ prepaid dental plan organizations/ biennial////////////////////////// 40/00

(12) Examination/ for or in connection with licensing of agents/ solicitors/ adjusters/ and consultants/////////////////////////////////////// 50/00

(13) Annual registration fee of unauthorized insurer/////////////////////////////////////// 500/00

(14) Advisory organizations/

(a) Application for license////////////////// 500/00

(b) Annual renewal/////////////////////////// 100/00

(15) Rate and form filings/

(a) Rate level revision filing in a non-competitive market/////////////////////////// 100/00

(b) Other rate and form filings/////////////// 5/00

]

[(16) Premium finance company license issuance and annual renewal//////////////////////////////// 100/00

(17) Cost of administering Subtitle 32 per membership contract in force on December 31st of each year, except the health insurance contract or contracts for state employes as authorized by KRS 18A.225// /10

(18) Miscellaneous services:

(a) Filing other documents, each////////////////// 5/00

(b) Commissioner's certificate under seal, other than certificates, licenses, and other documents above provided for, each//////////////////// 5/00

(c) For copies of any document on file with the Commissioner, per page//////////////////////////// /50

(d) Copy of annual statements, per page///////// 1/00

]

ADDENDUM

ADDENDUM

These proposals did not reach the Task Force in sufficient time to be studied; they have been included in the report so that they may be the subject of further review and discussion.

Settlement Incentives

(Bill Draft #A, Page 246)

Using the basic concept of the expanded Offer to Judgment (Issue #5), a settlement incentive act was presented to the Task Force. This approach encourages good faith offers of settlement, by plaintiffs and defendants, while penalizing those who make unreasonable demands or refuse reasonable offers of settlement, by requiring them to pay all expenses of litigation, including attorney fees.

Professional Malpractice Review

(Bill Draft #B, Page 253)

Our study leads us to believe claims for professional malpractice will continue to increase in the future. How best to assure sufficient quantity and reasonable quality of our professionals, while protecting the individual's right to sue,

is an unresolved problem. Professional malpractice review is a proposal which requires all professionals to participate as a prerequisite to being licensed or certified. It is envisioned a board would review claimed professional malpractice, make specific findings, and award damages.

The plaintiff is not required to submit his case to the board. However, if he does not submit it and is unsuccessful in his action, he will bear all costs of the litigation including the defendant's attorney fees. Neither party will be required to accept the decision of the board; however, the refusing party could be required to pay all costs.

Bill Draft A

SETTLEMENT INCENTIVE

SECTION 1. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

As used in this Act:

(1) "Net economic loss" means that economic loss of an injured party which includes the cost of reasonable and necessary medical or hospital care, the cost of physical rehabilitation and nursing care, lost wages or lost income, and reasonable expenses incurred by the injured party due to the occurrence of the injury, which may include but are not limited to the cost of adapting living quarters or an automobile for the specific use of the disabled injured party.

(2) "Pain and suffering" means physical discomforts and distress, and mental and emotional trauma which are recoverable as elements of damage in torts.

(3) "Periodic payment" means payment of a settlement amount in installments of successive periods separated by determined intervals of time.

(4) "Expenses of litigation" means those expenses incurred by a plaintiff or defendant in tort litigation initiated and maintained in the court system of the Commonwealth, through stages of available appeal up to and including appeal to the Supreme Court of Kentucky. The term includes reasonable

attorneys fees, court costs, reasonable fees for expert witnesses and reasonable and actual out of pocket expenses incurred in the litigation.

(5) "Party" means a potential plaintiff, plaintiff, potential defendant, or defendant in a tort litigation.

SECTION 2. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

(1) Any potential plaintiff, plaintiff, potential defendant, or defendant in a potential or ongoing tort litigation may tender an offer of settlement to an opposing party. In the case of multiple opposing parties, the offer of settlement may be made to any or all of them.

(2) An offer of settlement shall be in writing and shall set out with particularity the nature of the offer which shall include the amount of money offered to induce settlement, the manner and process of the payment of such monetary amount, and such other nonmonetary provisions as are relevant to the settlement offer. If nonmonetary suggested agreements are included in the offer of settlement, such offer shall include an estimate of their monetary value.

(3) An offer of settlement shall be modified, accepted or rejected within sixty (60) days of service upon the opposing party. An offer modified by an opposing

party shall be modified, accepted or rejected within sixty (60) days of service upon the original party offering settlement.

(4) Offers of settlement as described in this Act and related statements of modification, acceptance and rejection shall be served upon opposing parties and filed of record in accordance with rules promulgated by the Supreme Court. Provided, however, that such offers of settlement and related statements shall not be considered public record and shall be available only to the parties and to the trial and appellate courts upon initiation and maintenance of litigation.

(5) Offers of settlement as described in this Act and related statements of modification, acceptance and rejection shall appear on forms authorized by the Supreme Court and prepared by the administrative office of the courts.

SECTION 3. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

(1) Subject to subsection (4) of this section, if an offer of settlement is refused, the party refusing the offer shall pay all expenses of litigation of the party tendering the offer if final judgment after appeal is not as monetarily favorable to the refusing party as the total monetary value of the offer as determined by the trial court.

(2) Subject to subsection (4) of this section, if an offer of settlement offers to accept from or pay to a party an amount equal to the net economic loss of the injured party, as determined by the injured party, together with a designated amount of compensation for pain and suffering and the offer is refused, the party refusing the offer shall pay all expenses of litigation of the party tendering the offer unless the final judgment after appeal is at least thirty percent (30%) more monetarily favorable to the refusing party than the total monetary value of the offer as determined by the trial court.

(3) Subject to subsection (4) of this section if an offer of settlement offers to accept from a party net economic loss together with pain and suffering as described in subsection (2) of this section, and in addition offers to accept periodic payments of the total settlement amount and the offer is refused, the party refusing the offer shall pay all expenses of litigation of the party tendering the offer unless the final judgment after appeal is at least forty percent (40%) more monetarily favorable to the refusing party than the total monetary value of the offer as determined by the trial court.

(4) If a party, who is or becomes one (1) of either multiple plaintiffs or multiple defendants, refuses an offer of settlement and is subsequently liable for payment

of litigation expense of an opposing party as provided in this section, he shall only be liable for a percentage of such litigation expense equal to the percentage of entitlement to receive or obligation to pay the final judgment, as the case may be, which is assessed such refusing party as provided by the judgment.

(5) A party liable for the payment of litigation expense pursuant to any subsection of this section shall not be so liable pursuant to any other subsection of this section.

(6) Awards for the payment of the expense of litigation as provided by this section shall be made by the trial court and shall be considered separate from and collateral to the judgment. An award may be modified by the trial court upon subsequent modification of the judgment on appeal or upon subsequent incurrence of additional litigation expense on appeal or both.

SECTION 4. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

Upon tender of any offer of settlement pursuant to this Act and relating to potential tort litigation, the running of the applicable statute of limitations shall be tolled until such time as the offer is either accepted or refused.

SECTION 5. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

Should a party choose to offer, initially or in response to an offer of settlement by an opposing party, a monetary amount equal to the policy limits of any insurance coverage applicable to a particular occurrence of damages, he shall attach to the offer a sworn statement verifying that the policy represents the only insurance coverage applicable to such occurrence of damages. Further, a copy of the policy with the declaration sheet shall be attached thereto.

SECTION 6. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

All parties to tort litigation and their attorneys shall, upon filing their initial pleading in such litigation, execute a surety bond for payment of all expenses of litigation should any party or attorney be so liable.

SECTION 7. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

This Act shall be administered by the administrative office of the courts in accordance with reasonable rules promulgated by the Supreme Court to facilitate its implementation and operation.

SECTION 8. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

This Act shall not be construed to prohibit or discourage any formal or informal good faith attempt to

settle a dispute which is or may be the subject of civil litigation. Provided, however, that the award of expenses of litigation contemplated by this Act, may only be made upon compliance with this Act and rules promulgated pursuant thereto.

SECTION 9. A NEW SECTION OF KRS CHAPTER 411 IS CREATED TO READ AS FOLLOWS:

This Act may be cited as the "Settlement Incentive Act."

Bill Draft B

PROFESSIONAL MALPRACTICE REVIEW

SECTION 1. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

As used in this Act:

(1) "Profession" means a vocation or occupation requiring special education and skill and which also requires licensing or certification by the Commonwealth prior to the practice thereof.

(2) "Professional malpractice" means failure of one rendering the services commonly offered by a profession to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss or damage to the recipient of those services or to those entitled to rely upon them.

(3) "Board" means the professional malpractice review board.

(4) "Net economic loss" means that economic loss of an injured party which includes the cost of reasonable and necessary medical or hospital care, the cost of physical rehabilitation and nursing care, lost wages or lost income, and reasonable expenses incurred by the injured

party due to the occurrence of the injury, which may include, but are not limited to, the cost of adapting living quarters or an automobile for the specific use of the disabled injured party.

(5) "Pain and suffering" means physical discomforts and distress, and mental and emotional trauma which are recoverable as elements of damage in torts.

(6) "Expenses of litigation" means those expenses incurred by a plaintiff or defendant in professional malpractice litigation initiated and maintained in the court system of the Commonwealth, through stages of available appeal up to and including appeal to the Supreme Court of Kentucky. The term includes reasonable attorneys fees, court costs, reasonable fees for expert witnesses and reasonable and actual out of pocket expenses incurred in the litigation.

(7) "Party" means a potential plaintiff or potential defendant in a potential professional malpractice litigation and shall include the principal of a person that performs or offers the services of a profession as agent of the principal.

SECTION 2. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

(1) The board of professional malpractice review is created and vested with the authority to render arbitration and review services relating to claims of

professional malpractice which are submitted to the board as provided in this Act.

(2) For the purpose of reviewing any particular claim, the board shall be comprised of seven (7) members appointed by the governor, each for a term of four (4) years, except for initial permanent appointees as provided in subsection (3) of this section.

(3) Five (5) of the board members shall be classified as permanent members and shall sit on the board as it considers all claims submitted for review. One (1) of the permanent members of the board shall be an attorney admitted to practice law in Kentucky for at least eight (8) years. One (1) of the permanent members of the board shall be a certified public accountant, so certified to practice in Kentucky for at least eight (8) years. One (1) of the permanent members of the board shall be a licensed physician, so licensed to practice in Kentucky for at least eight (8) years. Two (2) of the permanent members of the board shall be citizens at large, without requirement or restriction as to professional background. The initial permanent members of the board shall be appointed for the following terms and until their successors are qualified and appointed: One 1 for one (1) year; two (2) for two (2) years; and two (2) for three (3) years.

(4) Two (2) auxiliary board members shall be appointed as provided in subsection (2) of this section

from each group of professionals licensed or certified by the Commonwealth. Each auxiliary board member shall have been licensed to practice his respective profession in Kentucky for at least eight (8) years. In any submission to the board of a claim alleging professional malpractice within a particular profession, the five (5) permanent board members shall be joined by the two (2) auxiliary board members representing the profession of the malpractice claim at issue. The resultant seven (7) members shall then comprise the board for the purpose of review of such claim.

(5) The governor shall designate one (1) of the permanent members of the board as chairman thereof, to serve as such at the pleasure of the governor.

(6) The administrative and rulemaking decisions and policies of the board shall be established by majority vote of the permanent board members and such action shall be in the name of the board.

(7) The board shall have the authority to establish and maintain an office within this state and to appoint employes as necessary and prescribe their duties and compensation. Among the employes authorized for appointment by this subsection, the board may maintain a panel of experts to offer advice regarding professional malpractice and award determination.

(8) The board shall have the authority to adopt,

promulgate, amend and rescind suitable rules and regulations to carry out the provisions and purposes of this Act.

(9) In regard to any particular claim, the full seven (7) member board shall have the authority to hold hearings, administer oaths or affirmations, examine any person under oath or affirmation, issue subpoenas requiring the attendance and giving of testimony of witnesses and requiring the production of any books, papers, documentary or other evidence, and to take or cause to be taken affidavits or depositions within or without the state. If it should be necessary to determine the will of the board in regard to the exercise of authority granted by this subsection, the determination shall be made by majority vote of both permanent members and those auxiliary members then sitting on the board.

(10) The governor shall establish the compensation of permanent and auxiliary members of the board of professional malpractice review pursuant to the provisions of KRS 64.640.

SECTION 3. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

(1) Any party to a potential professional malpractice litigation may voluntarily submit the claim to the board of professional malpractice review. The submission shall be upon forms prescribed and supplied by

the board.

(2) If, within thirty (30) days of the original submission, the opposing party or one (1) or more of multiple opposing parties voluntarily agrees to the submission, the board may proceed to review the claim of professional malpractice as between the parties who have submitted and agreed to the submission of the claim.

(3) Any person that performs or offers the services of a profession requiring state licensure or certification, or any person, business organization or entity that engages in a commercial enterprise requiring state licensure or certification that is named as an opposing party in any claim submitted to the board by a potential plaintiff in litigation pursuant to subsection (1) of this section, shall be deemed to agree to the submission.

(4) Within sixty (60) days of submission agreement as provided in subsections (2) and (3) of this section, the board shall schedule a hearing during which all parties shall be allowed to present such evidence in support or defense of the claim as may be allowed by the board. The board shall be empowered to demand production of additional evidence as may be necessary to properly decide the claim and to exercise the authority provided in subsection (9) of Section 2 of this Act.

(5) Within ninety (90) days of the date of

initiation of the hearing provided in subsection (4) of this section, the board shall issue an opinion which states its determination as to whether conduct was engaged in by one (1) or more of the parties to the claim which constituted professional malpractice and which caused damages to one (1) or more opposing parties to the claim. A party to the claim found to have been damaged by such professional malpractice shall automatically be entitled to an award equal to his net economic loss together with compensation for pain and suffering calculated at a rate of ten (10) times the net economic loss. Net economic loss and pain and suffering compensation shall be properly apportioned when causation of damages is attributable in part to a party to the claim and in part to a person or business entity not party to the claim. The determination of the value of the net economic loss and total award to a damaged party shall be made part of the opinion of the board. That portion of an award representing ascertainable future economic loss shall be payable to the claimant upon accrual of the loss, and the terms of such payment shall be reflected in the opinion.

(6) The parties to a claim shall either accept or reject, in writing upon forms provided therefor, the terms of the opinion and any award of the board within fifteen (15) days of its issuance. Any party failing to accept or reject within such time shall be considered to have

rejected the opinion and any award of the board. An opinion and any award of the board which is accepted by all parties shall be enforceable as a judgment in the circuit court.

(7) Application for discretionary review on the record by the Court of Appeals of the opinion and any award of the board may be made by any party within thirty (30) days of the issuance of the opinion. Such application may be made only if:

(a) The party so applying has previously accepted the opinion and any award of the board as may be modified but not contingent upon the outcome of the discretionary review; and

(b) The opposing party, to whom the applying party is liable or who is liable to the applying party pursuant to the opinion of the board, has previously accepted the opinion and any award of the board as may be modified but not contingent upon the outcome of the discretionary review.

SECTION 4. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

Upon a finding by the board of professional malpractice review as reflected in the opinion of the board that a professionally licensed or certified person has engaged in professional conduct constituting gross negligence or fraud, the license or certificate of such

person shall be immediately suspended, subject to de novo review by the appropriate professional licensing or certification board or association.

SECTION 5. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

(1) Subject to subsection (5) of this section, if a plaintiff fails to submit a claim to the board pursuant to subsection (1) of Section 3 of this Act prior to the initiation of any civil action which alleges and seeks damages for professional malpractice, he shall be liable to the defendants in such civil action for their expenses of litigation if the final judgment after appeal is not favorable to the plaintiff.

(2) Subject to subsection (5) of this section, if a party fails to agree to the submission of a claim to the board pursuant to subsection (2) of Section 3 of this Act, such party shall be liable to opposing parties who have submitted or agreed to the submission of the claim to the board for their expenses of litigation in any subsequent civil action relating to the incident forming the basis of the claim if the final judgment after appeal is not favorable to the party failing to agree to board submission.

(3) Subject to subsection (5) of this section and upon completion of review of a claim where the board finds that professional malpractice has not occurred, if the

party alleging damages initiates a subsequent civil action relating to the incident forming the basis of the claim, such party shall be liable to opposing parties for their expenses of litigation if the final judgment after appeal is not favorable to the party initiating litigation.

(4) Subject to subsection (5) of this section, and upon completion of review of a claim where the board finds that professional malpractice has occurred and makes a determination of loss, if a party refuses to accept or pay, as the case may be, the award set by the board, such party shall be liable to opposing parties for their expenses of litigation in any subsequent civil action relating to the incident forming the basis of the claim, unless the final judgment after appeal is at least twenty-five percent (25%) more monetarily favorable to the refusing party than the opinion and award of the board.

(5) If a party, who becomes one of either multiple plaintiffs or multiple defendants, is found to be liable for payment of litigation expense of an opposing party as provided in this section, he shall only be liable for a percentage of such litigation expense equal to the percentage of entitlement to receive or obligation to pay the final judgment, as the case may be, which is assessed such party as provided by the judgment.

(6) Awards for the payment of the expense of litigation as provided by this section shall be made by

the trial court and shall be considered separate from and collateral to the judgment. An award may be modified by the trial court upon subsequent modification of the judgment on appeal or upon subsequent incurrence of additional litigation expense on appeal or both.

SECTION 6. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

Upon submission of any claim to the board relating to allegations of professional malpractice, the running of the applicable statute of limitations shall be tolled until such time as the opposing party fails to agree to the submission pursuant to subsection (2) of Section 3 of this Act, or a party rejects the opinion and any award of the board pursuant to subsection (5) of Section 3 of this Act, whichever shall first occur.

SECTION 7. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

An opinion and any award of the board of professional malpractice review, whether accepted or rejected by any party, shall be admissible where relevant as competent evidence by the courts of the Commonwealth.

SECTION 8. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

(1) Every person that performs or offers the services of a profession requiring state licensure or certification shall be assessed an equal and annual fee by

the board of professional malpractice review. Such annual fees as collected shall establish the operating fund of the board. Failure of a professionally licensed or certified person to remit the fee provided herein shall result in license or certificate suspension until payment is made.

(2) The continuing administrative expenses of the board of professional malpractice review shall also be defrayed by assessment of the various professional licensing or certification boards and associations in proportion to the instances of malpractice claims, grouped by profession, reviewed by the board annually.

(3) The provision of this section shall be implemented by regulations promulgated by the board of professional malpractice review.

SECTION 9. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

The provisions of this Act shall be implemented and administered in accordance with such reasonable rules and regulations as may be promulgated by the board of professional malpractice review. Those regulations shall include, but shall not be limited to, rules pertaining to service of claims and subsequent filings, admissible evidence, and general matters of procedure before the board.

SECTION 10. A NEW SECTION OF KRS CHAPTER 417 IS

CREATED TO READ AS FOLLOWS:

All parties to civil litigation in which professional malpractice is alleged, who are potentially liable for payment of expenses of litigation of opposing parties pursuant to Section 4 of this Act shall, upon filing their initial pleading in such litigation, execute a surety bond for payment of such expenses of litigation should liability be imposed.

SECTION 11. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

This Act shall not be construed to prohibit or discourage any formal or informal good faith attempt to settle a dispute which is or may be the subject of civil litigation; provided, however, that the award of expenses of litigation contemplated by this Act may only be made upon compliance with this Act and rules promulgated pursuant thereto.

SECTION 12. A NEW SECTION OF KRS CHAPTER 417 IS CREATED TO READ AS FOLLOWS:

This Act may be cited as the "Professional Malpractice Review Act."

MINORITY REPORT

MINORITY REPORT
KENTUCKY INSURANCE AND LIABILITY TASK FORCE

SUBMITTED BY TASK FORCE MEMBER
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December 8, 1987

A. BACKGROUND

In order to put this Minority Report in proper perspective, it is important to consider the background in which the Task Force was established. As stated in House Joint Resolution No. 139 adopted by the 1986 Regular Session of the General Assembly, which established the Kentucky Insurance and Liability Task Force:

> "A JOINT RESOLUTION directing the Legislative Research Commission to appoint a Task Force to study and investigate the entire insurance industry, including the Kentucky department of insurance, and its effects on Kentucky.
>
> "WHEREAS, liability insurance premium increases of 25% to more than 1000% are being imposed on municipalities, and businesses of all sizes, including day care centers, nursing homes, and restaurants, as well as professionals such as accountants, architects, doctors, midwives, and lawyers; and
>
> "WHEREAS, residents in some parts of the Commonwealth are unable to obtain homeowners insurance, while others face high premiums for motor vehicle insurance; and
>
> "WHEREAS, some physicians in this state are taking early retirement and others are giving up their practices in obstetrics rather than pay exorbitant medical malpractice insurance premiums; and
>
> "WHEREAS, the department of insurance claims it is restricted in what it can do to end skyrocketing premiums and increase the avaiability of insurance due, in part, to its lack of jurisdiction over reinsurers who are demanding price increases ranging from 50% to 500%; and
>
> "WHEREAS, some persons question whether the current insurance crisis can be supported by insurance industry data and allege the crisis is a manufactured one to increase profits of insurers; and
>
> "WHEREAS, dissatisfaction with the insurance industry is widespread and the citizens of Kentucky are demanding that some action be taken to assure the availability of insurance at affordable rates."

House Joint Resolution No. 139 directed the legislative research commission "to appoint a Task Force to study and investigate the entire insurance industry, including the Kentucky Department of Insurance, and its effects on Kentucky." More specifically, the Resolution mandated that "the Task Force shall study and investigate insurance laws and regulations, insurance companies, the Department of Insurance, the availability of insurance as necessary."

It is the belief of the Task Force member submitting this minority report that the majority report of the Task Force substantially departed from the basic intent of the General Assembly as reflected in House Joint Resolution No. 139. This departure from the legislative mandate is not surprising, considering the makeup of the majority of the Task Force. It was apparent at the first meeting of the Task Force that the overwhelming majority of the Task Force members either represented the insurance industry in one capacity or another or represented interests that would benefit from limiting an individual's right to recover damages for injuries caused by the fault of another.

Instead of carrying out the directive of the General Assembly to study and investigate the insurance industry, the Department of Insurance, and the availabilty and affordability of insurance in Kentucky, the Task Force undertook as its major objective to bring about fundamental changes in the civil justice system of this state. The initial proceedings of the Task Force were based upon the premise that changes in the civil justice system, or so-called "tort reform", would help to make insurance

more available and affordable. At the early meetings of the Task Force, unsubstantiated claims were made that there has been a "litigation explosion" in Kentucky, and that verdicts and settlements have "skyrocketed."

It must be emphasized that during the entire period of approximately 18 months during which the Task Force held public hearings and meetings absolutely no evidence was presented to support the allegations of a "litigation explosion" or "skyrocketing verdicts and settlements" in Kentucky. In fact, according to a 1986 study by the National Center for State Courts, between 1978 and 1984, civil law suit filings increased at the rate of 3%, and the population in Kentucky increased at the same rate. During the fiscal year 1984-1985, 21,729 civil suits were filed in circuit courts in Kentucky, as compared to 20,806 civil suits filed five years earlier, an increase of only 903 civil suits over the five-year period. This is consistent with the conclusion reached by the objective study conducted by the National Center for State Courts:

> "Careful examination of current available trial court data relating to tort, contract, real property rights and small claims cases, from a representative group of state courts, provides no evidence to support the existence of a national "litigation explosion."

The National Center for State Courts Study, along with other similar evidence prompted a commentary in Business Week, April 21, 1986, entitled "The Explosion in Liability Law Suits is Nothing But a Myth."

The insurance carriers and their allies have sought to make it more difficult for injured victims to recover full

compensation for their injuries. Not only do such proposals fly directly in the face of Kentucky's State Constitution, but, more importantly, they allow the wrongdoer to shift the burden of loss to the victim. The fundamental purpose of the civil justice system was suscinctly stated many years ago by former Justice Stone of the U.S. Supreme Court: "The most elementary conceptions of justice and public policy require that the wrongdoer shall bear the risk of the uncertainty which his own wrong has created."

The pretext used by the special interest groups to tamper with the Kentucky Constitution and the civil justice system is the claim that excessive damages are being awarded. The facts simply do not support such claims. The fact of the matter is that throughout the entire United States with a population of some 240 million people, there have only been 1,642 verdicts in excess of $1 million in the last 14 years. More than two-thirds of these cases involved victims who suffered permanent paralysis, brain damage, amputation or death. The Rand Institute found that in 1985 the "average verdict" was in the range of $25,000. Moreover, the Rand Institute study concluded that "the million dollar verdicts that get so much attention are the exception rather than the rule."

In Kentucky, statistics regarding verdicts and settlements are kept only in the files of the insurance industry. Thus far, the insurance industry has failed to produce this information. However, with regard to medical malpractice, all payments must be reported to the Kentucky Department of Insurance. These figures show that there were only 249 medical malpractice cases

filed in the circuit courts of Kentucky between October, 1985 and September, 1986. In two-thirds of these cases, payments were under $5,000 and the average payment was only $40,000.

On the other hand, available data in Kentucky shows that:

(1) Kentucky engineers paid insurance premiums between 1983 and 1986 of $1,400,000, while claims paid by their insurance carriers to date have amounted to only $68,000.

(2) Kentucky lawyers between 1983 and 1985 paid insurance premiums of $4,011,776, as compared with claims paid to date totalling $208,604.

(3) Premiums paid by doctors for medical malpractice insurance based upon a national average of $8,200 would make premiums paid in Kentucky for 1984 and 1985 total $93,400,000. During this same period of time, the Kentucky Department of Insurance reports that claims paid in medical malpractice cases in Kentucky totalled $8,205,000.

(4) Day care centers in Kentucky paid premiums in 1985 in the sum of $1,750,000, while claims paid to date totalled $27,580, according to information furnished by the Committee for Coordination of Child Care to the Legislative Research Commission.

Based upon similar evidence, Consumer Reports in August, 1986 concluded that:

"The law suit crisis may be phony, but the insurance crisis is real. Towns, doctors, day care centers and others face urgent problems of insurance availability and affordability. What is needed to alleviate the problem is not tort reform, but better regulation of the insurance industry."

As reported by A.M. Best Review and Preview, 1986:

(1) The property and casualty industry's net worth rose by $7.6 billion.

(2) Insurance industry's stocks out performed the stock market by 100% in 1985.

(3) The insurance industry's profits for the last quarter of 1985 were up an incredible 881% over 1984.

The insurance industry claimed that it lost money in 1985. In reality, this claimed "loss" conveniently ignored their investment income and such other factors as capital gains, tax credits, and dividends paid to policy holders. When these were figured in, the loss became a profit of $5 billion for 1985. The property and casualty industry's net worth totalled $3.9 billion in the first quarter of 1987, up 70% over 1986, according to figures released by Insurance Services Office, Inc. and the National Association of Independent Insurors.

In short, the insurance industry does not deserve any sympathy for its financial health. This is certainly true in Kentucky. An article in the Louisville Courier Journal dated May 27, 1987, carried the headline "Insurance Firms are Ranking Stars of Kentucky Forty." According to the Courier Journal's story, insurance has become Kentucky's fastest growing industry, and the six insurance companies included in the "Kentucky Forty" increased their assets by 53% and their profitability by 44% in 1986 over the previous years.

It is interesting to review the results in states which have succumbed to the pressure tactics of the insurance industry and those who sought to limit their own liability. Some of these states adopted so-called "tort reform" measures. In Florida, various industry-sponsored limitations were imposed on the premise and promise that insurance rates would be reduced. Two of the nation's largest insurance companies, Aetna Life and Casualty Company and St. Paul Fire and Marine Insurance Company, filed rate filings with the Florida Insurance Commission which were to take

effect on January 1, 1987. In its rate filing, Aetna stated that the adoption of the tort law changes would have "little or no effect" on insurance rates. St. Paul, the nation's largest medical malpractice carrier, concluded that 4 out of 313 closed claims would have been affected by the change in tort law "for a total effect of about one percent savings." Even this was conceded as an overstatement by St. Paul's assessment that "it's highly likely that there would have been no savings on these claims had the bill been in effect."

Another state to be affected was the state of Connecticut, the home of many of the insurance companies. The Connecticut legislature reacted to the intense pressure of the insurance companies and enacted some of the requested tort law changes. The response from the insurance carriers was that no reductions would be granted in premium rates. The Connecticut legislature met in 1987 again and repealed most of the previously enacted legislation. The same experience occurred in the state of Washington.

Based upon the experience from other states which have passed "tort reform" legislation, the changes in the civil justice system recommended in the Majority Report of the Task Force will not make insurance more available or affordable in Kentucky.

B. PROPOSED CIVIL JUSTICE CHANGES

Let us now consider whether the civil justice changes recommended by the Task Force are desirable from a public policy

standpoint and serve the best interests of the people of Kentucky.

1. REPEAL OF SECTION 54 OF THE KENTUCKY CONSTITUTION

Kentucky's present Constitution was adopted in 1891. The framers of the Constitution, not unlike those persons who make up today's General Assembly, were representatives, indeed protectors of the citizens of Kentucky. In this role, the authors of Kentucky's Constitution framed several constitutional sections with the intent of protecting all of the people of Kentucky from rich and powerful individuals, corporations and special interest groups.

The Constitution of Kentucky, Section 54, provides:

> "The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property."

Section 54 is a recognition that the value of life and the damage from injury to either person or property cannot be limited or pre-determined. Section 54 was a privilege conferred on Kentuckians which has evolved into a right -- the right to seek full justice from the humiliation, indignity and pecuniary loss from an unjust death or injury.

The debates of the Constitutional Convention of 1890 underscore the deep-seated opposition to special favors and influences of special interest groups. One of the delegates expressed the mood in the following terms:

> "...if there is any one evil more than another which the people of this State have earnestly demanded should be corrected ..., it was that local and special legislation be rooted up entirely." (Debates, Vol. 3, p. 4019).

Any effort to deny the citizens of this State the rights provided by Section 54 will result in a denial of equal protection and due process. The supporters of this movement propose various solutions which would eliminate or restrict the rights of those who need it most. The special interests do not propose that the rich and powerful should be denied access to the courts or have limits placed on their damages.

The most unfortunate effect of this limitation is the callous indifference toward the rights of today's and tomorrow's innocent victims. These people cannot speak for themselves and rely upon the legislature to do so instead. Any in-road or change in Section 54 would be a major victory for the well-healed special interests and a catastrophic loss for the people of Kentucky.

Contrary to the view expressed in the Majority Report of the Task Force, the sound public policy behind Section 54 of our Constitution still exists today. In fact, today more than ever before, the powerful influence of the insurance industry and its allies is being exerted to increase their profits and limit their liability at the expense of the average citizen. Without the protection afforded by Section 54, the victims of negligence would be left vulnerable and unprotected in the future.

The General Assembly should resist the efforts to repeal Section 54 of the Kentucky Constitution.

2. PATIENT'S COMPENSATION PLAN

The so-called "Patient's Compensation Plan" recommended by the Task Force is a prime example of special interest legisla-

The repeal of Section 54 is being proposed as a solution to the alleged "insurance crisis." The evidence has overwhelmingly demonstrated little or no relationship between premiums and recoveries by victims through the justice system. Even more important for the representatives of Kentucky's citizens to consider, is the related fact that the repeal of Section 54 and other similar legislation will not result in decreased liability insurance premiums. It has not happened in a single state where similar legislation has been enaceted and this has been admitted by the insurance industry. On April 13, 1987, James Purcell, the regional manager for the American Alliance of Insurers admitted: "[t]here is no tie-in between tort reform and insurance rates -- we've claimed that from day one."

Why would anyone give away an important protection and sacred right for nothing in return? That is essentially what those who favor the repeal of Section 54 are asking the General Assembly to do.

The effect of such a repeal or amendment will unquestionably hit hardest upon situations involving the elderly and the very young. It is those groups, whose earning capacity is either non-existent or as yet undocumented, which rely heaviest upon the return of damages for pain and suffering, and due to wanton or malicious conduct. This Minority Report respectfully reminds the General Assembly that it represents these Kentucky citizens as well as those clamoring for a repeal of Kentucky Constitution Section 54.

doctor or hospital. Thus, a very significant percentage of medical malpractice victims will go uncompensated under this plan.

The proposed plan provides for the "right" of a patient to reject the plan. This so-called "right" is fictitious and illusary at best. The plan requires that the right of rejection be exercised by the patient prior to the injury or incident giving rise to the malpractice claim, unless the patient is unable to make the rejection decision at the time the medical procedure is performed.

One of the cruelest and most callous provisions of the "Patient's Compensation Plan" is that the statute of limitations for filing claims would apply to minors and persons under disability. This would mean that a child, or a senile person, or one who is otherwise mentally incompetent could lose the right to file a claim and recover any damages for medical malpractice.

The proposed plan would set up another bureaucracy of state government to handle medical malpractice claims. Compensation for "income benefits" would be patterned after the Worker's Compensation Law of Kentucky. This would mean that a person could recover no more than 66 2/3% of his or her average weekly wages, and in cases of permanent partial disability the benefits would be limited to 425 weeks. In a "humane" gesture, the proponents of this plan offer a funeral allowance of $2,500 to bury victims of medical malpractice.

tion which can only benefit the insurance industry and the medical profession.

This proposal is patterned after the Kentucky Worker's Compensation Law; however, Worker's Compensation and medical malpractice are totally different and should not be treated in the same manner. In a Worker's Compensation case, the injured worker is always a person with a demonstrated earnings record upon which to base the compensation for his or her injury. On the other hand, injuries and deaths from medical malpractice occur to many people who are not employed or employable, such as children, elderly, and women who are full-time mothers and housewives. Under the proposed "Patient's Compensation Plan" these unemployed and unemployable individuals would not be able to recover economic damages, except for payment of their medical expenses.

One of the harshest and most severe limitations contained in the "Patient's Compensation Plan" is that it would not allow the recovery of any damages for pain and suffering. In many medical malpractice cases pain and suffering is the largest element of damages, particularly for those who sustained catostrophic injuries, such as permanent paralysis, brain damage, or loss of a limb.

Another self-serving feature of the "Patient's Compensation Plan" proposed by the medical profession and its malpractice insurance carrier is that injuries or deaths resulting from "inherent risks" of medical treatment are excluded from the plan. It should be anticipated that in every medical malpractice claim, the defense of "inherent risk" will be asserted by the

No evidence of a medical malpractice crisis was presented to the Task Force. In fact, the Majority Report of the Task Force contains scant, if any, justification for such radical changes in our system of compensating the victims of medical malpractice. Overall, medical malpractice claims have increased in frequency in the last decade at an annual rate of 3.4%. During this period, physician density increased by 25%, surgical operations in short-stay hospitals increased 62%, and the complexity and intensity of medical care has increased. While the St. Paul Insurance group, the largest medical malpractice insurance carrier in the country, cites a 38% increase in claim size when measured against the consumer price index, compared to the medical cost index the growth is 8.4% a year, less than the MCI growth of 10.5% and 13.3% growth for all national health care expenditures.

Verdicts in medical malpractice cases have risen at or below the rate of health care expenditures. From 1981 to 1984, the average verdict increased at an annual rate of 3.9%; health care costs increased 11.8%. From 1977 to 1984, the average verdict increased at an annual rate of 14.7%, while health care costs increased 13.1%.

Malpractice premiums are a tiny portion of health care costs. Total malpractice premiums paid in 1984 were $1.7 billion, less than one-half of one percent of national health care costs of $400 billion. In 1983, Americans spent about $1,500 per capita on

health care, while only $6.08 of that was for malpractice premiums.

In 1984, the average physician spent only 2.9 percent of gross income (estimated at $200,000) on malpractice insurance and 2.3% on "professional car" upkeep. Neurosurgeons who pay the highest of any specialty, spent 5.8% of income.

Recent increases in malpractice premiums have resulted in part because of significant decreases in insurer investment income from interest rate reductions and low priced premiums based on competitive factors during the past five years to increase market share rather than premiums based on sound underwriting principles. The National Insurance Consumer Organization found that while medical mutual liability insurance rates increased 29% in 1985, they should only have increased 10.5%, because the company incorrectly assumed its investments will earn 5% interest instead of the market rate of 10%; and it assumed double digit inflation levels in a 4% economy. The president of this company acknowledged the data do not support the large increase for obstetricians but said it was the result of "strong suggestions" of the reinsurers (Lloyds of London).

As of December 31, 1984, the malpractice insurers nation wide earned, on assets encumbered by reserves for the occurrence years 1979-1984, over $330 million more in investment income than paid to victims of medical malpractice.

Kentucky Medical Insurance Company, along with the medical profession, is the main proponent of the proposed "Patient's Compensation Plan." According to the 1986 annual

report of Kentucky Medical Insurance Company, $13,146,577 was shown as premiums written; $2,560,131 was reported in investment income; and $337,192 was listed in commission and other income. KMIC also ended the year with enough money to add $11,329,284 to its reserve holdings. During the 1985-1986 filing period, KMIC paid only $5,227,159 to injured claimants, yet they showed a net income loss of $293,143. This appears to be a case of "creative" financial reporting.

The medical profession should assume its rightful responsibility for policing its members. Paul Dudley White, M.D., President Eisenhower's physician, said in 1976: "The surest way to cut down on malpractice costs would be by cutting down on malpractice itself." The American Medical Association acknowledges that about 10%, or 45,000 doctors in America, are impaired -- suffering from some type of serious mental or emotional problem including drug or alcohol abuse. In 1983, only 563 serious disciplinary actions were taken against almost 400,000 non-federal patient care doctors. This amounts to one serious disciplinary action (revocation or suspension of license or probation) for every 700 physicians. Yet, the number of patients injured from physician negligence is 250 to 450 times higher. Studies from other states have shown that a significant source of malpractice claims comes from the incompetence and negligence of a small number of physicians and hospitals, resulting in death and lifetime injury for hundreds of thousands of patients each year. Yet the medical profession gives sparse attention and resources to policing malpractice. A number of steps should be taken:

(1) Greatly increase doctor disciplinary actions by state licensing boards by enacting legislation to increase annual license fees to fund adequate enforcement staff. Also, the General Assembly should require non-physician members of licensure boards and authorize subpoena power and public hearings.

(2) Require periodic recertification of doctors based on written exams and audit of doctor performance, such as medical record review. In addition, continuing education for physicians should be required.

(3) State licensing boards should be required to report actions against incompetent doctors to the federal government to stop Medicare and Medicaid payments.

(4) Doctors should be rated on performance for malpractice premiums; competent doctors should not subsidize incompetent ones. With the exception of Colorado, few states have higher premiums for doctors with multiple claims against them.

(5) The number of classifications of doctor specialties for insurance rating purposes should be reduced because the risk pools for some are too small and are overly influenced by a few losses.

(6) Citizens should be encouraged to participate in proceedings for rate requests and other actions by the insurance regulatory commissions through the adoption of state legislation authorizing the creation of voluntary citizen insurance boards with notification to all insureds of the opportunity to join.

(7) Require investment income to be counted in insurance rate requests decisions and full disclosure by companies justifying premium levels and lack of availability of insurance.

The label "Patient's Compensation Plan" is a misnomber. It should be more accurately described as the "Doctor's Benefit Plan." There has been no testimony presented to the Task Force that would justify such fundamental changes in our system of justice, which can only benefit the medical profession and its insurance carriers. The rights of citizens injured by negligent health care providers must be preserved and protected. These victims of medical negligence must be allowed to have their day in

court before a jury of their peers, rather than to be subjected to the limitations inherent in the radical "Patient's Compensation Plan" proposal.

3. MANDATORY STRUCTURED SETTLEMENTS OR PERIODIC PAYMENTS

A structured settlement, as it is currently used on a voluntary negotiated basis, is when the plaintiff takes a stream of monthly or annual payments in lieu of a lump sum. These payments are normally funneled through an annuity purchased from an insurance company. Structuring settlements has been a popular concept over the past ten years, however, its popularity has diminished somewhat since 1985. Tax changes and lower interest rates have caused many in the personal injury field to look at other financial alternatives.

Mandatory structured settlements would preclude plaintiffs from investing their money into vehicles such as money markets, mutual funds, certificates of deposit, and tax-free bonds that might be more suited to their needs. With a mandatory structured settlement, there is little incentive to assign the liability to an annuity company, since the money is paid out on a formula based on a discount rate. This being the case, the plaintiff would suffer an even greater loss of possible investment income than he would with a traditional structured settlement invested in a competitive annuity.

Unlike the negotiated form of structured settlements, mandatory structured settlements have a variety of economic and flexibility disadvantages to the plaintiff, security risks to the plaintiffs and disadvantages to the taxpayers of Kentucky and

society at large. Inflexibility and inflation are the two greatest obstacles that a structured settlement must overcome. This is magnified even further in the case of mandatory structured settlement since the plaintiff rarely has input in planning a program to meet his financial needs. Payments on a fixed schedule leave no flexibility to combat inflation or any change in personal condition. If a recipient of such a program, particularly one who had injuries that made him unemployable, found himself in a situation where unforeseen medical or personal expenses occurred, he would probably have to turn to the state's welfare and medical programs for assistance, creating an unnecessary burden for the state's taxpayers.

Putting a person in a situation where he has no input into the stream of payments and locking him into an inflexible plan that might not meet his future needs is adverse to most common financial planning strategies and is obviously not desirable to the plaintiff.

There can be little question that mandatory structured settlements will result in an economic advantage to the defendant, since they are able to take the lump sum that the plaintiff would get and invest it themselves. This point is also a disadvantage to Kentuckians in light of the fact that the many out-of-state insurers and corporations who do business in Kentucky would not filter the income throughout the Kentucky economy.

The determination to seek a structured settlement depends on several factors. Most important is the needs of the injured plaintiff. Only secondarily important are the tax and

economic benefits of the arrangement. Some people, because of their age or mental status need a structured settlement as a protection against a wasting of the asset. This differs very little from the same considerations that an estate planner would look at when deciding whether to advise an absolute bequest or one to a trust. Mandatory structured settlements take away that flexibility that is a necessary component in any determination of this type. It would be as if life insurance proceeds would be mandatorily paid out in an annuity instead of a lump sum. In some cases, the beneficiary should take out an annuity and that option should be available. In other cases, the beneficiary can make a better use of a lump sum and he should also have that option.

The injured person needs the flexibility of choosing a lump sum settlement when appropriate and choosing periodic payments when they are appropriate. This choice is made after taking into consideration the needs of the injured person. To ignore the needs of the injured person to assauge the tortfeasor is a moral travesty. Our government does not regulate the use of any other person's money. Why should it now seek to regulate the money of an injured person, especially since this person needs additional flexibility to meet unknown and unforeseeable medical expenses.

4. JOINT AND SEVERAL LIABILITY

Abolition or modification of the doctrine of joint and several liability would not lessen insurance rates; more likely, it would increase taxes and necessitate larger government assistance programs for the injured victims.

Joint and several liability means that when more than one party is responsible for an injury to another person, the victim is entitled to full compensation, even if some of the parties are unable to pay.

Suppose five companies all dump hazardous waste at a particular site. Over the years, one of the polluters goes out of business, so, by the time the site is discovered to be an environmental disaster area, there are only four companies left to compensate the victims. Under joint and several liability, those four parties will pay for the damages caused by their wrong doing and will assume the liability for the fifth, insolvent company. Without joint and several liability, who would pay for that fifth polluter's share? The innocent injured residents of the community out of their own limited resources? Or all the taxpayers in the form of government assistance programs? Obviously, the only beneficiaries would be the insurance companies.

With no evidence that altering joint and several liability will improve the insurance situation, the industry wants to enact measures that will undo a logical and efficient solution to the problem of fairly allocating responsibility in complex law suits, especially those arising from catastrophic occurrences. Should it succeed, the end result would be less compensation for innocent victims, higher taxes, and, of course, increased profits for the insurance industry.

If judgments are, indeed, unfair, they are invariably reduced or nullified through appeal or reduced through subsequent settlement. Our legal system should not be designed to limit

penalties for illegal or wrongful conduct, either crimial or civil.

5. PUNITIVE DAMAGES

Punitive damages are the civil justice system's way of punishing defendants for gross, wanton, or willful conduct that approaches criminal behavior.

Advocates of "tort reform" want to eliminate or limit punitive damages on the grounds that they are a windfall to undeserving plaintiffs and are "out of control." What they fail to recognize is that ordinary damages often cannot adequately compensate for death or injury, and that ordinary damages may not be sufficient to deter others who might follow the same behavior.

In condemning punitive damages, the "reformers" cite no statistics to support their contention that punitive damage awards are "out of control." In Kentucky, punitive damages are an extreme rarity. Moreover, in medical malpractice and product liability cases which figure so prominantly in the discussion of "tort reform", punitive damages are practically unheard of in this state. Most cases in which punitive damages have been awarded have involved personal violence, fraud, false and malicious arrests, and insurance bad faith. There is simply no reason to make it more difficult to recover punitive damages in appropriate cases.

6. COLLATERAL SOURCE RULE

The Collateral Source Rule prohibits a defendant from offering into evidence information that the plaintiff has already

or will receive compensation from third parties (health insurance, etc.) for damages incurred. This evidence is deemed prejudicial for the jury to hear since the jury is given the job of assessing damages.

The rationale for eliminating or restricting the effect of the Collateral Source Rule is that the plaintiff is allowed a double recovery. In reality, however, subrogation prevents the plaintiff from recovering double damages, since the source of the benefit (the health insurance or worker's compensation policy) has a subrogation clause under which that carrier is paid back from the plaintiff's award. Two other points worth noting -- a responsible plaintiff who buys disability, life and/or health insurance is penalized for his action in that he or she paid premiums yet can recover less damages, while a plaintiff without insurance suffers no reduction. Many Collateral Source bills go beyond an evidentary change and require a mandatory reduction in the amount a plaintiff recovers for any collateral benefits received.

It should be emphasized that the amount and fact of a defendant's insurance coverage is also inadmissable premised on prejudicial grounds.

C. INSURANCE INDUSTRY REFORM

The real cause of the problems of affordability and availability of insurance is the "cash flow underwriting" practice of the insurance industry. During the early 1980s, the industry underpriced its products in order to earn premium dollars on which it could gain investment income. When the interest rates declined

during the middle 1980s, the industry drastically raised premiums and cancelled customers as it tried to catch up in one year for the reduced income caused by its past mismanagement. At the same time, the industry reduced the scope of coverage under many policies and cancelled many businesses and individuals who never had any claims against them. This collaborative strategy was designed to drive up profits, and was coupled with both a lack of concern for insurance consumers and a severe neglect of loss prevention or safety advocacy responsibilities by the insurance industry.

The primary causes of past insurance problems must be addressed. Remedial legislation should be passed to prevent or minimize the effects of cyclical changes in the insurance industry. In addition, the Commissioner of Insurance of Kentucky should be granted additional statutory authority to oversee the insurance business in this state for the good of all of our citizens. Many of the insurance reform recommendations of the Task Force are worthy of favorable consideration by the General Assembly. Such proposals include:

(1) Expansion of the FAIR Plan

(2) Removal of Barriers to Insurance Pooling and Repeal of the Fictitious Group Statute

(3) Extended Notification of Cancellation or Non-renewal

(4) Increased Reporting of Medical Malpractice and Confidentiality of Peer Review Records

(5) Triggered Filing Approach; Flex Rating

(6) Kentucky Claims Experience

(7) Consent to Changes in Rate and Coverage

(8) Closed Claim Information

(9) Policy Simplification

(10) Surplus Lines Policies

(11) Unfair Claims Practices Act

(12) Insurance Consumers Advisory Council

(13) Increased Funding for the Department of Insurance

(14) Child Care Facility Liability Insurance

In addition, the Task Force member submitting this Minority Report believes that the following recommendations should be included in the area of insurance reform:

(1) Enactment of a State Disclosure Law to Require the Industry to Provide Information on Premiums Paid, Investment Income Earned and Claims Paid for all Classes of Insureds, Subline by Subline. The Industry has Refused to Disclose this Information.

(2) Requirements that Insurance Companies Engage in Greater Loss Prevention Efforts Such as Advancement of Health and Safety Conditions and Experience Loss Rating.

(3) Requirements that Insurance Companies Disclose Evidence of Known Defective Products or Hazardous Conditions to Appropriate Law Enforcement Authorities.

(4) Adequate Budget and Staff so the Kentucky Department of Insurance Can Do Its Job.

(5) Experience-Rate Doctors to Target the "Bad Actors" Who are Causing Sharply Increased Rates for Certain Medical Specialties.

(6) Establish Pre-Trial Screening Panels for Medical Malpractice Suits.

(7) Require Public Hearings on Premium Rate Increases Exceeding 10% Within 60 Days of Rate Filings.

C. CONCLUSION

If the insurance industry is so sure that placing restrictions on a victim's ability to obtain just compensation for injuries will increase the reasonableness of insurance for consumers, then Kentucky legislators should have no hesitation in demanding forced rate roll-backs, of the kind adopted by the Florida legislature.

In fact, the industry knows that scapegoating proposals to limit the legal rights of innocent victims will do nothing to lower insurance rates.

The "crisis" brought about by the insurance industry will not be solved by placing further obstacles in an already difficult process of injured or sick citizens prevailing in court before judge and jury. Effective insurance reforms will stop the cyclical insurance crisis.

Respectfully Submitted,

By: _____

CHARLES S. WIBLE, Member,
Kentucky Insurance and Liability
Task Force

APPENDIX

GENERAL ASSEMBLY

COMMONWEALTH OF KENTUCKY

REGULAR SESSION 1986

HOUSE JOINT RESOLUTION NO. 139

THURSDAY, MARCH 13, 1986

The following joint resolution was reported to the Senate from the House and ordered to be printed.

A JOINT RESOLUTION directing the Legislative Research Commission to appoint a task force to study and investigate the entire insurance industry, including the Kentucky department of insurance, and its effects on Kentucky.

WHEREAS, liability insurance premium increases of 25% to more than 1000% are being imposed on municipalities, and businesses of all sizes, including day care centers, nursing homes, and restaurants, as well as professionals such as accountants, architects, doctors, midwives, and lawyers; and

WHEREAS, residents in some parts of the Commonwealth are unable to obtain homeowners insurance, while others face high premiums for motor vehicle insurance; and

WHEREAS, some physicians in this state are taking early retirement and others are giving up their practices in obstetrics rather than pay exorbitant medical malpractice insurance premiums; and

WHEREAS, the department of insurance claims it is restricted in what it can do to end skyrocketing premiums and increase the availability of insurance due, in part, to its lack of jurisdiction over reinsurers who are demanding price increases ranging from 50% to 500%; and

WHEREAS, some persons question whether the current insurance crisis can be supported by insurance industry data and allege the crisis is a manufactured one to

increase profits of insurers; and

WHEREAS, dissatisfaction with the insurance industry is widespread and the citizens of Kentucky are demanding that some action be taken to assure the availability of insurance at affordable rates;

NOW, THEREFORE,

Be it resolved by the General Assembly of the Commonwealth of Kentucky:

Section 1. The Legislative Research Commission is directed to appoint a task force to study and investigate the entire insurance industry, including the Kentucky department of insurance, and its effects on Kentucky. The task force shall be appointed no later than July 1, 1986. The task force shall be comprised of, but not limited to, representatives of the medical profession, legal profession, local governments, insurance agents, insurance companies, trade associations, chamber of commerce, and citizens at larger.

Section 2. All state departments and agencies shall cooperate with the task force and make available, upon request, such documents, data and records as are relevant, and provide full assistance and information to the task force.

Section 3. The task force may require information on

oath of any person touching any matter which is under study, investigation or audit by the task force, and shall have the power to subpoena witnesses and records for such purposes, and otherwise compel the giving of evidence of any matters under study.

Section 4. The Legislative Research Commission may appoint a director of the task force if such is deemed necessary. The task force shall have the power to hire a staff and to issue personal service contracts as it deems necessary.

Section 5. The task force shall study and investigate insurance laws and regulations, insurance companies, the department of insurance, the availability of insurance to Kentuckians, the rate making process, and other areas of insurance as necessary.

Section 6. The task force may work with other legislative committees, task forces, and special committees. The task force shall consider and, as necessary, develop legislative proposals and recommendations. The task force shall report its findings and recommendations to the Legislative Research Commission on or before December 1, 1987.

Section 7. Staff services to be utilized in completing this investigation and study shall be provided from the regular Legislative Research Commission budget, subject to the limitations and other research

responsibilities of the Commission.

ADDITIONAL SOURCES OF INFORMATION

All tapes, folders and minutes of each meeting are available in the Legislative Research Commission Library upon request.

SOURCE: Report of the Action Commission to Improve the Tort Liability System, American Bar Association 1987 Midyear Meeting, New Orleans, Louisiana

Common Forms of Alternative Dispute Resolution

* Arbitration is the best understood and the most widely practiced form of ADR. It is private adjudication in which the parties to a dispute agree, either by contract or at the time of disagreement, to accept the judgment of a third party (or panel of arbitrators) in resolution of their dispute. The proceedings may be quite informal or as formal as a court, with all the paraphernalia of discovery, witnesses, court reporters and written decisions. The most important characteristic is that the determination is binding and ordinarily enforceable in court. The striking exception to that principle is court-annexed arbitration, which is compulsory under court rules adopted in a number of state and federal jurisdictions. But the determination is not binding if either party is unwilling to accept the result and instead demands a trial by judge or jury. Despite that option, the percentage of acceptances of the determination of the arbitrator ordinarily runs well in excess of 90 percent.

* Mediation is fast growing in popularity, both as a matter of private agreement to use the services of a third party to assist the parties in resolving their dispute, and as a matter of court suggestion or direction. Some states have even gone so far as to require that, before certain kinds of disputes may be tried in court (divorce cases, for example), the parties must submit the matter to mediation. Only if that is unsuccessful may they resort to the formal court procedures.

* Negotiation is like mediation in that the objective is for the disputants to reach agreement between themselves, but unlike mediation in that no third party is involved. That is -- or at least should be -- the first step in every dispute. Indeed, most disputes, within families, in businesses, even among nations, are settled by negotiation. If that were not so, the courts would surely be overwhelmed. The only new point is that negotiating skills are not necessarily intuitively understood. The art of negotiation is increasingly the subject of research, and techniques for its mastery can be taught.

* Mini-trials are a rapidly developing form of private adjudication in which the parties to a dispute agree upon a private "judge" before whom they present an abbreviated trial, after which the adjudicator offers a recommended "judgment" which

the parties use as a basis for settlement negotiations. They are not bound by the decision, but the process has proved highly successful in complex intercorporate disputes and disputes with government agencies. A key element is that a representative of each client, bearing the authority to settle, is expected to be present for the "trial."

* Other court-related procedures include the summary jury trial and reference to special masters for settlement discussions. The summary jury trial, now used in a number of federal district courts, is to all appearances a regular jury trial, but with abbreviated procedures and lacking the force of a binding judgment (although the jurors may not be advised of the fact that their judgment is not binding). This, too, has proved useful as a settlement device because the parties have an opportunity, at reduced cost and in a shortened time period, to assess the strengths and weaknesses of their own case and that of their opponents.

304.99-020. Civil penalties. — (1) For any violation of this code where the commissioner has the power to revoke or suspend a license or certificate of authority he may in lieu thereof or in addition to such revocation or suspension impose a civil penalty against the violator in the case of an insurer, a fraternal benefit society, nonprofit hospital, medical-surgical, dental, and health service corporation, health maintenance organization, or prepaid dental plan organization, of not more than ten thousand dollars ($10,000) per violation; in the case of an agent, broker or solicitor of not more than one thousand dollars ($1,000) per violation; in the case of an adjuster, administrator, or consultant of not more than two thousand dollars ($2,000) per violation.

(2) Such civil penalty may be recovered in an action brought thereon in the name of the Commonwealth of Kentucky in any court of appropriate jurisdiction.

(3) In any court action with respect to a civil penalty, the court may review the penalty as to both liability and reasonableness of amount. (Enact. Acts 1970, ch. 301, subtitle 99, § 2; 1982, ch. 320, § 43, effective July 15, 1982; 1986, ch. 162, § 11, effective July 15, 1986; 1986, ch. 437, § 39, effective July 15, 1986.)

Legislative Research Commission Note. This section was amended by two 1986 Acts which do not appear to be in conflict and have been compiled together.

CABINET FOR HUMAN RESOURCES
COMMONWEALTH OF KENTUCKY
FRANKFORT 40621

DEPARTMENT FOR SOCIAL SERVICES

May 15, 1987

Mr. W. Stephen Wilborn, Chairman
Insurance and Liability Task Force
Capitol Annex Building
Room 20
Frankfort, Kentucky 40601

Dear Mr. Wilborn:

The Department for Social Services, as a result of the 1985 Special Session of the Legislature, was authorized to secure liability insurance for foster parents caring for children committed to the Commonwealth of Kentucky. Foster parents can be held liable for the damages caused by foster children, as well as being subject to suits by natural parents. Protection was needed for foster parents. As authorized by House Bill 2, the Department for Social Services secured liability coverage effective October 1, 1985, through September 30, 1986. The cost was $96 per year per foster home. With the assistance of the Kentucky Department of Insurance, the Department for Social Services successfully implemented liability coverage by insurance purchased from St. Paul Fire and Marine Insurance Company through R.N. Inman and Associates Insurance Agency, Inc. (formerly S.C. Barnes Insurance Agency, Inc.). Maximum coverage per year per foster home was $3,000,000 with a maximum of $1,000,000 per incident. Other benefits included legal defense of lawsuits and related costs, legal bonds up to the limits of coverage, and payments to foster parents for reasonable costs while helping investigate or defend a claim or suit, including up to $200 per day for earnings actually lost while being a witness in a trial.

The Department provided coverage for approximately 1,131 foster homes per month. However, the St. Paul Insurance Company decided not to renew coverage after the first year and coverage ended November 6, 1986. The Kentucky Department of Insurance and R.N. Inman and Associates continued to help try to locate another carrier but only one proposal resulted. The proposal was from the Northfield Insurance Company through Inman Associates. The proposed coverage was significantly reduced from $3,000,000 to $500,000 per foster home per year at a cost of $300/foster home per year, compared to St. Paul's coverage for $96. The Northfield proposal was also a $1,000 deductible; St. Paul's coverage required no deductible. The proposed coverage excluded "sexual and mental abuse and acts of the children"; these exclusions were covered under the St. Paul policy, if legal liability was established in court. The sharp increase in the proposed cost, and the exclusion of some major areas of coverage of concern to the Department and foster parents, made the proposal inadequate and too costly.

AN EQUAL OPPORTUNITY EMPLOYER M F H

The Department has continued to follow any leads for other insurance carriers but has been unsuccessful. The most recent contact was with State Farm Insurance, which has a type of "child care rider" on their homeowners policy. The coverage was not inclusive of 24-hour care as needed for foster parents.

The Department believes that the Insurance and Liability Task Force should make this concern a part of any reports or recommendations produced by the task force. Adequate coverage at a reasonable cost is desired if we are to expect any significant increase in the Department's ability to attract additional foster home participation. Any efforts of the task force to address this matter will be appreciated.

Department staff will be available as may be needed to discuss this concern in more detail.

Sincerely,

Anna Grace Day

Anna Grace Day
Commissioner

cc: Secretary Austin

December 1, 1986

CABINET FOR HUMAN RESOURCES

LIABILITY INSURANCE ADVISORY COMMITTEE REPORT
(Executive Summary)

The Cabinet for Human Resources is concerned about the need, availability, affordability and feasibility of liability protection coverage for its employees, especially those occupying front line service positions. Currently, the issue is of particular importance in view of the nationwide increase in the number of liability actions, the diminishing dollar amount of commercially available coverage, the narrowing scope of actions covered by those policies which are available, the increasing costs of purchasing the diminished coverage, and the unavailability at any cost of some forms of commercial liability protection for public entities and their employees.

Administrative Order 86 HR 19 established the Cabinet for Human Resources Liability Insurance Advisory Committee. This Committee was charged with reviewing and making recommendations to the Secretary regarding:

1) the overall need for liability coverage for state social workers in child and adult protection;

2) the issue of liability coverage in CHR for other personnel within the agency;

3) the feasibility, impact and cost of liability protection coverage;

4) actions taken in other states;

5) possible changes in state laws;

6) other such areas as may be related.

The Committee has investigated and considered the causes of the liability crisis, the position of public entities in relation to the crisis, various alternative solutions to the crisis which have been implemented in other states, and the current situation in the Commonwealth of Kentucky.

The major findings of the Committee are:

1. There is a perceived need among some state employees for protection from liability actions. This is particularly so for social workers engaged in services at the local level. The chief concern is the possibility that high damage awards might be made against them in the event of a successful suit.

2. Non-degreed social workers have always experienced difficulty obtaining liability coverage. Earlier this year, social workers employed by the Commonwealth and engaged in child and adult protective services had their liability coverage cancelled. Until recently social workers who were members of NASW (a professional organization for degreed social workers) could purchase liability coverage for both clinical and administrative activities. Coverage for administrative decisions is no longer available through NASW insurers.

3. Although there have been around 100 cases of litigation involving the Cabinet for Human Resources in the last five years, there have been no monetary judgements against any individual employees of this Cabinet. So far as is known, there have never been any such judgements against individual employees of CHR.

4. Currently, state employed social workers, and all other CHR personnel, are protected by the state's sovereign immunity when the actions they perform are within the course and scope of their employment and under the auspices and direction of state law and policy. State social workers in child and adult protection, acting upon the orders of the court, enjoy the additional protection of prosecutorial immunity.

5. To the extent that they are provided for by statute, the purchase of commercial insurance or the establishment of some form of self-insurance may constitute a partial waiver of sovereign immunity.

6. Legal services are provided by CHR to state employees against whom civil actions are brought, when these employees were acting within the course and scope of their employment, unless there is a clear conflict of interests.

7. Under the provisions of KRS 194.350 the Cabinet now purchases liability insurance for physicians, hospital directors, and administrators employed by CHR. It is noted that because of a history of malpractice suits, these employees have high target profiles. The areas covered are medical malpractice (50 physicians and 3 dentists) and professional liability (14 administrative positions).

8. Other states facing the problems of exposure to liability actions have adopted various strategies. At present at least thirty have, or are establishing, centralized risk management programs. Around forty are considering tort reform. Many states with centralized risk management have created self-insurance programs and insurance pools, while at the same time retaining or legislating some degree of immunity.

Recommendations

Based upon consideration of the issues examined in its report and pursuant to the findings specified above, the committee makes the following recommendations:

1. It is recommended that existing policies be continued. These policies are:

   -- The provision of legal services to employees against whom civil actions are brought, when these employees were acting within the course and scope of their employment, unless there is a clear conflict of interests;

   -- The purchase of liability insurance for physicians, hospital directors and administrators employed by the Cabinet for Human Resources.

2. It is recommended that the Cabinet consider legislation which would:

   -- Provide protection to the individual employee in cases where there is a conflict of interests between defending the employee and defending the Cabinet;

   -- Provide protection to the individual employee against whom a judgement for negligence is awarded in the event such cases are tried outside the venue of the Board of Claims.

   -- Amend the existing legislation relating to purchase of liability insurance for physicians, hospital administrators and directors employed by the Cabinet (KRS 194.350) to specify that such legislation shall not be construed as a waiver of sovereign immunity.

3. It is recommended that individual offices and departments of the Cabinet for Human Resources, in consultation with the Office of Counsel, provide training to their employees with regard to procedures which will minimize exposure to liability actions.

4. It is recommended that the Executive Branch conduct a study of centralized risk mangement/self-insurance programs provided in other states, including an indepth analysis of the respective state constitutional and legislative provisions, to determine the feasibility and costs which would be involved in implementing a centralized risk management program in Kentucky.

PUBLIC PROTECTION AND REGULATION CABINET ADMINISTRATIVE REGULATIONS
Department of Insurance
(Proposed Regulation)

806 KAR 3:021

RELATES TO: KRS 304.3-240

PURSUANT TO: KRS Chapter 13A, 304.2-110 and 304.3-240

NECESSITY AND FUNCTION: KRS 304.2-110 provides that the Commissioner of Insurance may make reasonable regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code. KRS 304.3-240 requires that each insurer file with the Commissioner a statement of its financial condition, transactions, and affairs as of December 31 preceding, and authorizes the Commissioner to require supplemental information therein. This regulation requires casualty insurers to maintain and report as an exhibit to the annual statement certain information regarding bodily injury claims made against the insurer and which were closed during the period covered by the statement.

Section 1. Definitions. As used in this regulation:

(1) "Annual statement" means the annual statement required by KRS 304.3-240 and all supplements, exhibits or schedules thereto required by the Commissioner;

(2) "Casualty insurance" has the meaning set forth in KRS 304.5-070;

(3) "Commissioner" means the Commissioner of the Kentucky Department of Insurance;

(4) "Authorized insurer" has the meaning set forth in KRS 304.1-100;

(5) "Bodily injury" means any physical or corporeal injury caused by external violence to a living person;

(6) "Workers compensation insurance" has the meaning set forth in KRS 304.5-070(1)(c).

Section 2. Every authorized insurer which writes casualty insurance in this state shall develop, maintain and report to the Commissioner of Insurance, as an exhibit to its annual statement, such information as shall be required by the Commissioner with regard to each bodily injury claim made against it or its insured by any person who has sustained bodily injury from an accident occurring within the confines of this Commonwealth. Each such claim shall be reported only with the annual statement covering the period during which the claim was closed. The Commissioner may, upon 90 days' notice to any authorized insurer, require information on claims closed during any other period designated by him.

Section 3. The information to be maintained and reported on each bodily injury claim which is closed is as follows:

1. (a) Claim file identification number _____
   (b) Claim file identification name _____

2. (a) Policy type
   1____ Monoline general liability
   2____ Commercial multiperil
   3____ Commercial automobile
   4____ Personal automobile
   5____ Personal multiperil
   6____ All other
   (b) Business class
   1____ Municipal/public liability
   2____ Schools
   3____ Day care centers

2. (b)
4____ Liquor liability
5____ Non-profit organizations
6____ Construction firms
7____ Apartments, townhouses and condominiums
8____ Mercantile and offices
9____ Churches
10____ Personal residences or properties
11____ All other

(c) Policy limits (bodily injury only)
1____ Per person
2____ Per occurrence/accident
3____ Combined single limit

3. (a) Age of injured person at time of injury _____

(b) Was injured person employed at time of injury?
1____ Yes
2____ No

(c) Was injured person in course of employment at time of injury?
1____ Yes
2____ No

4. (a) Type of injury
1____ Death
2____ Permanent total disability
3____ In hospital treatment required
4____ Emergency room/outpatient treatment required
5____ Treatment by other than M.D.
6____ No treatment

5. (a) Was attorney involved for plaintiff?
1____ Yes
2____ No

(b) Was attorney involved for insured?
1____ Yes
2____ No

(c) Was separate attorney involved for insurer?
1____ Yes
2____ No

6. (a) Stage of legal system at which settlement was reached or award made
1____ No suit filed
2____ Arbitration
3____ Suit filed--settled before trial
4____ Settled during trial, before verdict
5____ Court verdict
6____ Settled after verdict, before appeal
7____ Settled after appeal filed
8____ Appeal determined payment

(b) If court verdict is indicated in 6(a), indicate results:
1____ Directed verdict for plaintiff
2____ Directed verdict for defendant

6. (b) 3____ Judgment not withstanding the verdict for the plaintiff
4____ Judgment not withstanding the verdict for the defendant
5____ Judgment for the plaintiff
6____ Judgment for the defendant
7____ For plaintiff, after appeal
8____ For defendant, after appeal
9____ All others

(c) If case did go to trial, was case tried by jury?
1____ Yes (by judge and jury)
2____ No (by judge alone)

7. (a) Were there defendants other than your insured?
1____ Yes
2____ No

(b) If 7(a) is yes, how many other defendants? _____

(c) If 7(a) is yes, indicate type of other defendants (choose all that apply).
1____ Individuals (private)
2____ Individuals (business)
3____ Partnerships, corporations or other business organizations
4____ Non-profit organizations
5____ Governmental entities

8. (a) If case was tried to verdict, what percentage of fault was assigned to your insured? _____%

(b) If claim was settled, estimate the percentage of fault for your insured: _____%

(c) What percentage of final award or settlement was paid by you? _____%

9. Please indicate the following with respect to the total amount paid to claimant.

(a) Amount paid by you, the insurer
$_____

(b) Amount paid by insured, due to retention or deductible
$_____

(c) Amount paid by excess carrier
$_____

(d) Amount paid by insured due to settlement or award in excess of policy limits
$_____

(e) Amount paid by other defendants/contributors
$_____

(f) Total amount of settlement or award (a+b+c+d+e)
$_____

10. Were collateral sources, such as medical insurance, disability insurance, social security disability or workers' compensation available to the injured party?
1____ Yes
2____ No 3____Unknown

11. (a) Was a structured settlement used in closing this claim?
1_____ Yes
2_____ No

(b) If 11(a) is yes, did structured settlement apply to plaintiff's attorney's fees as well as indemnity payments?
1_____ Yes
2_____ No

(c) If 11(a) is yes, indicate amount of immediate payment.
$_____

(d) If 11(a) is yes, indicate present value of projected total future payout (price of annuity if purchased)
$_____

(e) If 11(a) is yes, indicate projected total future payout
$_____

12. Injured person's medical expenses through date of closing
$_____

13. Injured person's anticipated future medical expense
$_____

14. Injured person's wage loss through date of closing
$_____

15. Injured person's anticipated future wage loss
$_____

16. Injured person's other expenses through date of closing
$_____

17. Injured person's anticipated future other expenses
$_____

18. Amount of non-economic compensatory damages
$_____

19. (a) Actual amount of prejudgment interest, if any, paid on award
$_____

(b) Estimated amount of prejudgment interest, if any, reflected in settlement
$_____

20. (a) What role did punitive damages play in this claim?
1_____ Asked for in petition, not granted
2_____ Asked for and granted by court or jury
3_____ Asked for in settlement, not granted
4_____ Asked for in settlement and paid by insurer
5_____ Not asked for by claimant

(b) If punitive damages were asked for in a petition, what was the amount?
$_____

20. (c) If punitive damages were actually awarded by judgment, what was the amount?

$_____

(d) If punitive damages were asked for in settlement, what was the amount?

$_____

(e) If punitive damages were considered in determining the final settlement amount, estimate the amount that is attributable to punitive damages

$_____

(f) If the dollar impact of punitive damages on final settlement cannot be separately identified, what impact did the allegation of punitive damages have on the settlement amount?

1_____ Major
2_____ Minor
3_____ None

(g) If punitive damages were paid by the insured, what was the amount?

$_____

(h) If punitive damages were paid by the insurer, what was the amount?

$_____

21. (a) Amount paid to outside defense counsel

$_____

(b) Amount of other allocated loss adjustment expenses, such as court costs and stenographers fees

$_____

(c) Total allocated loss adjustment expense (a+b)

$_____

Section 4. This regulation does not apply to bodily injury claims reported under workers' compensation insurance.

STATE BOARD OF INSURANCE

Texas Commercial Liability Insurance Closed Claims Survey

1. a) **Name of Insurer**

_/_
_/_
_/_
_/_

b) **Name of Insurer Group**

_/_
_/_
_/_

c) **Claim File Indentification**

_/_

d) **Name of Person Completing Form**

_/_

e) **Telephone Number**

(/ /) / / / / / / / /
Area Code

2. a) **Date of Injury**
   Mo__/Day__/Yr__

   b) **Date Reported to Insurer**
   Mo__/Day__/Yr__

   c) **Date Closed**
   Mo__/Day__/Yr__

3. **Age of injured person at time of injury** __ __

4. a) **Was injured person employed at time of injury?** 1___Yes 2___No

   b) **If yes, did injury occur in course of employment?** 1___Yes 2___No

5. **Type of Injury**
   1___Wrongful Death
   2___Permanent Total Disability
   3___Other Bodily Injury

6. a) **Policy Type**
   1___Monoline General Liability (All forms including CGL, OL&T, M&C, and Contractual Liability)
   2___Commercial Auto
   3___Texas Commercial Multi Peril (Sec. II Liability)

   b) **Business Class**
   1___Municipal/Public Liability
   2___Schools (Public & Private)
   3___Daycare Centers
   4___Liquor Liability
   5___Non-profit Organizations
   6___Construction Firms
   7___Apartments, Townhomes & Condominiums
   8___Office
   9___Churches
   10___Other _____

   c) **Policy Limits (Bodily Injury)**
   Per Person (Commercial Auto only)
   1. $___,___,___,___.
   Per Occurrence/Accident
   2. $___,___,___,___.
   Combined Single Limit (if Applicable)
   3. $___,___,___,___.

7. a) **State where injury occured**
   1___Texas 2___Other

   b) **If Texas, enter county code where injury occurred** ___

   c) **If Texas, enter county code where suit was filed** ___

   d) **If Texas, enter county code where case was tried** ___

8. a) **Was an attorney involved for plaintiff?** 1___Yes 2___No

   b) **Was an attorney involved for insured**
   1___Yes 2___No

   c) **Was a separate attorney involved for the insured?**
   1___Yes 2___No

9. a) **Stage of legal system at which settlement was reached or award made:**
   1___Binding arbitration
   2___No suit filed
   3___Suit filed but settlement reached before trial
   4___During trial, but before court verdict
   5___Court verdict
   6___Settlement reached after verdict
   7___Settlement reached after appeal was filed

   b) **If a court verdict is indicated in 9(a) above, indicate result:**
   1___Directed verdict for plaint
   2___Directed verdict for defenc
   3___Judgment not withstanding the verdict for the plainti
   4___Judgment not withstanding the verdict for the defenda
   5___Judgment for the plaintiff
   6___Judgment for the defendant
   7___For plaintiff, after appeal
   8___For defendant, after appeal
   9___All others

   c) **If case did go to trial, was case tried by jury?**
   1___Yes (by judge and jury)
   2___No (by judge alone)

10. a) Were there defendants other than your insured?
1___Yes 2___No

b) If 10(a) is yes, how many other defendants? _ _ _ _ _ _ _

c) If 10(a) is yes, indicate type of other defendants (Choose all that apply).
1___Individuals (Private)
2___Individuals (Business)
3___Partnerships, Corporations, or Other Business Organizations
4___Non-profit Organizations
5___Governmental Entities

11. a) If case was tried to verdict, what percentage of fault was assigned to your insured?
_ _ _%

b) If claim was settled, estimate the percentage of fault for your insured:
_ _ _%

c) What percentage of final award or settlement was paid by you?
_ _ _%

12. Please indicate the following with respect to the total amount paid to claimant
a) Amount paid by you, the insurer
$_ _ _,_ _ _,_ _ _,_ _ _.
b) Amount paid by insured, due to retention or deductible
$_ _ _,_ _ _,_ _ _,_ _ _.
c) Amount paid by excess carrier
$_ _ _,_ _ _,_ _ _,_ _ _.
d) Amount paid by insured due to settlement or award in excess of policy limits
$_ _ _,_ _ _,_ _ _,_ _ _.
e) Amount paid by other defendants/contributors
$_ _ _,_ _ _,_ _ _,_ _ _.
f) Total amount of settlement or award (a+b+c+d+e)
$_ _ _,_ _ _,_ _ _,_ _ _.

13. Were collateral sources, such as medical insurance, disability insurance, social security disab or workers' compensation availab to the injured party?
1___Yes
2___No
3___Unknown

14. a) Was a structured settlement used in closing this claim?
1___Yes 2___No

b) If 14(a) is yes, did structured settlement apply to plaintiff's attorney's fees as well as indemn payments?
1___Yes 2___No

c) If 14(a) is yes, indicate amount of immediate payment
$_ _ _,_ _ _,_ _ _,_ _ _.

d) If 14(a) is yes, indicate present value of projected total future payout (price of annuity if purchased)
$_ _ _,_ _ _,_ _ _,_ _ _.

e) If 14(a) is yes, indicate projecte total future payout
$_ _ _,_ _ _,_ _ _,_ _ _.

15. Injured person's medical expenses through date of closing
$_ _ _,_ _ _,_ _ _,_ _ _.

16. Injured person's anticipated futur medical expense
$_ _ _,_ _ _,_ _ _,_ _ _.

17. Injured person's wage loss through date of closing
$_ _ _,_ _ _,_ _ _,_ _ _.

18. Injured person's anticipated futur wage loss
$_ _ _,_ _ _,_ _ _,_ _ _.

19. Injured person's other expenses through date of closing
$_ _ _,_ _ _,_ _ _,_ _ _.

20. Injured person's anticipated futur other expenses
$_ _ _,_ _ _,_ _ _,_ _ _.

21. Amount of non-economic compensatory damages

$_ _ _,_ _ _,_ _ _,_ _ _.

22. a) Actual amount of prejudgment interest, if any, paid on award

$_ _ _,_ _ _,_ _ _,_ _ _.

b) Estimated amount of prejudgment interest, if any, reflected in settlement

$_ _ _,_ _ _,_ _ _,_ _ _.

23. a) What role did punitive damages play in this claim?

1___Asked for in petition, not granted
2___Asked for and granted by court or jury
3___Asked for in settlement, not granted
4___Asked for in settlement and paid by insurer
5___Not asked for by claimant

b) If punitive damages were asked for in a petition, what was the amount?

$_ _ _,_ _ _,_ _ _,_ _ _.

c) If punitive damages were actually awarded by judgment, what was the amount?

$_ _ _,_ _ _,_ _ _,_ _ _.

d) If punitive damages were asked for in settlement, what was the amount?

$_ _ _,_ _ _,_ _ _,_ _ _.

e) If punitive damages were considered in determining the final settlement amount, estimate the amount that is attributable to punitive damages

$_ _ _,_ _ _,_ _ _,_ _ _.

f) If the dollar impact of punitive damages on final settlement cannot be separately identified, what impact did the allegation of punitive damages have on the settlement amount?

1___Major
2___Minor
3___None

g) If punitive damages were paid by the insured, what was the amount?

$_ _ _,_ _ _,_ _ _,_ _ _.

h) If punitive damages were paid by the insurer, what was the amount?

$_ _ _,_ _ _,_ _ _,_ _ _.

24. a) Amount paid to outside defense counsel

$_ _ _,_ _ _,_ _ _,_ _ _.

b) Amount of other allocated loss adjustment expenses, such as court costs and stenographers fees

$_ _ _,_ _ _,_ _ _,_ _ _.

c) Total allocated loss adjustment expense (a + b)

$_ _ _,_ _ _,_ _ _,_ _ _.

RETURN THIS FORM TO:

Texas State Board of Insurance
Research & Information Services
1110 San Jacinto
Austin, Texas 78701-1998

KENTUCKY'S MAJOR INSURANCE TAXES

Insurance Premium Tax

Insurance Premium Surcharge

Dee F. Baugh

Constitutional Authority

"The General Assembly may, by general laws only, provide for the payment of license fees on franchises, stock used for breeding purposes, the various trades, occupations and professions, or a special or excise tax..." Section 181.

Statutory Authority

Premium Tax:

"Every foreign life insurance company doing business in this state, other than fraternal assessment life insurance companies, shall return to the

revenue cabinet a statement of all premium receipts on business done in this state during the preceding calendar year or since the last return was made....Every company shall, at the time of making the return, pay a tax of two dollars upon each one hundred dollars of such premium receipts." KRS 136.330

"Every stock insurance company, other than life, doing business in this state shall return to the revenue cabinet a statement of all amounts paid to the company or its representative, whether designated as premiums or otherwise, for insurance or services incident thereto, on property or risks in this state during the preceding calendar year or since the last returns were made, including amounts received for reinsurance on Kentucky risks from unauthorized companies, and shall at the same time pay a tax of two dollars upon each one hundred dollars of such amounts paid to the company, less amounts returned on canceled policies and policies not taken." KRS 136.340

"All mutual companies other than life doing business under this law shall pay to the revenue cabinet a tax of two percent of all amounts paid to the company or its representative, whether designated as premiums or otherwise, for insurance or services incident thereto, including amounts paid for membership or policy dues or fees, on property or risks in this state during the preceding calendar year, including amounts received for reinsurance on Kentucky risks from unauthorized companies. In addition, mutual insurance companies and Lloyd's insurers shall pay an annual tax as prescribed for stock insurance companies by KRS 136.360 and for like purposes. The provisions of

this section shall not apply to domestic mutual companies, cooperative or assessment fire insurance companies." KRS 136.350

"Every stock insurer other than life doing business in this state shall pay to the department of revenue for the purpose of defraying the expenses authorized by KRS Chapters 227 and 304, subtitle 24, three-fourths of one percent of all amounts paid to such insurance company during the previous calendar year for fire insurance and that portion of the premium reasonably allocable to insurance against the hazard of fire included in other coverages other than life and disability insurance." KRS 136.360

"When by or pursuant to the laws of any other state or foreign country or province any taxes, licenses and other fees, in the aggregate, and any fines, penalties, deposit requirements or other material obligations, prohibitions or restrictions are or would be imposed upon Kentucky insurers, or upon the agents or representatives of such insurers, which are in excess of such taxes, licenses and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements or other obligations, prohibitions, or restrictions directly imposed upon similar insurers, or upon the agents or representatives of such insurers, of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses and other fees, in the aggregate, or fines, penalties, or deposit requirements or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the commissioner upon the insurers, or upon the agents or

representatives of such insurers, of such other state or country doing business or seeking to do business in Kentucky." KRS 304.3-270

"All foreign mutual assessment companies, associations, individual firms, underwriters or Lloyd's, having resident members doing business in this state, who shall enter into contracts of insurance with each other or into agreements to indentify each other against losses by fire, lightning, windstorm or other casualties for which there is no premium charged or collected at the time insurance is made, shall be deemed to be doing insurance business in this state, and shall annually pay to the department of revenue a license tax of two dollars upon each $100 of assessments paid or collected in any one year." KRS 136.390.

Premium Surcharge:

"Every domestic, foreign or alien insurer, other than life and health insurers, which is either subject to or exempted from Kentucky premium taxes as levied pursuant to the provisions of either KRS 136.340, 136.350, 136.370 or 136.390, shall charge and collect a surcharge of one dollar and fifty cents upon each $100 of premium, assessments, or other charges, except for those municipal premium taxes, made by it for insurance coverage provided to its policyholders, on risk located in this state, whether such charges are designated as premiums, assessments or otherwise." KRS 136.392

History

The first insurance premium taxes were levied in Kentucky in 1906. One taxed out-of-state (foreign) life insurance companies other than fraternal assessment life insurance companies doing business in Kentucky. The rate has not changed from the initial levy of two dollars per $100 of premiums. The second taxed foreign companies doing business in this state by insuring each other against losses by fire, lightning, windstorms or other casualties at a rate of two dollars per $100 of assessment paid or collected in one year. That rate remains unchanged. In 1916, foreign mutual companies were taxed at a rate of two percent of taxable premiums. That rate remains unchanged. Four years later, foreign companies were assessed to provide funds to administer these taxes at a rate of one-half of one percent of gross premiums. In 1928, foreign insurance companies other than life were taxed at a rate of two dollars per $100 of premiums. The rate remains unchanged.

In 1942, the tax on foreign insurance companies other than life was changed to apply to stock companies other than life; the tax on foreign mutual companies was restricted to all foreign mutual companies other than life; the administrative-cost tax on foreign insurance companies was changed to apply to all stock fire insurance companies other than life.

In 1954, the administrative tax was raised to 3/4 of one percent. In 1966, collection and administrative responsibility shifted to the department of revenue from the commissioner of insurance. Retaliatory provisions were

added in 1970 applying to discriminatory or onerous requirements by other states or countries. Assessments by insurance guaranty associations were exempted from those provisions in 1972. Also in 1972, the administrative tax for fire protection was shifted from the use of the commissioner of insurance to the commissioner of public safety. Two years later, those funds were again shifted, this time to the General Fund.

In 1982, the insurance premium surcharge of $1.50 per $100 of premium, assessment or other charges was imposed on all insurance companies, except life and health, doing business in Kentucky. The surcharge resulted from a two-year task force formed by the 1980 General Assembly to evaluate the Kentucky Law Enforcement Foundation Program Fund which provided salary supplements to local law enforcement officers completing certain training requirements. Established initially with Federal funds, the KLEFP Fund had become dependent on General Fund monies by 1980.

When imposed, the surcharge rate was set at a level to not only provide current funding for the program but to also build a surplus that would eventually allow the fund to become self-sustaining through investment income and allow the surcharge to be repealed. Also eligible for funding by the surcharge were Professional Fire Fighter's Foundation Program Fund programs. Recent legislatures have added statutory restrictions on the use of the surcharge funds for groups outside the intent of the original KLEFP Fund legislation.

In 1984, health insurance contracts for state employees were exempted from the premium taxes. In 1986, the requirement that premium reports relating to the premium taxes to the revenue cabinet be made "under oath" was stricken.

Structure/Rates

Three taxes - foreign life insurance; all stock insurance companies other than life; and, foreign companies that insure each other against natural disasters - are levied at a rate of two dollars on each $100 of premiums or services related thereto. Foreign mutual companies, other than life and Lloyd's insurers, are taxed at a rate of two percent of all amounts paid to the company. The administrative tax on fire insurance premiums paid to stock insurance companies is levied at a rate of .75 percent of all amounts paid to such companies. Retaliatory provisions mirror taxes, fees or licenses of other states or countries.

The insurance premium surcharge is levied at a rate of 1.5 percent of all premiums, assessments or other charges made for insurance coverage provided to policyholders on risk located in Kentucky. All of these taxes, including the surcharge, are administered by the revenue cabinet. The surcharge is collected by the insurer from the policyholder when premiums are assessed.

Incidence

The insurance premiums taxes are paid by all stock companies other than life, all foreign mutual companies other than life, and all foreign life insurance companies, except fraternal assessment life insurance companies doing business in Kentucky. The economic incidence of these taxes is assumed to be passed on to policyholders. The legal incidence of the surcharge falls on every domestic, foreign or alien insurer other than life, health and worker's compensation, doing business in this state. However, the economic incidence of the surcharge falls on the policyholders and the surcharge is separately identified as such on premium assessments.

Exemptions

Health insurance contracts for state employees are exempt from the three insurance premium taxes. Also exempt from the premiums taxes by definition are domestic life and domestic mutual insurance companies and self-insurers. Domestic mutual companies, cooperative or assessment fire insurance companies are exempt from the two percent premium tax. In computing the amount of premium on which to base the premium taxes, deductions are allowed for amounts refunded on policies canceled or not taken and dividends paid or credited to policyholders. Exemptions from the insurance premium surcharge include: monies returned to policyholders as applicable to the unearned portion of the premium on policies terminated by either the insured or the insurer; municipal

premium taxes; and premiums for life, health and worker's compensation insurance.

Equity

Equity appears to be a serious issue with the premiums taxes, since domestic life and domestic mutual insurance companies are exempt from those taxes, creating a potentially discriminatory differential. At least eleven out-of-state insurance companies have filed requests to have their complaints heard before the Kentucky Board of Tax Appeals on the equity issue. In 1985, the U.S. Supreme Court ruled that a similar tax levied in Alabama was unconstitutional in imposing "discriminatory taxes on non-resident corporations solely because they are non-residents." The case appears in Appendix I. The out-of-state companies are citing that decision in their quest for refunds in Kentucky. Non-state insurers paid more than $21 million to Kentucky in 1985-86 under the premiums taxes.

However, the Alabama decision is not final because it has been sent back to state courts for further review. Since the Alabama decision, several states with similar taxes threatened by the question of differentials have refunded money to out-of-state insurers and/or altered their legislation to equalize the tax rates. The municipal premium tax, which is a local, not a state tax, is levied at varying rates across the state, and is also coming under fire on the equity question.

Receipts/Reliability

Both the premiums taxes and premium surcharge are highly reliable taxes, requiring a low enforcement effort by the Revenue Cabinet. As the following receipt figures indicate, the premiums taxes make a significant contribution to the state's General Fund.

TABLE 1

INSURANCE PREMIUMS TAXES

Fiscal Year	Foreign Life Insurers	All Insurers Other Than Life	Fire Ins. Tax	Retaliatory Tax	Total
1985-86	$20,871,024	$30,353,133	$1,613,658	$555,379	$53,393,194
1984-85	21,145,458	22,732,614	1,296,569	573,701	45,748,342
1983-84	17,969,006	20,823,357	1,246,347	589,071	40,627,781
1982-83	16,129,262	19,746,293	1,225,711	473,904	37,575,170
1981-82	15,277,698	19,934,186	1,197,361	442,374	36,851,619
1980-81	14,297,131	19,998,333	1,279,051	424,912	35,999,427
1979-80	14,036,785	19,185,471	1,116,892	462,161	34,800,509
1978-79	13,443,931	17,919,626	1,113,239	400,324	32,877,120
1977-78	12,237,271	15,162,220	955,907	338,564	28,693,962
1976-77	11,225,832	12,983,981	833,941	269,047	25,312,801

The following table shows collections from the Insurance Premium Surcharge since its inception. The General Fund receipts in 1981-82 and 1982-83 are merely return of funds "lent" to the programs when Federal funds were withdrawn. The allocation of funds to the progams is mandated by statute.

TABLE 2

INSURANCE PREMIUM SURCHARGE

Fiscal Year	General Fund	Professional Fire Fighters Foundation Program Fund	Law Enforcement Foundation Program Fund	Volunteer Fire Department Aid Fund
1985-86	-	$10,288,343	$10,288,343	$2,085,890
1984-85	-	8,156,075	8,156,075	1,741,507
1983-84	-	7,239,083	7,239,083	1,537,931
1982-83	$6,934,088	3,760,147	3,760,147	1,475,661
1981-82	959,312	0	0	124,769

Problems/Complaints

The most immediate and substantive problem with the premium taxes arises from the differential rates applied to insurance companies domiciled in Kentucky and those out of state. Eleven cases have been filed with the Kentucky Board of Tax Appeals by out-of-state companies requesting refunds of their taxes, citing the Supreme Court case involving a similar statute in Alabama. Each request has asked that the insurance premium taxes be declared unconstitutional.

The U.S. Supreme Court, while holding the Alabama law unconstitutional because promotion of a domestic industry was an insufficient reason for the differential, has returned the case to a lower state court to allow other justification for the differential to be put forth. Thus, while several states have responded to the Supreme Court's 1985 ruling, others are waiting for a more definitive judgment. A list of states, premium tax rates and forms of differential treatment appears in Appendix II. Kentucky's litigation could become a lead case on the differential issue, should the Alabama case remain hung up in lower courts. While hearings by the Board of Tax Appeals have not been scheduled, they probably will be heard prior to the 1988 Session.

The insurance premium surcharge, while opposed by the commissioner of insurance when imposed, has received no objection from the current commissioner except when domestic companies are subjected to retaliation as a

result of the surcharge when doing business out of state. Also, the subcommittee is aware of the potential for expanding groups that would be eligible for salary supplements funded by the 1.5% surcharge. That expansion could be accompanied by a swift depletion of the fund's surplus and by proposals to raise the surcharge rate to meet the new demands.

The municipal premium surcharge, assessed at varying rates by cities across the state, however, has come under fire from the insurance industry and the insurance department. Objections center on the varying rates which generate complicated administrative paperwork involving almost two hundred towns and five different forms. In addition, the department of insurance claims that the administrative burden of that tax combined with other state taxes has had a restrictive effect on companies doing business in Kentucky, and thus, has lowered competition and the availability of insurance to Kentuckians.

The municipal surcharge is also threatened by the Alabama case because of its rate differentials.

Alternatives

To resolve objections to the premium taxes, the differential rates would need to be equalized either by repealing rates for out-of-state companies and thus significantly reducing revenue or by raising domestic rates and raising a

modest amount of revenue. The Insurance Department, which does not administer the provisions, is recommending resolution of the issue but without providing specific proposals. The Revenue Cabinet may come to the legislature with proposals for change but stresses that no litigation has been concluded that would jeopardize this state's statutes. The argument could be made that the aggregate tax burden for domestic and foreign insurers is not dramatically different when domestic property taxes are factored in. Whether that rationale could overcome the differential rate issue is questionable, however.

The primary industry objections to the surcharge center not on the 1.5% state-imposed tax but on the municipal surcharge. The Insurance and Liability Task Force has studied this issue and is considering recommending that the 1988 General Assembly set a single rate or a range of rates as other states have done to reduce the administrative burden on the companies.

In addition, the Revenue and Taxation Subcommittee of the Legislative Research Commission on Constitutional Review is considering recommending that the Constitution be amended to allow the General Assembly to give local governments authority to impose broad-based taxes to replace smaller taxes such as the municipal premium surcharge.

Conclusions

The differential rate issue with the insurance premium taxes needs to be

resolved as soon as possible to avoid the possibility of lengthy legal tangles and costly refunds to out-of-state insurers.

The insurance premium surcharge faces no serious industry objection at its current rate. However, that rate could be raised if the KLEFP Fund eligibility is expanded. The municipal premium surcharge assessed by cities appears to need the attention of the 1988 General Assembly, either by setting a single rate or a range for rates. Such a move could encourage more insurers to write risks in Kentucky thereby boosting competition and availability of insurance. The move could also encourage more insurers to domicile in Kentucky.

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State Capitol Frankfort, Kentucky 40601 502-564-8100

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M E M O R A N D U M

TO: W. Stephen Wilborn, Chairman
Insurance and Liability Task Force

FROM: C. Gilmore Dutton, Staff Administrator
Dee Baugh, Staff
Appropriations and Revenue Committee

DATE: October 1, 1987

SUBJECT: Request for information on the Law Enforcement and Firefighters Funds

This is response to your request, transmitted through your staff, for projections regarding the Kentucky Law Enforcement Foundation Program Fund (KLEFPF) and the Professional Firefighters Foundation Program Fund.

You specifically asked for the date that the KLEFPF would become self-sustaining and the date that the two funds, combined, would become self-sustaining. In the later case, you also asked for a projection under a scenario where the insurance premium surcharge would be increased from $1.50 to $2.00 per $100 of premium.

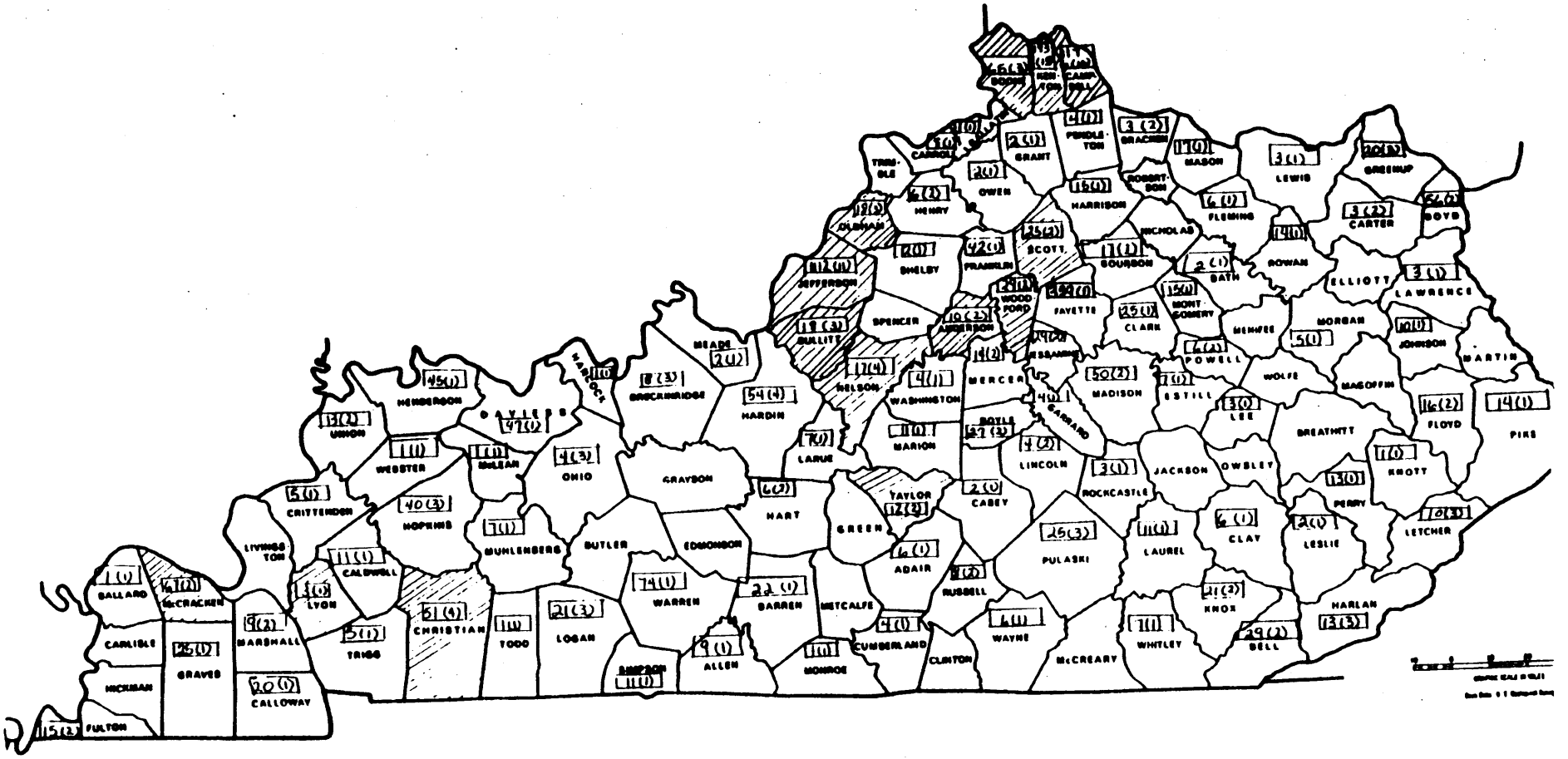
The two funds had a combined balance, as of July 1, 1987, amounting to $23,554,822, of which the law enforcement component accounted for $12,739,470 and the firefighters component accounted for $10,815,352. The net receipts (insurance premium surcharge revenues less expenses) for the two funds for fiscal year 1986-87 amounted to $9,894,026, of which the law enforcement component accounted for $5,665,180. Assuming the same level of income and expenses, with investment income projected at a 7.5 percent interest rate, the two funds, combined, would reach a self-sustaining balance

of $187 million by the end of calendar year 1996. The KLEFPF, under current levels of income and expenditure and a 7.5 percent rate of return on investments, would also become self-sustaining by the close of calendar year 1996, with an accumulated balance of $106 million.

Postulating an insurance premium surcharge of $2.00 per $100 of premium, effective July 1, 1988, the combined funds would become self-sustaining by the close of calendar year 1994, with an accumulated balance of $187 million. This scenario also assumes a rate of return on investments of 7.5 percent.

You also asked about the possibility of additional expenditures being made from either of the two funds, specifically in the amount of $367,300 per year. No funds may be expended from the surcharge receipts for purposes other than those set out in KRS 95A.220 and KRS 15.430, the statutory sections providing for the Professional Firefighters Foundation Program Fund and the Kentucky Law Enforcement Foundation Program Fund, respectively. From a budgetary point of view, either of the two funds could accommodate additional expenditures in the amount indicated; however, if those expenditures were different in kind from those currently provided for, an amendment to current law would be required.

CGD/DB/lh:1728p



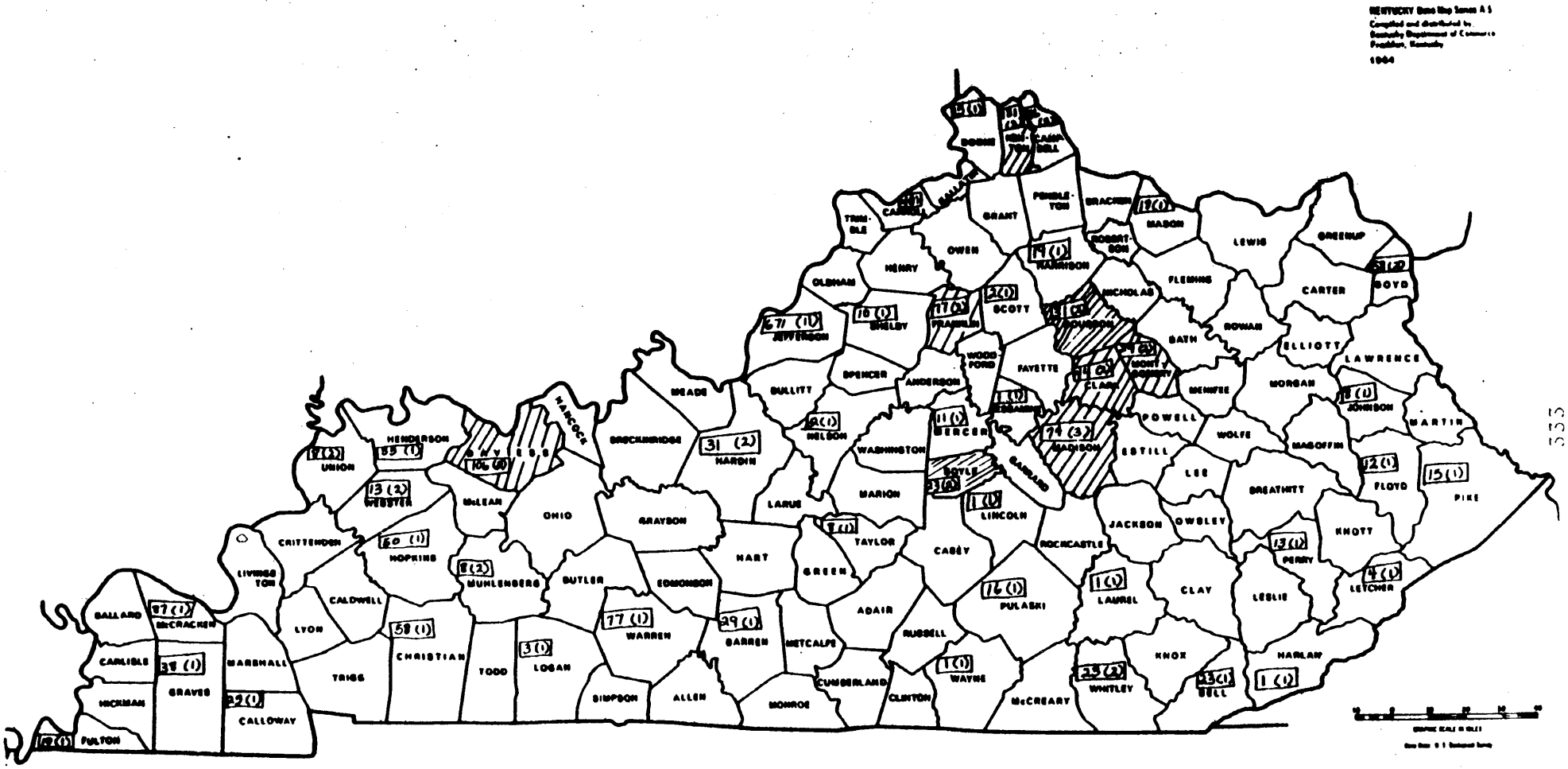
Counties which receive funds.

4(2) Number of officers receiving funds followed by number of governments in county receiving funds.

14 county governments receive funds.

85 counties contain a city which receives funds.

refighters



Counties which receive funds.

4(2) Number of officers receiving funds followed by number of governments in county receiving funds.

8 county governments receive funds.

40 counties contain a city which receives funds.

COMMONWEALTH OF KENTUCKY

IARTHA LAYNE COLLINS
GOVERNOR

GORDON C. DUKE
SECRETARY

FINANCE AND ADMINISTRATION CABINET
DEPARTMENT FOR ADMINISTRATION
DIVISION OF ACCOUNTS
332 CAPITOL ANNEX
FRANKFORT, KENTUCKY 40601
(502) 564-7750

MITCHELL H. PAYNE
COMMISSIONER

EDGAR C. ROSS
DIRECTOR

October 7, 1987

The Honorable Dottie Priddy
9001 Whipporwill Road
Louisville, Kentucky 40229

Dear Representative Priddy:

Enclosed is the Surtax Receipts Statement for the Law Enforcement and Professional Firefighters Foundation Programs, which reflects the current month of September 1987 and year-to-date activity for the period July 1, 1987 thru September 30, 1987.

If you have any questions concerning this statement, please contact me at 564-7750.

Sincerely,

Edgar C. Ross, Director
Division of Accounts

Enclosure

cc: Ms. Paulette Childers, Department of Housing
Ms. Gay Trevino, Legislative Research Commission
Mr. Don Rouse, GOPM
Mr. Ed Sergent, GOPM
Mr. Allen Johnson, Department of Justice
Mr. James Ramsey, Office for Investment and Debt Management
Mr. Wayne Jordan, Commission on Fire Protection
Personnel Standards and Education
Mr. Basil Seale, Kentucky Law Enforcement Council
Mr. Ronald E. Gnagie, Louisville Professional Firefighters
Mr. Kerry A. Curry
Chief Don Roberts, Florence Vol. Fire Department
Mr. Mike Fleming, Legislative Research Commission

An Equal Opportunity Employer M/F/H

Commonwealth of Kentucky
Law Enforcement & Firefighters Fund
Surtax Receipts
For the Period July 1, 1987 - September 30, 1987

	CURRENT MONTH	YTD
Tax Receipts Collected by Department of Revenue	2,333,518.94	6,870,980.31
Gross receipts		(804.21)
Revenue refunds		0.00
Unhonored checks		0.00
Receipt adjustments		
Net receipts to be distributed	2,333,518.94	6,870,176.10
Balances Forwarded from FY 86-87:		
Law Enforcement		12,739,470.27
Firefighters		10,815,351.85
Cash Balances August 31, 1987		
Law Enforcement	14,723,562.96	
Firefighters	11,396,527.57	
Deposits to:		
1. Law Enforcement:	1,330,105.79	3,916,458.75
Revenue refunds prior years		0.00
Revenue refunds current year	(261.13)	(458.40)
Refund of prior year disbursements		0.00
Unhonored checks		0.00
Receipt adjustments		0.00
Net deposits	1,329,844.66	3,916,000.35
2. Firefighters:	1,003,413.15	2,954,521.56
Revenue refunds prior years		0.00
Revenue refunds current year	(197.00)	(345.81)
Refund of prior year disbursements		0.00
Unhonored checks		0.00
Receipt adjustments		0.00
Net deposits	1,003,216.15	2,954,175.75
Investment income:		
Law Enforcement		62,034.97
Firefighters		170,783.70
Expenditures:		
Law Enforcement	659,791.78	1,323,889.75
Firefighters	33,810.49	1,574,378.07
Cash Balances September 30, 1987		
Law Enforcement	15,393,615.84	15,393,615.84
Firefighters	12,365,933.23	12,365,933.23

NO COVERAGE FOR HOME DAY CARE BUSINESS

HO-322
(Ed. 10-85)

If an **insured** regularly provides home day care services to a person or persons other than **insureds** and receives monetary or other compensation for such services, that enterprise is a **business** pursuit. Mutual exchange of home day care services, however, is not considered compensation. The rendering of home day care services by an **insured** to a relative of an **insured** is not considered a **business** pursuit.

Therefore, with respect to a home day care enterprise which is considered to be a **business** pursuit, this policy:

1. does not provide Section II—Liability Coverages because **business** pursuits of an **insured** are excluded under exclusion 1.b. of Section II—Exclusions;
2. does not provide Section I—Coverage B coverage where other structures are used in whole or in part for **business**;
3. does not provide Section I—Coverage C coverage because Coverage C—Property Not Covered, items 10. and 11., exclude:
   a. **business** property pertaining to a **business** actually conducted on the **residence premises**; and
   b. **business** property away from the **residence premises.**

THIS ENDORSEMENT DOES **NOT** CONSTITUTE A REDUCTION OF COVERAGE.

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