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AN ANALYSIS OF THE CAUSES OF THE CURRENT
CRISIS OF UNAVAILABILITY AND UNAFFORDABILITY
OF LIABILITY INSURANCE

Prepared for The National Association of Attorneys General

By:

Francis X. Bellotti
Attorney General of Massachusetts

John Van de Kamp
Attorney General of California

Lacy H. Thornburg
Attorney General of North Carolina

Jim Mattox
Attorney General of Texas

Charlie Brown
Attorney General of West Virginia

Bronson C. LaFollette
Attorney General of Wisconsin

May, 1966

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This report was prepared by Joan Ruttenberg and Sharon Feldman, Assistant Attorneys General, Commonwealth of Massachusetts with editorial assistance from John Donohue, Assistant Attorney General and Chief, Insurance Division, Commonwealth of Massachusetts.

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SYNOPSIS

This report has been prepared to provide Attorneys General with an analysis of the commonly suggested causes of the current crisis of unavailability and unaffordability of liability insurance. The purpose of this report is not to advocate for or against changes in the tort system. Rather, so that any such debate can be based on accurate facts, this report was prepared to provide a review of the factual basis for the following propositions:

1. That the property/casualty insurance industry is in terrible financial straits;
2. That there has been a drastic increase in the number and size of present and future liability claims;
3. That the increased claims are the cause of the current problems in availability and affordability of liability insurance;
4. That the most effective way to resolve the present crisis and prevent future problems of availability and affordability is to change our tort system to limit the number and size of liability claims.

These propositions constitute the basic elements of the call by both the insurance industry and the federal government for massive changes in our civil justice system to end the current insurance "crisis". Based on a careful analysis of the facts relied on by the insurance industry and the federal government to support their arguments, this report concludes that there is little evidence to support these propositions.

Based on our analysis, a more accurate description of the causes of the current crisis is as follows:

1. When the financial situation of the property/casualty insurance industry is reviewed in the same fashion as that of other large corporations, rather than based on the artificially inflated reserve and accounting requirements used for statutory reporting purposes, the companies are continuing to make a profit and are recovering very effectively from their recent price wars;
2. The suggested "explosion" in both the number of lawsuits filed and the size of claims paid is overstated and based on a misuse of statistics;
3. The present "crisis" of unavailability and unaffordability is not caused by the civil justice system but by the unrestrained price cutting recently undertaken by the industry when it attempted to obtain as much new business as possible to invest premiums at the then high interest rates;
4. There is little evidence that making the changes in the tort system proposed by the federal government and the insurance industry will prevent a similar "crisis" in the future given the cyclical nature of the insurance industry.

The report concludes by recommending that each Attorney General carefully scrutinize the facts surrounding the present "crisis" before he or she join in any rush to significantly alter the civil justice system. While periodic review of the fairness and efficiency of our system of compensating victims is appropriate, it should not be automatically assumed that adoption of the proposed changes in

our tort system will have any significant impact on assisting consumers and businesses to obtain more affordable liability insurance. In addition, such a review is best conducted on a state level where the common law of tort recovery originates and where rests the primary regulatory jurisdiction over insurance.

I. INTRODUCTION

Summary and Purpose

In recent months, liability insurance for many organizations, municipalities and professionals has increased in cost tremendously, has been drastically restricted in its coverage, or has become unavailable at any price. The property/casualty insurance industry argues strongly that the costs of insuring against many forms of liability are too great, and that change in the system of civil justice to limit the rights of victims is the only solution. This same conclusion was reached by the February, 1986 Federal government "Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability" (hereinafter "Justice Department Report") produced by an inter-agency working group, and recently mailed to each Attorney General.

Clearly our federal and state court systems are not perfect; there is always room for improvement in the efficiency and fairness of our civil justice scheme. It is both important and valuable periodically to evaluate the development of the common law of negligence, strict liability and damages to guarantee that both plaintiffs' and defendants' rights are being protected.

Yet it is also important to approach change in this system carefully and methodically, and with full understanding of the perceived problems we seek to solve. Change in the civil justice system would have long-term and far reaching consequences. Before instituting any such change in an effort to solve the "insurance crisis", one must first determine whether the civil justice system is in fact responsible for the crisis. If the civil justice system is found not to be at fault for the crisis, we may yet wish to institute civil justice reform for other reasons. If this is the case, however, the urgency of reform evaporates, and proposed reforms can be evaluated deliberately and without the undue haste brought about by panic and a "crisis" situation.

Therefore, to place this debate in its proper context and to assist Attorneys General in evaluating independently the causes of the current problems of unavailability and unaffordability of liability insurance, we have prepared the following analysis of the major conclusions of the Justice Department Report and the insurance industry position. Since the states enjoy primary and virtually complete responsibility for the regulation of insurance, state Attorneys General have an important role to play in the solution of the "crisis".

Our purpose is not to advocate one position or another in the debate over the need for further regulation of the

insurance industry or for changes in the civil justice system. We believe, however, that it is crucial that any such debate be based upon an accurate statement of the facts. This paper is intended to help provide such accuracy, and thereby to promote a calm and rational discussion of the issues.

Suggested Causes for the Current "Crisis"

The position of the Justice Department Report, the insurance industry and others who argue that the present insurance crisis is caused by a "tort explosion" depends to a large extent upon the truth of at least the following four propositions:

1. The property/casualty insurance industry is in terrible financial straits and therefore cannot continue to provide liability coverage without enormous premium increases, reductions in coverage and cancellations.
2. There have been vast increases in the number and size of liability claims which the property/casualty insurance industry has had or will have to pay.
3. These increased claims are the cause of the insurance industry's financial plight, and therefore of the availability and affordability problems.
4. The most effective way to address the current "crisis" in insurance availability and affordability and to avoid drastic premium increases and sudden cancellations, therefore, is to change legal rules to limit the numbers and size of liability claims which insurers will have to pay.

Each of these propositions is based on a presentation of factual evidence, much of it collected in the Justice Department Report. Statistical evidence presented in support of these propositions, as in the Justice Department Report, should be scrutinized by trained lawyers and experts just as evidence presented in any trial. The remainder of this memorandum will review the factual support for each of the four critical propositions. Our purpose is to address the question of whether each of these propositions is true. Such a review is crucial since the truth of each of these propositions must be accepted by each Attorney General before he or she can accept with confidence the solutions offered by the federal government and the insurance industry to the current problems in cost and availability of liability insurance.

Important Underlying Issues

Although this memorandum will concentrate on the narrower issue of whether advocates for change in the civil justice system have statistically and financially proven their case, there are also larger and more basic philosophical and factual questions which must be posed and answered before changes in the civil justice system can be seen as a panacea. When an injury has occurred, the victim or victims have and will suffer costs. No modifications of the tort system will change this.

Instead, changes in the law of tort liability or damages will simply relocate these costs so that a larger proportion of them rest with victims rather than with defendants or with society as a whole as costs are spread by defendants' insurance. Whether a new allocation of costs may be desirable is a question which should be considered on its own merits and based on the specific facts in each state, not one to be decided as an unexamined side effect of efforts to resolve problems with insurance coverage. In this light, for example, an increase in the size of jury awards ought not be automatically viewed as a problem needing correction simply because it may signal a need for insurance premium increases; instead, it could be considered as an indication of increased justice to victims, or increased spreading of risk within society.

Important factual questions are also raised by the prospect that changes in insurance payouts are linked to real-world changes rather than merely to changes in the law of tort liability or damages. For example, are serious product-caused injuries actually becoming more widespread, rather than simply more widely compensated? Are we seeing an increase in the severity of injuries, or of more reckless and unsafe conduct by defendants? Are jury verdicts proportionately scaled to seriousness of injury? What proportion of injuries are left uncompensated by the tort system, and has this proportion changed over time? Such issues must be kept in mind throughout any evaluation of the current situation.

II. DISCUSSION

QUESTION #1:

IS THE PROPERTY-CASUALTY INSURANCE INDUSTRY IN TERRIBLE STRAITS FINANCIALLY?

Underwriting losses are frequently cited by the insurance industry and others as evidence of the industry's financial difficulties. The Justice Department Report states that the property-casualty industry has, in the past two years, suffered "significant underwriting losses (\$21 billion in 1984; \$25 billion in 1985) which have limited its ability to offer as much insurance as its customers desire, and have made it reluctant to insure high risk activities which may expose it to further substantial underwriting losses." (Justice Department Report, at 1). But there have been numerous criticisms of both the significance and accuracy of these underwriting loss figures. Critics have asserted that if the insurance industry's financial picture is reviewed in the same way as the financial soundness of other businesses, the picture isn't nearly so gloomy.

The Limitations of Underwriting Results As A Measure of Profitability

Underwriting results for insurance companies are the measure of the difference between premiums paid in and claims

(and claims adjusting expenses) paid out in a given period. Losses result when claims and expenses exceed premiums; gains occur when the reverse is true.

It is crucial to realize, however, that underwriting results are only one of two sources of property/casualty income; the other source is investment gain. Investment gain allows a company to "...have net income even though its premium revenues alone are not large enough to cover claims and expenses." (Statement of Johnny C. Finch, Senior Associate Director, General Government Division, U.S. General Accounting Office, Before The Subcommittee on Oversight, Committee on Ways and Means, House of Representatives, on Profitability of the Property/Casualty Insurance Industry, at 2 (April 28, 1986) [hereinafter "Finch Statement"]).

There are several sources of investment gains which are available to property/casualty insurers, as they are to all businesses, and which are not accounted for in underwriting result figures. When these sources of gain are included in calculations, the property/casualty industry shows substantial profits.

First, figures on underwriting gain or loss do not take into account the income insurers have actually earned in any given year by investing premiums. In lines of insurance business like liability coverage, there is generally a long lag

between the payment of the premium for a period of coverage and the ultimate payment of a claim incurred during that period (this is often referred to as a long "tail"). For example, for an act of medical malpractice taking place in 1975, a final judgment might not be entered and a claim actually paid by the malpractice insurer until 1980. The insurer would therefore invest the 1975 premium and earn interest on it for five years before payout would occur. Thus, in such long-tailed lines as liability insurance, there is a great opportunity for investment gains on premium income. The federal government's General Accounting Office (GAO) has noted, for example, that while medical malpractice coverage represented less than 2% of total property/casualty insurance premium in 1984-85, its premiums accounted for approximately 6% of the industry's investment gains. Likewise, while general liability coverage represented about 6% of total industry premium, this 6% accounted for 14% of the industry's investment gains. (Statement of William J. Anderson, Director, General Government Division, U.S. General Accounting Office, Before the Subcommittee on Oversight Committee on Ways and Means, House of Representatives, on Profitability of the Property/Casualty Insurance Industry, at 11 (March 3, 1986) [hereinafter "Anderson Statement"]). The property/casualty industry had investment income of \$19.7 billion in 1985. (Best's Insurance

Management Report, at 1 (December 30, 1985) [hereinafter "Best's I"]; (Insurance Information Institute, The Executive Letter Special Report, at 2 (January 13, 1986) [hereinafter "III Report"])).

Second, investment can produce income not only in the form of interest and dividends, but also in the form of realization of capital gains on assets which have appreciated in value and which are then sold. The Insurance Services Organization (ISO) and the Insurance Information Institute (III) have stated that the property/casualty industry realized capital gains of \$5.3 billion in 1985. (ISO, Insurer Profitability -- The Facts, at 22-23 (February, 1986) [hereinafter "Insurer Profitability"]; III Report, at 2; Best's Review, Property/Casualty Insurance Edition, at 6 (February, 1986), citing the III [hereinafter "Best's II"])). This is not surprising, given the character of the property/casualty industry's investment portfolio. Today, the industry is heavily invested in bonds; for example, in 1984, 54% of the industry's portfolio was invested in bonds. (Best's Aggregate & Averages, Property Casualty, at 2 (1985)). Since bonds have fixed rates of interest, bonds purchased while interest rates are high appreciate in value as interest rates later fall. In the face of the falling interest rates of the last 5 years, many of the property/casualty industry's assets have appreciated tremendously. Realization of significant

amounts of these gains while interest rates are low and value is high is therefore to be expected from a reasonable investor.^{1/} Yet, realized capital gain is also not taken into account when underwriting loss is calculated.

The insurance industry itself calculates that when underwriting loss is set off by investment income and realized capital gains alone, a net gain of \$51.4 billion for the decade 1975-1984 results. (Insurer Profitability, at 31). The GAO has calculated the same figure for the later decade 1976-1985 as a net gain of \$51 billion (Finch Statement, at 5).

Third, in large part because of its practice of failing to discount reserves, the property casualty industry has rarely paid any federal income tax.^{2/} The industry routinely receives federal income tax credits, which it then uses to offset federal taxes in future or past years. Thus, in any given year the property/casualty industry

^{1/} While it is true that bonds become correspondingly less valuable in times of very high interest rates, such as the late 1970's and early 1980's, insurers gave no indication during that period of high income that the decreased bond value created financial difficulties for the industry. It is only now, when these assets have appreciated, that a "crisis" is said to be occurring.

^{2/} The insurance industry is entitled to federal income tax deductions for its reserves. To the extent that these reserves are considered too large because of a failure to discount, the tax deduction is overstated as well.

may use tax credits earned in past years to offset its federal income tax obligations, and may additionally gain further tax credits. From 1975-84 the property/casualty industry received tax credits totalling \$125 million. (Address by Natwar M. Gandhi, General Government Division, U.S. General Accounting Office, Before the Insurance Tax Conference, at 3 (November 7, 1985) [hereinafter "Gandhi Address"]; Anderson Statement, at 5-6). In addition, a one year shift in reporting period produces dramatically larger results. The GAO has estimated that for 1976-1985, the tax credit figure rose to \$1.5 billion. This increase is due to losses reported for tax purposes in 1985. (Anderson Statement, at 6). The insurance industry itself acknowledges that, in 1985, it received \$1.9 billion in federal tax credits. (Insurer Profitability, at 24). These tax credit figures are also not subtracted from the industry's underwriting loss figures before they are reported to the public.

The Insurance Information Institute (III) and the National Insurance Consumer Organization (NICO) have estimated that taking account of 1985's investment income, realized capital gains and tax credits, the property/casualty industry has in fact registered a gain of \$1.7 billion in 1985. (III Report at 2; 5 NICO Newsletter, at 9-10 (January-February, 1986) [hereinafter "NICO Newsletter"]). Another insurance industry

source estimates the net gain for 1985 at \$2 billion. (Best's Review, Property/Casualty Insurance Edition, at 14 (May, 1986) [hereinafter "Best's III"]). Thus, while analysts may differ slightly as to the exact value of, or relationship between, the various sources of revenue described above, there is no doubt that the bottom line is decidedly positive.

In addition, the GAO has recommended to Congress that two other sources of income be added in calculating the industry's profitability. These changes significantly increase profit figures. First, the GAO recommends that investment gains include unrealized as well as realized capital gains. Thus, if an insurer's investments have appreciated in value, that increased value would be taken into account when calculating the company's financial status. The GAO reasons that "...it is well within a company's control to manage its investment portfolio so as to realize these gains while the investments are profitable." (Finch Statement, at 5). The property/casualty industry registered \$1.2 billion in unrealized capital gains in 1985. (Best's I, at 1; Best's II, at 6). While analysts may differ as to what proportion of unrealized gains should be included in profit calculations, it is clear that at least some of these gains should be reflected, and equally clear that insurance industry calculations of profit and loss omit these gains completely.

Second, the GAO recommends that underwriting results should not include a debit for the payment by a company of dividends to policyholders. (Insurers currently consider such dividends as liabilities when calculating profitability.) The GAO reasons here that these dividends are "voluntary distributions by the companies", not unavoidable expenses. (Anderson Statement, at 7; Finch Statement, at 5). In 1985, the industry considered \$2.1 billion of policyholder dividends as liabilities when calculating losses. (III Report, at 1). When these two further adjustments are made, NICO concludes that the industry's net gain rises to \$5.0 billion for 1985 (NICO Newsletter, at 9) and the GAO calculates that industry net gains for the 1976-85 period total \$75 billion. (Finch Statement, at 4).

The Artificiality of Underwriting Results

In determining underwriting results, insurers count as liabilities the reserves they set aside to pay future claims, despite the fact that, in reality, much of this money remains available for use for long periods. In calculating these reserves, insurers use accounting methods prepared to assure state regulators of the companies' solvency. Such regulatory accounting is based on a "worst case scenario", which states that an insurer's reserves must be big enough to pay all claims

if, at the end of the year in question, the following two events will come to pass: all policies will be cancelled (so that the insurer cannot rely on a continuing stream of income) and all claims filed or expected to be filed during the year will be paid in full. Critics such as NICO have argued that while such a "worst case scenario" may be an appropriate way for state regulators to protect their citizens from insurer insolvency, it is not an appropriate basis upon which to estimate reserve liabilities in calculating the actual profitability of the industry. (NICO, And Now the Real Facts, A Response To The Insurance Services Office's "Insurer Profitability - The Facts", at 4-5 [hereinafter "Response"]).

Instead, critics have recommended that property/casualty reserves be estimated in a more realistic fashion, taking into account the ability of the reserves to earn investment income in future years. Reserve estimates could thus be smaller, or "discounted," since a smaller reserve amount invested now would produce the larger, full amount needed later when claims come due. The GAO has criticized the failure of insurers to discount their reserves.^{3/}

^{3/} It should be noted that critics have also asserted that, at times, the industry overestimates its reserves, and that reserves should therefore be smaller even independently of discounting. (See, e.g., NICO Newsletter, at 10).

(Gandhi Address, at 8). NICO has estimated that this modification and one other related adjustment would by themselves increase the 1985 net gain figure by \$5.5 billion. (Response, at 5).

CONCLUSION #1:

THE PROPERTY/CASUALTY INDUSTRY IS IN ADEQUATE AND IMPROVING FINANCIAL CONDITION

Based on the foregoing discussion, it is clear that to obtain a complete and accurate picture of the current profitability of the property/casualty insurance industry, one must look beyond underwriting income alone. The inadequacy of underwriting income alone as a measure of profitability is well illustrated by this calculation of the GAO:

... while the property/casualty companies had about \$46 billion in underwriting losses from 1975 through 1984, they also had about \$121 billion in investment gains during this period, resulting in a net gain of about \$75 billion for those years. (Anderson Statement, at 4).

And although from 1980-84, the industry registered a \$45 billion underwriting loss, \$82 billion in investment gain resulted in a net gain to the industry for those years of \$37 billion. (Finch Statement, at 5). Thus, by virtually any of the standard measures of profitability, the property/casualty industry is far from the brink of disaster. Given this more accurate picture of industry profitability, it is not

surprising that even the Justice Department Report concedes that "the industry is currently making a profit..." (Justice Department Report, at 18).

As for the future, the GAO reports that estimates made by the property/casualty industry itself:

...show that over the next 5 years the industry expects substantial net gains. Our calculations, made from industry estimates, indicate an expected net gain before taxes of over \$90 billion for the years 1986-1990. (Anderson Statement, at 8-9; Finch Statement, at 7-8).

Likewise, the investment analysis firm of Salomon Brothers, Inc. has forecasted that profits for the property/casualty industry will rise at a rate of 25% per year during the 1985-89 period. (Id., citing: Salomon Brothers, Inc., Property/Casualty Insurance Organizations, Five-Year Review and Outlook, 1985 Edition (August, 1985)).

With such optimistic predictions, it should also not be surprising that the value of the property/casualty industry's stock has risen dramatically in recent years and months, even when compared to a dramatically rising market in general. In 1985, property/casualty stocks rose in value by 50%, twice the rise in the Dow Jones industrial average. Best's Review characterized this leap as "[t]he most spectacular performance last year by a component of Best's Insurance Stock Index...." and stated that this advance "show[ed] renewed confidence by

investors..." after lesser gains in 1984. (King, Best's II, at 21). In the first quarter of 1986, the same pattern has emerged: property/casualty stocks are up by 26%, again about twice the increase in the market. Since 1975, the property/casualty insurance stock index has risen more than 500%, which is more than five times the rise of the Dow. (Real Facts, at 4). And over the last 16 years, Best's points out that "...the Property/Casualty index was the growth leader with [a growth rate of] 524%." (King, Best's III, at 21). Finally, of the 17 property/casualty stocks which constitute Best's index, only one declined in value in 1985. Of the 30 property/casualty stocks Best's follows, only three declined in value in 1985. (Id., at 99).

Thus, there is considerable evidence that the property/casualty insurance industry, far from being in dire financial straits, is in fact doing quite well financially. The emphasis on a need for change in the civil justice system to rescue the insurance industry from financial problems is therefore entirely misplaced.

QUESTION #2:

HAVE THERE BEEN VAST INCREASES IN THE NUMBER AND SIZE
OF LIABILITY CLAIMS WHICH THE PROPERTY-CASUALTY
INSURANCE INDUSTRY HAS HAD OR WILL HAVE TO PAY?

The insurance industry, in seeking to effect changes in the civil justice system, argues that the major source of any financial reversals the industry may be suffering is an "explosion" in litigation and in the size of tort judgments. An argument of this sort is also made by the Justice Department Report:

[A] major factor underlying the availability/ affordability crisis is the insurance industry's attempt to bring premiums quickly back into line with rapidly growing liability risks. The high -- and in some areas unaffordable -- insurance premiums reflect the fact that tort law is now placing a massive compensation burden on the private sector. (Justice Department Report, at 3).

This "explosion" means, according to the industry and the Justice Department Report, that losses are too unpredictably high for companies to sell insurance, or to sell it without drastic premium increases. Yet the statistics presented in the Justice Department Report do not demonstrate a "litigation explosion" nor does the report acknowledge the contrary evidence contained in existing research on litigation and litigation expenditure.

The Justice Department Report cites as evidence of a "litigation explosion" increases in the average size of jury verdicts, and increases in the number of large awards. (Id., at

2-3, 35-52). A cause of both these changes is argued to be the growth of punitive damages and other noneconomic compensation. (Id., at 39). The Justice Department Report also seeks to justify its conclusions by purporting to document an increase in the number of law suits filed. (Id., at 45). What follows is an analysis of the statistical basis for these conclusions.

The Frequency of Litigation

The overall picture of our society which the Justice Department Report appears to paint is that society is becoming increasingly litigious. Individuals are said to rush to the court house in the event of any misfortune. As an example of the sudden litigiousness of tort victims, the Justice Department Report states: "[T]he number of product liability cases filed in federal district courts has increased from 1,579 in 1974 to 13,554 in 1985, a 758% increase. There is no reason to believe that the state courts have not witnessed a similar dramatic increase in the number of product liability claims." (Justice Department Report, at 45).

However, there is now substantial reason to believe that state courts have not witnessed such a dramatic increase. A statistical study recently released by the National Center for State Courts shows that in fact claims filed in state courts have not increased significantly over the last several years.

(National Center for State Courts, A Preliminary Examination of Available Civil and Criminal Trend Data in State Trial Courts for 1978, 1981, and 1984, at 1 (April, 1986)). This study finds that the countrywide increase in tort claims has been only 9% in 6 years, and that this increase is virtually identical to population increases of 8% over that time period. (Id., at 2, and Table 34).

The National Center for State Courts study does not, of course, measure increases in federal litigation. However, since state court litigation represents the vast majority (98%) of cases, any increases in federal litigation are of extremely limited significance. (Trubek, Sarat, Felstiner, Kritzer & Grossman, The Costs of Ordinary Litigation, 4 U.C.L.A. L. Rev. 72, 81 n. 21 (1983) [hereinafter "Trubek & Sarat"]). One possible explanation for any difference in caseload between court systems is that a preference for the federal forum, frequently noted by federal judges in recent years, has led to a disproportionate increase in federal court litigation. (See, e.g., Bumiller, Choice of Forum in Diversity Cases: An Analysis of a Survey and Implications for Reform, 2 Civil Litigation Research Project: Final Report, III-310 (1983)).

Some evidence does suggest that the number of claims may have been increasing slightly more than the population for certain types of torts, but not by the exorbitant amounts

represented in the Report. For example, State Government News cites National Center of State Courts data showing a 20% increase in liability claims over the last 7 years. ("The Liability Crisis: Who's to Blame" at 4, 5 (March/April 1986)). These increases, however, do not even approach the several hundred-fold increases in state court litigation implied by the Justice Department Report, and there is no indication that such moderate rises would not have been predictable in earlier years. Researchers do not consider such increases as "explosive", nor supportive of a conclusion that society is becoming increasingly litigious. (Galanter, Reading the Landscape of Disputes: What We Know and Don't Know (and Think We Know) About Our Allegedly Contentious and Litigious Society, 31 U.C.L.A. L. Rev. 4 (1983) [hereinafter "Galanter"]).

To put the amount of litigation in its proper context it is important to understand that only a very small fraction of injurious experiences result in litigation.^{4/} Even where victims are aware that they have been tortiously injured, many choose not to make any type of claim, and many who do

^{4/} "Any empirical discussion of the frequency of litigation must employ a baseline -- some measure of the number of opportunities to use the courts against which actual filing rates can be compared. . . . If one were concerned with medical malpractice litigation, for example, it would be inadequate merely to note an increase in the number of cases filed. One would want to relate this to rates of professional contacts which might generate lawsuits." (Trubek, Grossman, Felstiner, Kritzer & Sarat, Summary of Principle Findings, 1 Civil Litigation Research Project: Final Report, at S-17 (1983)).

make claims do not pursue these claims to the courts. (See, e.g., Galanter, at 11; Trubek & Sarat, at 83-86). A study of hospital records in the mid-1970's showed that only 1 in 10 instances of medical malpractice led to a claim, and of those, only 40% resulted in payment. One researcher concludes from this that even under the most generous assumptions about litigation rates, the social cost of medical malpractice far exceeds the cost of medical malpractice claims. (Danzon, Medical Malpractice: Theory, Evidence, and Public Policy, at 25 (Harvard University Press, 1985) [hereinafter "Danzon"]).

The Asserted "Explosion" in the Compensation of Tort Victims

The statistics presented by the Justice Department Report on jury awards at first glance seem to indicate that there has been a huge increase in the average size of jury awards for medical malpractice and products liability claims: "According to a jury verdict reporting service, between 1975 and 1985 the average medical malpractice jury verdict increased from \$220,018 to \$1,017,716 and the average product liability jury verdict increased from \$393,580 to \$1,850,452." (Justice Department Report, at 2-3).

To determine the impact of these figures on overall increases in claims payments by insurance companies for tort liability, however, the relationship between jury awards and overall claims paid by insurance companies to victims of

negligence must be reviewed. Only a tiny proportion (5-10%) of tort cases filed result in jury verdicts^{5/} (Galanter, at 27; Trubek & Sarat, at 89); the vast majority are settled, and settlements are overall considerably smaller than verdicts. (See Danzon, at 31, showing that for a sample of cases closed in 1974 and 1976, the average verdict award was 4 times the size of the average settlement award). Even for those few claims which result in jury verdicts for the plaintiff, the verdicts are frequently overturned, reduced on appeal, reduced by judges or trimmed in post-verdict settlements. Thus, the average actual compensation to tort victims is certainly much smaller than the average jury verdict.

It is also important to realize that to determine the typical award to a tort victim, it is necessary to consider the median award, not merely the average or mean figure used by the Justice Department Report. (See, e.g., Daniels, Punitive Damages: A Storm on the Horizon? Preliminary Report of the Punitive Damages Project, at 13 (prepared for delivery at the American Bar Foundation Fellows Seminar, February 8, 1986) [hereinafter "Daniels"]; Localio, Variations on \$962,258: The Misuse of Data on Medical Malpractice, 13 Law, Med. & Health Care 126 (1985)). A median figure is the midpoint figure for

^{5/} Note also that the number of jury trials has actually been decreasing in recent years. (See, e.g., Shanley & Peterson, Civil Jury Verdicts in San Francisco and Cook County, 1959-1980 (Rand Corp., 1983)).

all awards; it therefore shows the maximum compensation received in at least half of all jury verdicts. For jury awards, the median is much smaller than the average, which can be significantly influenced upward by a few very large claims. For example, in Cook County in 1983, the average award for reported verdicts was \$137,350 whereas the median award was only \$8,800. 87.7% of cases had awards lower than the average. (Daniels, at 13). In fact, although evidence shows the average award has been increasing, the median jury award has not increased more than the rate of inflation, which shows that at least half of all jury awards still involve very small amounts. (See, e.g., Rand Corp., Institute for Civil Justice: An Overview of the First Five Program Years, at 23 (1985) [hereinafter "Overview"]).

Given the relatively small percent of total claims paid which is represented by jury verdicts, the large inflation shown in the average jury verdict may not accurately describe what is happening to overall tort claim payments by insurance companies. Large verdicts may be peculiar to the types of cases, perhaps more serious cases, which are likely to go to trial, and the vast majority of cases which do not reach a verdict may not show the effects of such large inflation. Several studies have in fact shown that cases which go to trial tend to be more serious than cases which settle. (Danzon, at

46; Wittman, Price of Negligence Under Differing Liability Rules, 29 J. L. and Econ. 151, 162 (April, 1986) [hereinafter "Wittman"]).

Even the evidence cited by the Justice Department Report does not support the report's conclusion of an "explosion" in the size of average jury awards. The data shows substantial fluctuations in average verdict size from year to year rather than huge or sudden increases in the most recent years. For example, the Justice Department Report documents an increase of only 10% in average jury awards for medical malpractice victims during the last 3 years. (Justice Department Report at 37 Chart D, for 1982-1985, as reported by Jury Verdict Research, Inc.). This increase is comparable to the rate of inflation during that time period. In fact, the yearly average jury verdicts actually decrease in some years. (Justice Department Report at 37, Chart D, for years 1984, 1979, 1976, and at 38, Chart E, for years 1984, 1980, 1979 and 1976).

The Justice Department Report also does not attempt to offer any systematic explanation for increases in the average jury award, other than to attribute such increases to growth in noneconomic compensation. Other plausible explanations should also be considered. First, growth in jury awards may be due to growth in the medical compensation portion of verdicts. The rate of inflation in the costs of medical services over the last few years has been considerably higher than the general

inflation rate reported by the Consumer Price Index. For all medical services, the price level from 1967-1985 quadrupled while the consumer price index (usually used to measure inflation) only tripled. (Economic Report of the President, at 318 (February 1986)). Second, growth in the portion of verdicts compensating victims for lost earnings may be having an effect on the size of overall jury verdicts. Over the last 5 years, interest rates have been falling. This would require an increase in the amount of compensation which must be awarded in today's dollars to represent lost future earnings. (This is because a lump sum payment will earn less interest during future years.) Thus there are legitimate and appropriate reasons which can explain seemingly large increases in jury awards without an assumption that jury behavior in awarding increased damages has changed irrationally.^{6/}

The Failure To Demonstrate An Explosion In The Number of "Large" Verdicts

Many news accounts have been focusing attention on a few multimillion dollar awards which are portrayed as

^{6/} There seems to be no support for the claim frequently made that in cases of serious injury juries compensate without regard to fault. (See, e.g. Justice Department Report, at 31-32). In her study of medical malpractice cases, Danzon concluded: "The data ... clearly refute the extreme charge that juries compensate without regard to fault... The more severe the injury, the more likely the verdict will favor the plaintiff, but this may simply reflect the fact that severe injuries are in fact more likely to result from negligence than from simple bad luck". (Danzon, at 50).

representative of an overall increase in "large" verdicts. The "large" verdict is thus the means used by proponents of changes in tort law to suggest that victims are being overcompensated, and has become the target of many proposed tort law changes. The Justice Department Report adopts this same approach, stating:

"[T]he percentage rate of increase of verdicts is far higher for large verdicts than for small or medium-size verdicts. Since a significant distinguishing factor between large and small or medium-size verdicts is that large verdicts tend to be composed to a far greater extent of non-economic damages, this strongly suggests that non-economic damages play a major role in the explosive growth of large verdicts." (Justice Department Report, at 39).

In an attempt to show that there has been a disproportionate increase in very large verdicts, the Justice Department Report cites two statistics: first, that the number of \$1 million medical malpractice verdicts increased 1200% from 1975 to 1984; and second, that excluding \$1 million dollar verdicts lowers the increase in average jury awards from 363% to 26% over 10 years. (Justice Department Report, at 39).

The Justice Department Report's reliance on the million dollar verdict presents an inaccurate picture of the true significance of these figures for two basic reasons. First, a large rise in the number of \$1 million verdicts could as easily be attributable to the existence of a number of verdicts just under \$1 million in 1975 as to some unexplained growth at the

upper end of verdict amounts. The general rate of inflation would be enough to raise such verdicts above \$1 million.

Second, the statistic showing the purported reduction in the average verdict when \$1 million verdicts are removed is virtually meaningless. The Justice Department Report's comparison assumes not that all verdicts are capped at \$1 million, but that all \$1 million verdicts are somehow reduced to zero. No serious critic of the tort system, not even the Justice Department, is proposing to deny all recovery to plaintiffs whose damages are currently judged to exceed \$1 million. A more useful figure would be the increase in the average verdict if all verdicts were capped at \$1 million, but the Justice Department Report does not present this statistic. Thus the figures presented in the Justice Department Report are meaningless and cannot be taken to present any evidence whatsoever that the percentage rate of increase is higher for large verdicts than for small or medium size verdicts. The number of million dollar verdicts is of even less significance because in fact such verdicts constitute only a small fraction of 1% of all claims filed. (Daniels, at 6).

The Impact of Punitive Damage Awards On Tort Claim Payouts

The Justice Department Report attributes the purported increase in large verdicts to an increase in noneconomic compensation, and concludes: "Damages have become excessive,

particularly in the area of non-economic damages such as pain and suffering, mental anguish and punitive damages." (Justice Department Report at 52). When the underlying data is carefully reviewed there is little support for this assertion. The punitive damage statistics presented as an example of the explosion in noneconomic compensation drastically overstate the significance of punitive damage awards.

First, punitive damages are awarded infrequently. (Daniels, at 10; See also, Institute for Civil Justice, Summary of Research Results on the Tort Liability System, Statement by Deborah R. Hensler, prepared for Senate Committee on Commerce, Science, and Transportation, at 4 (February 27, 1986), [hereinafter "Hensler Statement"]). For example, Cook County jury awards included punitive damages in only 2.2% of cases. (Daniels, at 10-11). Punitive damages are even less frequently awarded in either products liability or medical malpractice cases. (See, e.g., Daniels, at 15; Hensler Statement, at 4; Landes and Posner, A Positive Economic Analysis of Products Liability, 14 J. Legal Stud. 535, 565 (1985) [hereinafter "Product Liability"]).^{7/} In addition,

^{7/} For example, in New York City, of the 48 products liability cases reported in 1981-83 which went to trial none included a punitive award. Of the 318 medical malpractice cases reported, only 1 included a punitive award. (Daniels, at Table 6). Landes and Posner conclude: "Punitive damages are not routinely awarded in products liability cases, but only where there are circumstances of aggravation. These include reckless indifference to safety, gross negligence, or concealment by the manufacturer of the dangerousness of his product from consumers." (Product Liability, at 564).

in many jurisdictions insurance companies cannot legally pay punitive damage awards. In those states where they may, they typically can do so only if such awards are assessed through vicarious liability. (See, e.g., Annot., 16 A.L.R. 4th 11 (1982); Sales and Cole, Punitive Damages, 37 Vand. L. Rev. 117, 1163 n. 209 (1984)).

Second, the average punitive damage award statistics cited by the Justice Department Report ignore the effects of post-verdict reductions through appeal, remittitur, and settlement. In fact, studies show that post-verdict reduction is particularly significant for punitive damage awards. One study found that punitive damages were upheld on appeal in only 4 out of 10 products liability cases. (Product Liability, at 565). These findings are confirmed by the full analysis of the data performed by the Institute for Civil Justice, which found that the final amount of punitive damage jury awards actually paid is on average only 50% of the original jury award. (Hensler Statement, at 4).

Third, the statistics presented compare average punitive awards in Cook County only, which has an unusually large number of \$1 million verdicts. (Daniels, at 17). These statistics are therefore not representative of Illinois, much less the country as a whole. (See Daniels, at 1-6). Daniels finds tremendous variability in both the frequency and size of punitive damage awards among the many different sites studied. (Id., at 10, 13).

Fourth, the increases in average punitive awards shown by the Justice Department Report statistics are not useful because so few punitive damage awards are tallied (e.g., 23 in a 5 year period) that the results are very susceptible to the effects of one large award in a five year period. Whereas the Justice Department Report cites the average Cook County punitive damage award for the period 1980-84 (\$489,000), the median award for the period was only \$20,000. (Peterson , Punitive Damages: Preliminary Empirical Findings (Rand Corp., 1985)). Other reports not discussed by the Justice Department Report show that overall, both the size and number of punitive damage awards remain moderate. (Daniels, at 19).

Finally, the number of punitive damage awards is such a small percent of all awards that any observed increase in the size of such awards could have no major impact on the overall increase in tort claims payments. Thus, punitive damages in tort claims should be of limited concern to insurance companies.^{8/}

^{8/} Interestingly, research shows that one of the largest sources of punitive damage awards is bad faith claims against insurance companies. ("[P]unitive award[s] are clustered, typically, in a small set of causes of action: personal violence, fraud, false arrest, and insurance bad faith." Daniels, at 14). This clearly is of great concern to the companies, though they do not argue that such awards are unjustified, or that the awards fail to provide an efficient deterrent to future unfair claims settlement practice.

The Evidence On Pain and Suffering Awards

The largest category of noneconomic damage is awards for pain and suffering. The Justice Department Report states: "Such non-economic damages are inherently open-ended and subjective, and therefore, easily susceptible to dramatic inflation." (Justice Department Report, at 39). No evidence is presented by the Justice Department Report or the industry to show that such awards are increasing. The statistic cited by the Justice Department Report shows that "large" awards contain a higher proportion of noneconomic damages than smaller awards, but no evidence is presented as to whether or not this percentage (54%) is increasing or decreasing. Such information is necessary to determine whether in fact pain and suffering awards have been increasing in size. It is reasonable to assume that if the data showed any significant increase in these awards it would have been documented in the Justice Department Report. Finally, it is important to remember that whereas punitive damages serve a deterrent purpose, pain and suffering awards represent compensation for real and very serious damage to an injured victim.

CONCLUSION #2:

THE EVIDENCE SHOWS NO VAST OR EXPLOSIVE INCREASES IN CLAIMS OR PAYMENTS TO VICTIMS

The Justice Department Report has not provided any significant evidence that society has suddenly become much more

litigious. The statistics cited do not show meaningful increases in the number or size of awards, or in the noneconomic damage portion of awards. The Report fails to show that those areas of increase are large enough to impact overall tort claim payouts by insurance companies. This criticism of the Justice Department Report is not meant to imply that the civil justice system and the laws for compensating victims do not deserve close scrutiny. The more appropriate conclusion is that such scrutiny should be exercised by each state of its own experience independently from any considerations of the current problems of the unavailability and unaffordability of insurance.^{9/}

^{9/} This point is further underscored by the fact that any evolution in our civil justice system toward providing more compensation to victims has occurred over the last 10-20 years in a constant manner. (See, e.g., Overview, at 24-26; Shanley & Peterson, Civil Jury Verdicts in San Francisco and Cook County, 1959-1980 (Rand Corp., 1983)). Over this period, the industry remained extremely profitable, and in fact engaged in at least two significant periods of price cutting. Thus, it does not appear logical that the industry could have been taken by surprise by any increases in compensation to victims.

QUESTION #3:

ARE INCREASED CLAIMS THE CAUSE OF THE INSURANCE INDUSTRY'S FINANCIAL PLIGHT, AND THEREFORE OF THE AVAILABILITY AND AFFORDABILITY PROBLEMS?

To understand how to remedy the current problems in insurance cost and availability, it is essential that we understand what has actually caused these problems. Altering the common law system of civil justice is a drastic step. To take such action as a "cure" for the current "crisis" would be a mistake if in fact the character of the civil justice system has little or no responsibility for the high cost and unavailability of liability insurance.

What, then, is the reason for the recent drastic increases in liability insurance premiums, the reductions in coverage, and the policy cancellations? As discussed in the previous section, statistics show that there has not been the sort of explosion in litigation or payments to victims in the recent past which some have reported. The GAO and others are confident that past premiums, when combined with investment income, were adequate by and large to cover past claims and allow for a comfortable profit.^{10/}

^{10/} 1984 was apparently one of the least profitable of recent years for the property/casualty industry. It should be noted, however, that results for later periods show an upturn in profitability (see Conclusion #1 above). In addition, due to losses reported for tax purposes in 1984, the industry garnered federal tax credits of \$1.9 billion. (Anderson Statement, at 6).

Thus, it seems clear that past experience has not provoked the current problems. Even the industry insists that current premium increases are not intended to compensate for past "losses". (Insurer Profitability, at 9).

Rather, the industry argues that it has merely set premiums at levels adequate to pay future claims, which it argues will burgeon due to the litigation "explosion." (Id.). The Justice Department Report agrees, noting that "[t]he insurance availability/affordability crisis is one symptom -- albeit the most dramatic and acute symptom -- of the dislocations and problems generated by a malfunctioning tort system." (Justice Department Report, at 3). But if, as is shown above, future claims are not likely to be burgeoning, then why are insurers seeking to increase premiums?

The answer lies in the industry itself.

There is considerable evidence, much of it from the insurance industry, that the industry itself bears much, if not all, of the responsibility for the current pricing and availability problems. The attractiveness of liability lines due to the opportunities they offer to invest premium income has been discussed above. It is undeniable that in the late 1970's and early 1980's, the property-casualty insurance industry engaged in "years of substantial underpricing." (Insurance Services Office, 1985, A Critical Year, at 5 (May, 1985) [hereinafter "Critical Year"]). During this period,

interest rates were increasing rapidly and peaking at their highest point this century (21.5% in late 1980 and early 1981). Thus, "In an attempt to generate cash flow for investment, insurers competed aggressively for premium dollars, knocking prices more and more out of line with loss costs." (Critical Year, at 4). Another insurance industry publication, quoted in the Justice Department Report, stated:

For the better part of seven years, the insurance industry has been engaged in a brutal price war. During the early 1980's, the price for commercial insurance was decreasing, sometimes sharply, as insurers vied for premium dollars to invest at the high interest rates then in effect... (Justice Department Report, at 22, quoting ISO, Financial Condition of the Insurance Industry -- An Update (1985)).

As noted in Business Week, "[t]he rate hikes ... result largely from the insurance industry's own mismanagement." (Glaberson and Farrell, Commentary, Business Week, at 24 (April 21, 1986)). The GAO noted that the industry's "... strategy has been to sacrifice underwriting gains for investment gains." (Finch Statement, at 3). To summarize succinctly, and in the words of the industry itself, "[p]ricing that failed to keep pace with loss costs and lagged the nation's overall economic growth has brought insurers into their current predicament." (A Critical Year, at 6).

Thus, while premiums were priced adequately to pay for losses during periods of high interest rates, those premiums may have been inadequate to pay for losses once interest rates

plummeted. This phenomenon is independent of rises or falls in loss levels; if premiums were set below loss levels (which at times they were), then even if loss levels remained the same, falling interest rates would reveal the inadequacy of these premiums.

Many commentators, even industry critics, therefore agree that premium increases in liability insurance are likely in order. However, when the spectre of a litigation "explosion" is removed, it becomes clear that the appropriate increase is no more than that needed to bring premiums in line with the moderate current and the equally moderate expected future losses. The GAO has estimated that an approximate 30% increase in general liability insurance premiums in 1984 would have been sufficient for insurers to break even, and a 20% increase in medical malpractice premiums would have produced the same result. (Finch Statement, at 10, and Attachments IV and V). Since 1984 was the industry's worst year, it is likely that even more moderate increases would have sufficed in 1985 and beyond. Yet in 1985 the industry recorded an increase in general liability premiums (supposedly based on past experience) of 81%, and simultaneously narrowed many coverages. The 1985 increase in medical malpractice premium was 47%. (Best's III, at 16).

CONCLUSION #3:

THE CYCLICAL NATURE OF THE INDUSTRY ITSELF, AND NOT ANY CHANGE IN TORT CLAIMS, IS LARGELY RESPONSIBLE FOR THE CURRENT "CRISIS"

The insurance industry, rather than any sudden change in liability suits or recoveries, clearly bears great responsibility for the recent premium hikes and cancellations. Efforts to prevent these undesirable events in the future are therefore likely to fail if they do not focus on the industry's cyclical pricing practices of the past. Given these facts, an exclusive and unquestioning focus on altering the civil justice system is inappropriate, and is likely to be a futile means of addressing the problems in the insurance market today.

QUESTION #4:

IS THE WAY TO AVOID DRASTIC PREMIUM INCREASES AND
SUDDEN CANCELLATIONS, THEREFORE, TO CHANGE LEGAL
RULES TO LIMIT THE NUMBERS AND SIZE OF LIABILITY
CLAIMS WHICH INSURERS WILL HAVE TO PAY?

As stated above, changes to the tort system may or may not be appropriate. However, to see such changes as a cure to current and future liability insurance "crises" presupposes the conclusion that increased claims play the primary role in increased premiums and cancellations. To the contrary, the evidence of a strong cyclical pattern in the industry, independent of claim size or frequency, renders it unlikely that changes in claim patterns alone can avoid another "crisis".

First, an examination of the insurance industry shows that its booms and busts over the years exhibit a cyclical pattern. As the GAO has described it:

[w]e ... believe that the industry is particularly subject to profit and loss cycles ... Unlike most other industries the property/casualty insurance industry is flexible with respect to capacity. When times are good, insurance companies can increase their capacity, take varied and greater risks, and generally lower their premium rates in order to achieve a greater market share. This results in a change from favorable premium profit margins to unfavorable margins, resulting in profit and loss cycles. Thus, the industry pricing strategy can result in financial cyclicity. (Anderson Statement, at 7).

This cycling is tied to interest rates and insurance industry sales tactics rather than to loss or claims patterns. Thus, altering these claims patterns may do absolutely nothing toward preventing the cycle from bottoming out again at some future point.

Second, during the last low point in the cycle in the mid-1970's, similar arguments were made by the insurance industry concerning the need for a narrowing in the civil justice system. However, in many of those localities where significant changes were made, the current cycle has still resulted in numerous availability and affordability problems. For example, Pennsylvania passed the Political Subdivision Tort Claims Act of 1978 in response to problems in cost and availability of liability insurance for municipalities. The Act, among other things, bars all tort claims against local government which do not fall within certain exceptions, caps recoveries within those exceptions, reduces compensation by any amount available from collateral sources, and requires that injury be permanent to be actionable. Yet municipalities in Pennsylvania are apparently suffering under the same drastic premium increases as elsewhere. (Titelman, The "Crisis" of Cost and Lack of Availability of Liability Insurance, 16 Barrister 4, at 41 (Winter 1985-86)).

In addition, in 1985, a study of medical malpractice insurance partially funded by the U.S. Health Care Financing Administration (HCFA) concluded that:

Almost all states enacted legislation in response to the rapid rise in malpractice insurance premiums which occurred during the mid-1970's ... The empirical results of the study presented here give no indication that individual state legislative actions, or actions taken collectively, had their intended effects on premiums.

(Sloan, State Responses to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment, 9 Journal of Health Politics, Policy and Law 629 (1985)). Thus, there is as yet no evidence that narrowing of the civil justice system does avoid skyrocketing premiums and cancellations when the industry reaches the bottom of its cycle; the available evidence, in contrast, seems to show just the opposite.

CONCLUSION #4:

CHANGES IN THE CIVIL JUSTICE SYSTEM ARE NOT LIKELY TO
SOLVE THE CURRENT OR FUTURE PROBLEMS IN AVAILABILITY
AND AFFORDABILITY OF LIABILITY INSURANCE

Insurers today are arguing and lobbying vociferously for changes in the civil justice system, yet the industry will make no commitments to restrain premium increases or cancellations if particular changes in the civil justice system are enacted. Serious questions are raised above concerning the very existence of a litigation "explosion" and the connection between any such "explosion" and current insurance problems. In addition, evidence indicates that cycling of insurance rates takes place independently of claims levels. Given this, enactment of statutory changes designed to narrow common law rights of recovery with no commitment by insurers that premiums will stabilize as a result is a greater risk than even the insurers themselves would consider prudent.

III. CONCLUSION

After careful review of the major assumptions and conclusions underlying the Justice Department Report, it is clear that they are substantially unsupported by the facts. The facts do not bear out the allegations of an "explosion" in litigation or in claim size, nor do they bear out the allegations of a financial disaster suffered by property/casualty insurers today. They finally do not support any correlation between the current crisis in availability and affordability of insurance and such a litigation "explosion." Instead, the available data indicate that the causes of, and therefore the solutions to, the current crisis lie with the insurance industry itself. Thus, to the extent that civil justice reform may be desirable, it would be for reasons entirely separate from the liability insurance "crisis". The rush to put such civil justice changes in place is therefore uncalled-for and potentially quite harmful, since these changes would remain in place, while providing little relief from any cyclical "crisis" period the insurance industry might pass through in the future. In particular, the implementation of such changes at the federal level would create inflexibility and would eliminate states' abilities to make their own judgments as to the real causes and proper solutions to the current unavailability and unaffordability of liability insurance.

*Tort Cost Trends:
An International Perspective*

Tort Cost Trends: An International Perspective updates a study first conducted in 1985 at the behest of the American Insurance Association. It was expanded for the 1989 Actuarial Centennial Celebration, marking the 100th anniversary of the actuarial profession in North America, and was presented at a panel on liability insurance.* The expanded analysis not only compares the growth of tort costs in the United States with increases in the cost of other U.S. social systems, but also looks at tort costs in 12 other countries around the world. (The data on which the analysis is based are presented in the Appendix, in the back of this publication.)

What the updated analysis shows, disturbingly, is that tort costs in the U.S. are escalating at a pace far faster than in any other modern, competitive economy studied. Equally disturbing, the revised analysis indicates that cost escalation in the U.S. has accelerated in the years since the first study was conducted.

During the 1980s, U.S. tort system costs almost tripled — rising to nearly \$120 billion from just over \$40 billion. Although the cost of other social welfare systems rose as well, the rate of growth has moderated, leveling off at about half that of the tort system. This represents a departure from the findings of the 1985 study, where the rise in tort costs appeared to be no worse than that of many other entitlement systems in our society.

Certainly, cost is not the only problem plaguing the tort system today. Inefficiency also remains a serious dilemma in a system that costs more than \$117 billion annually, yet returns only 50% of that sum to victims, 25% as compensation for economic loss.

**Both the original study and the expanded analysis were undertaken by Robert W. Sturgis, who is currently a Vice President and Director of Towers Perrin and Managing Principal of Tillinghast's risk management and casualty insurance division.*

Mr. Sturgis presented the results of the original study to the American Insurance Association in the fall of 1985. Subsequently, he testified on the findings before the U.S. Congress Joint Economic Committee. The results have also been widely quoted by both proponents and opponents of tort reform, suggesting that the study's straightforward analysis of tort system costs and trends has proved to be not only informative, but also objective and unbiased.

Total Cost *1987*

Insured
Self-Insured

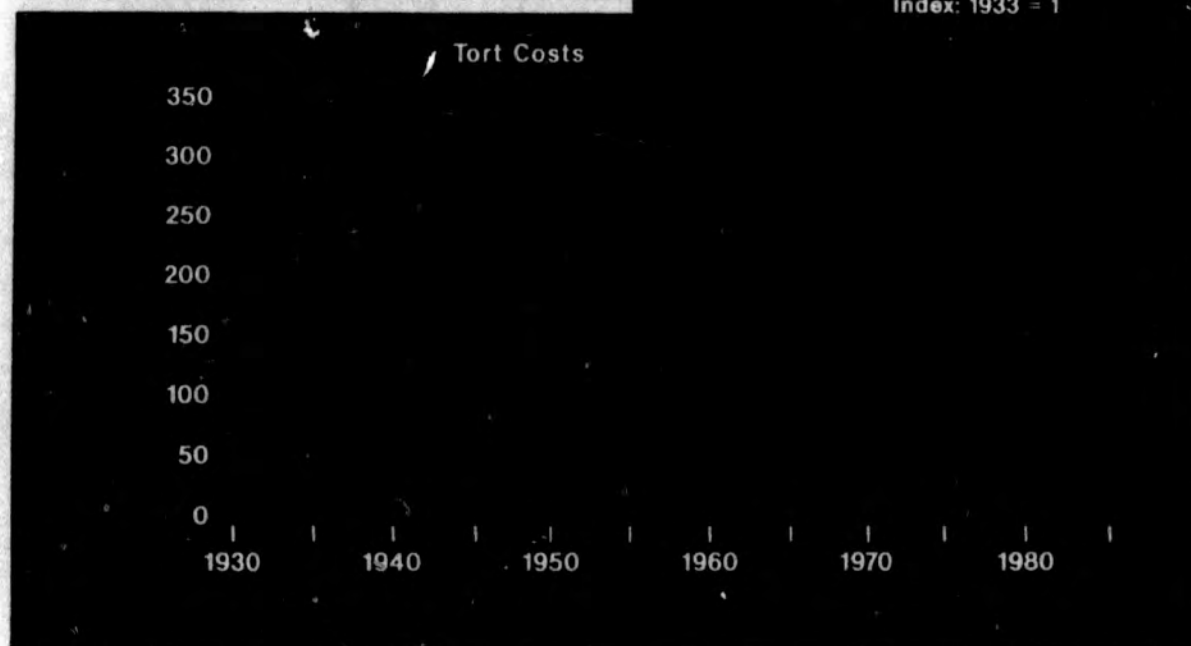
\$93B

\$24B

- In 1987, the estimated total cost of the U.S. tort system was \$117 billion. Note that this represents a gross cost, one that has not been adjusted to reflect any social or economic benefit derived from the system.
- Insured costs were \$93 billion, making up roughly 80% of the total cost.
- Self-insured costs — at \$24 billion — came to just over 20% of the total and 50% of the insured commercial lines portion.

57 Years Of Escalation

Index: 1933 = 1

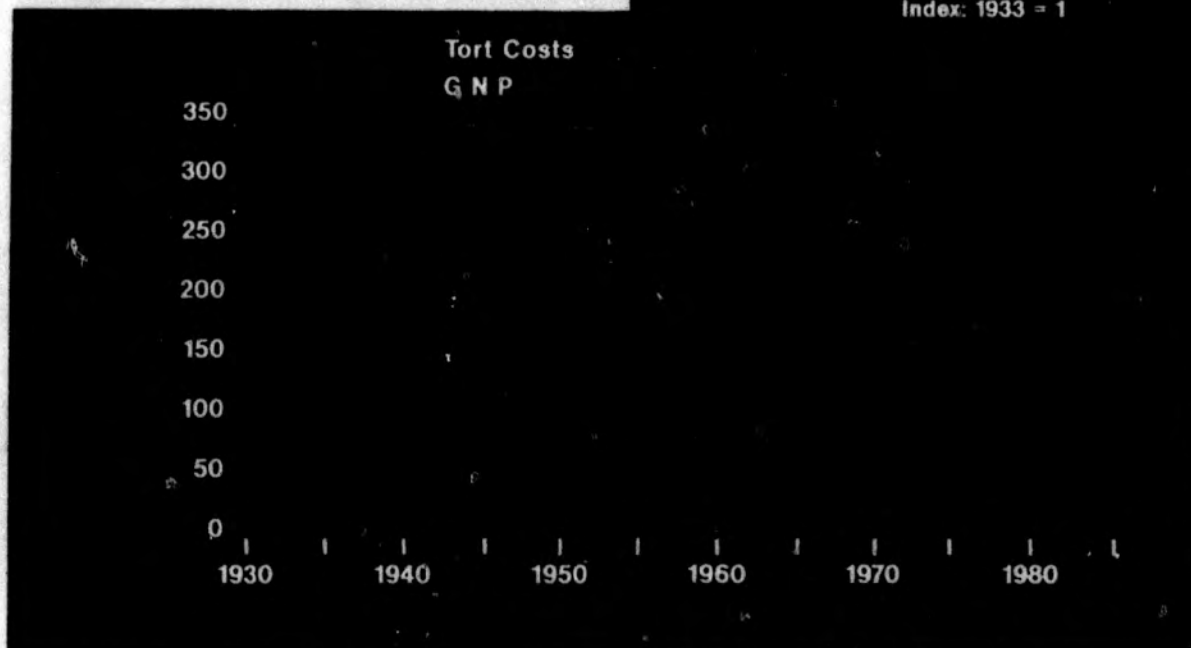


- Over the past 57 years, total tort costs increased approximately 300 times — from slightly less than \$500 million in 1930 to the \$117 billion total noted for 1987.
- Between 1930 and 1950, costs quadrupled, rising from the half-billion-dollar mark to close to \$2 billion in 1950.
- Since 1950, however, costs have quadrupled *every 12 years*.

GROWTH

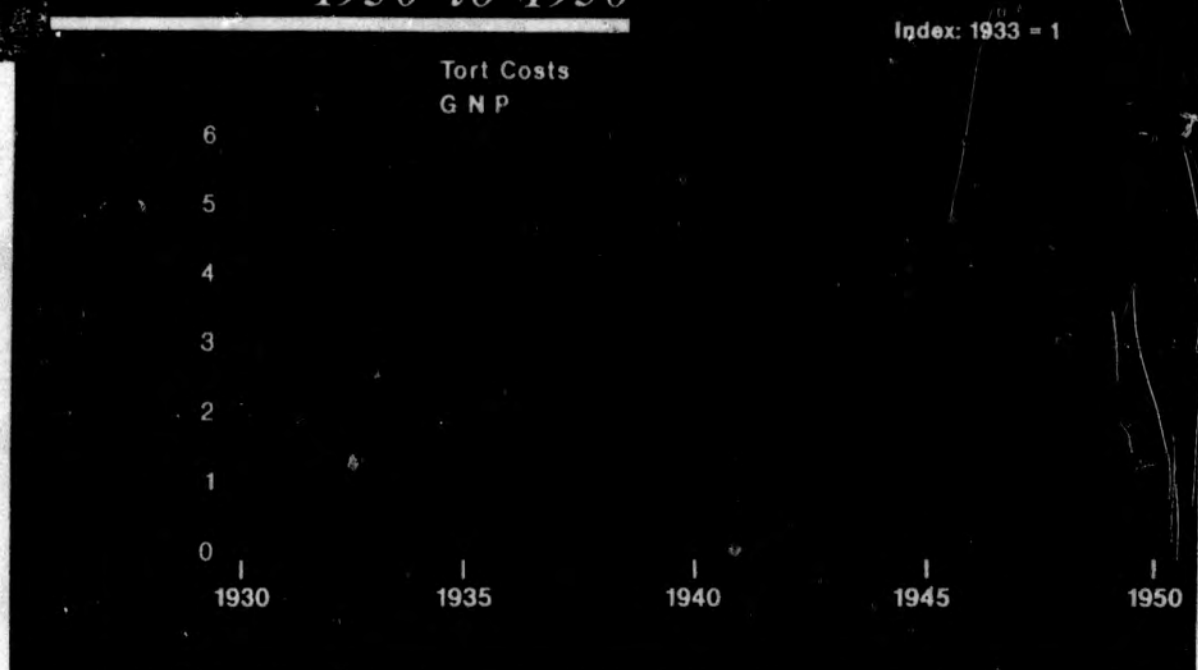
Torts vs. GNP

Index: 1933 = 1



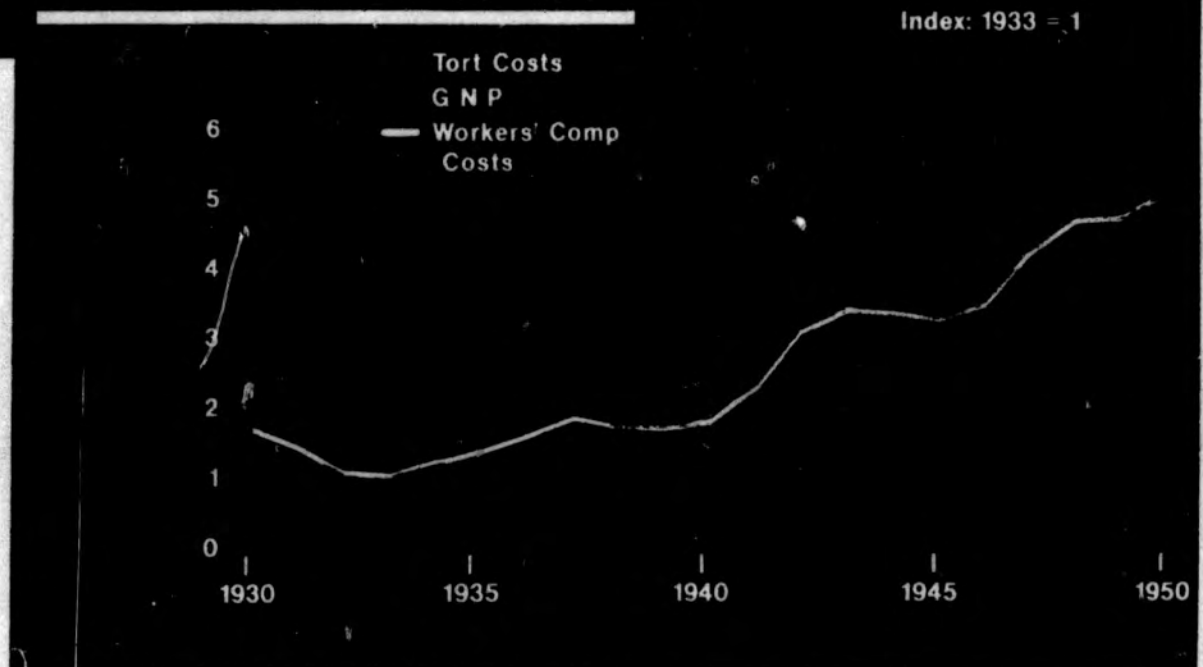
- Tort cost growth far outstripped GNP growth since 1930, increasing 300 times over this 57-year period, compared with a 50-fold increase for GNP.
- Until shortly after World War II, growth in both tort costs and the GNP ran fairly parallel. Only in the late 1940s and early 1950s did the two diverge, with tort costs consistently outpacing GNP growth.

and Historical Perspective 1930 to 1950



- Between 1930 and 1945, tort costs remained almost level; GNP, by comparison, began to grow steadily from 1940 on, surging with the war effort.
- After the war, tort costs accelerated, reaching the level of GNP by 1950 and outpacing it steadily thereafter.
- Overall, between 1933 and 1950, tort costs and the GNP had the same compound growth rate; both increased over those 17 years by a factor of five.

Historical Perspective 1930 to 1950



- Over those same 17 years, workers' compensation costs followed an almost identical course to the GNP. In fact, between 1933 and 1950, workers' compensation costs grew at the same compound rate as GNP and the tort system — rising by a factor of five.

Real Growth After 1950

Index: 1950 = 1

Tort Costs
G N P
Workers' Comp Costs
Population

20

15

10

5

0

1950

1960

1970

1980

■ A look at tort cost growth in relation to changes in other economic indicators shows that escalation is just as marked when costs are analyzed in "real" terms — i.e., adjusted for inflation and compared in constant dollars — as it was in previous analyses. Since 1950, for example:

- tort costs increased by a factor of 13.8
- workers' compensation costs rose by a factor of 9.7
- GNP grew by a factor of 3.3
- the U.S. population increased by a factor of only 1.6.

*During This
Same Period?*

Real Growth After 1950

Index: 1950 = 1



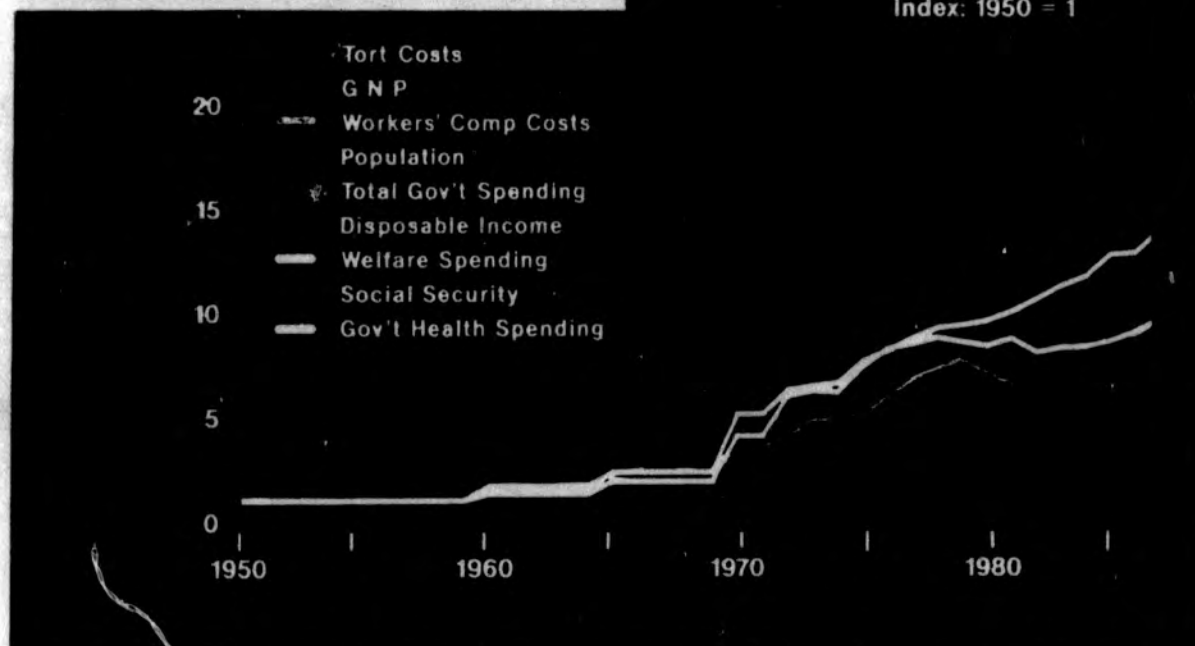
- A comparison of changes in other key economic indicators — disposable income, total government expenditures and public welfare system expenditures — shows that tort system growth continued to outpace virtually everything else in the past 37 years. During the period that tort costs rose almost 14 times in constant dollar terms, for example:

- disposable income rose by a factor of only 2.7
- total U.S. government expenditures jumped by a factor of 5.3
- public welfare expenditures increased by a factor of 9.7.

**Welfare
System Grown
As Fast as
Tort Costs?**

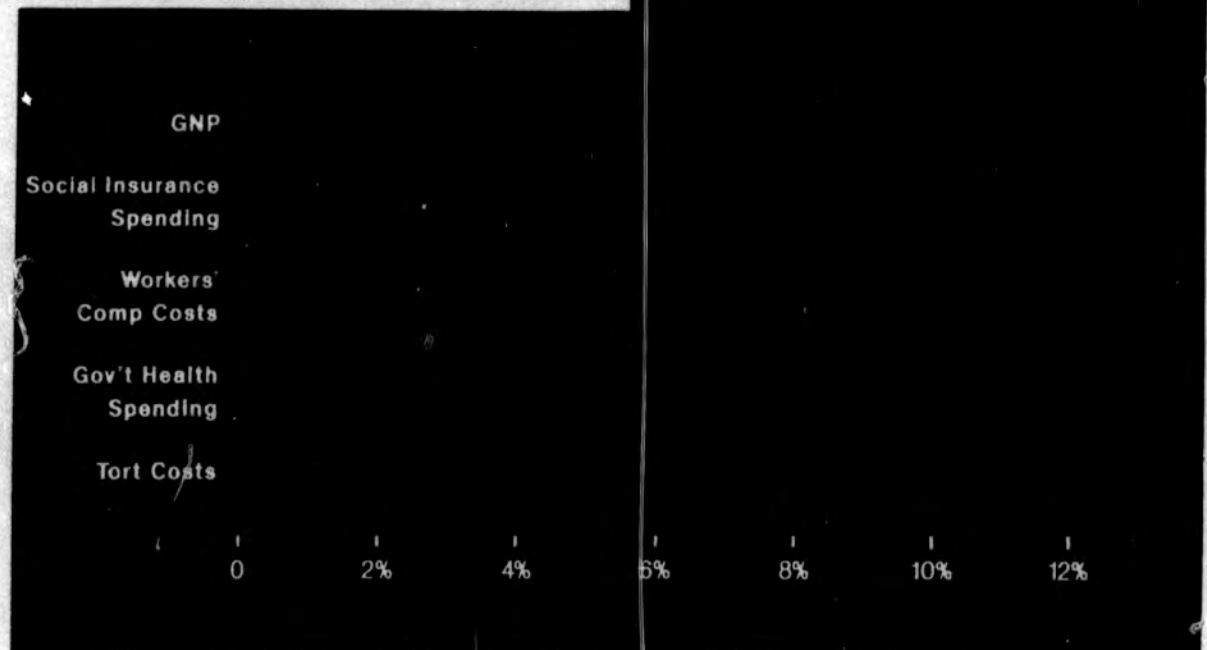
Real Growth After 1950

Index: 1950 = 1



- Two other social insurance systems have rivaled the tort system in cost escalation since 1950:
 - One is government health. Between 1950 and 1987, government health expenditures increased by a factor of 12.8, close to the 13.8 growth rate recorded for the tort system.
 - The other is Social Security. Over the same 37-year period, total social insurance expenditures increased by a factor of 17.3, making it the only system that has increased at a faster rate than the tort system.

Annual Growth Since 1980



■ As noted, cost escalation has moderated for all social systems but torts. Between 1980 and 1987, for example, tort costs rose at an *annual* rate of 16%, or 10.6% when adjusted for inflation. This compares with the following annual increases (also adjusted for inflation) of:

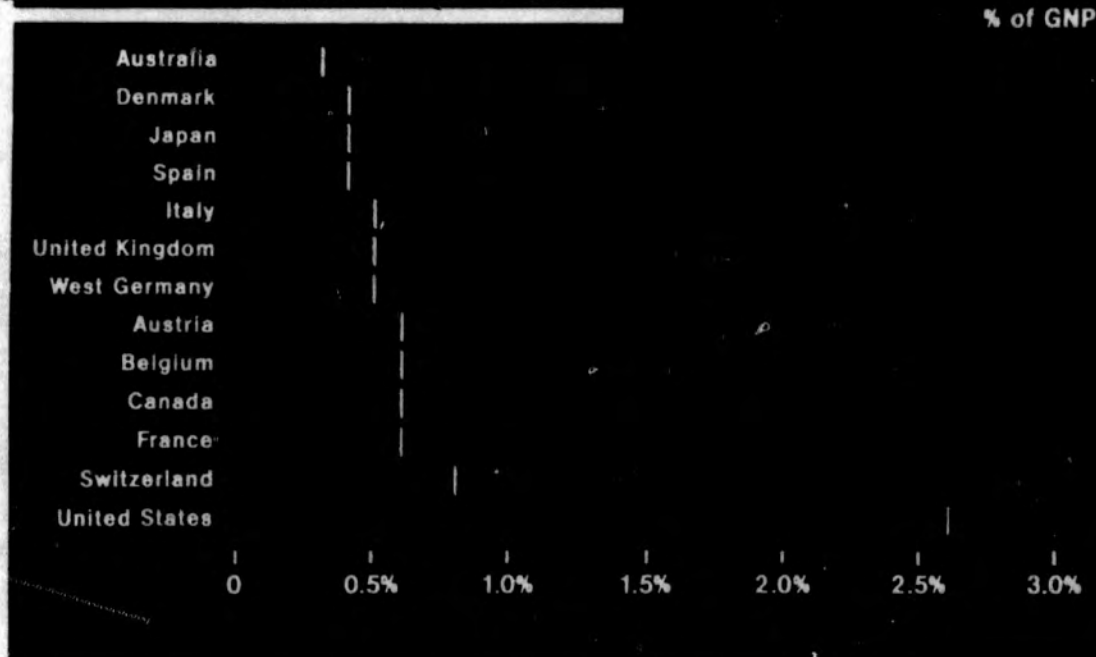
- 5% for government health expenditures
- 4.5% for workers' compensation costs
- 4.2% for Social Security expenditures
- 2.7% for GNP.

The Global View

- To put U.S. tort system costs into perspective, it is useful to compare them with tort cost growth in other competitive world economies. Note, however, that insurance statistics from other countries are not as consistent or reliable as those available from U.S. sources. In addition, self-insurance data are rare or nonexistent.
- These caveats notwithstanding, broad conclusions can be drawn about the relative differences in tort system costs inside versus outside the United States.

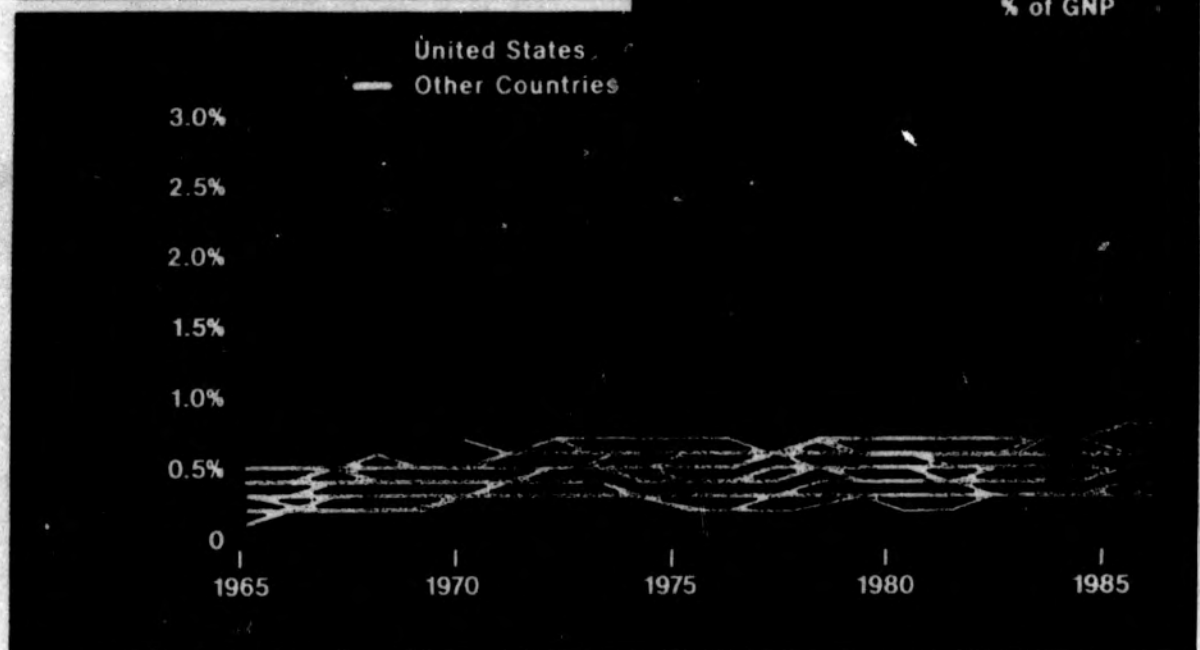
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Relative Costs



- The cost of the U.S. tort system is far greater than that of any other free world economy studied. Comparing costs relative to each country's gross domestic output, the U.S. tort system — at 2.5% of GNP — ranges between three and eight times the relative cost of tort systems in major European countries as well as in Australia and Japan.

International Cost Trends



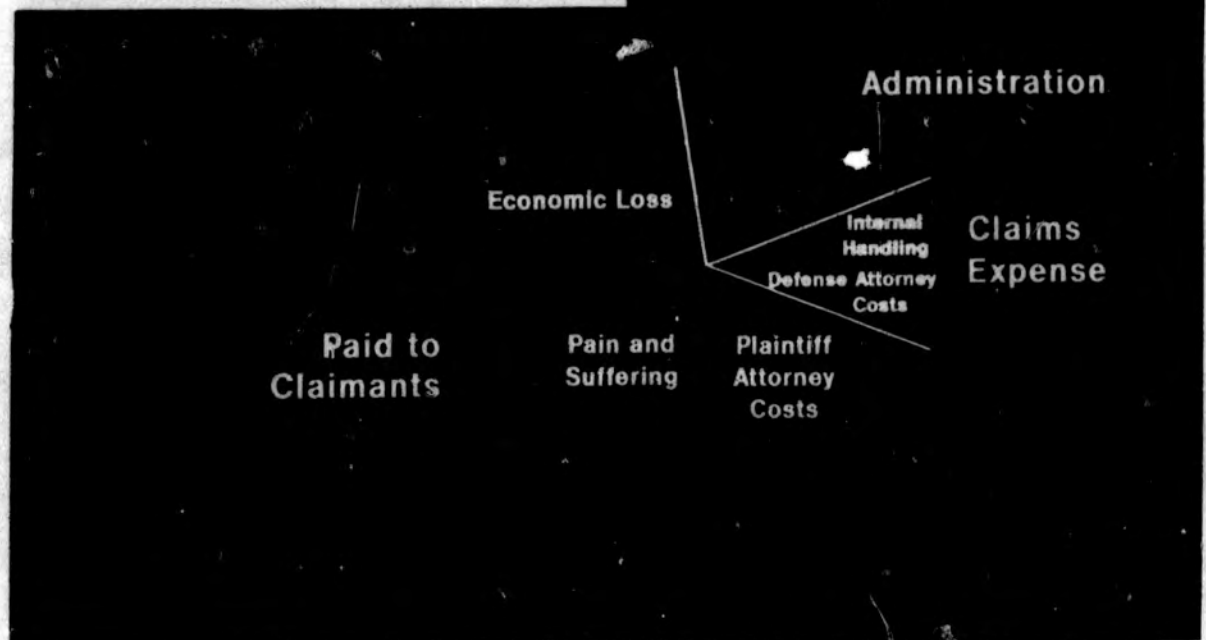
- In 1965, U.S. tort costs were just over 1% of GNP, about double the average noted for the other free world economies.
- Since that time, other countries' costs have remained remarkably stable. U.S. costs, however, have increased to 2.5% of GNP, about five times the average of the other countries studied.

The U.S. Tort System

Where Does the Money Go?

- In comparing tort systems, it is important to remember that the costs analyzed here are gross costs; i.e., they do *not* take into account the social and economic benefits derived from the system. Moreover, because America's social welfare system is considerably smaller than that of any other country studied, one can argue that the tort system is simply filling the gap created by inadequate government social programs — in essence, serving as a safety net for victims.
- The flaw in this argument, however, is that the tort system is not designed to be a welfare system and is terribly inefficient in this role.

Cost Breakdown



- Only about 50% of the total cost of the tort system is retained by claimants and
- Only about 25% of the total cost represents compensation for claimants' actual economic losses.
- Depending on one's view of the economic validity of pain and suffering awards, the tort system is either 25% or 50% efficient.

System 2
Not Effective
Serve Victims
Needs

Efficiency Comparisons

Portion Returned to Beneficiary

50%

70%

85%

99%

Torts

Workers'
Comp

Health
Insurance

Social
Security

- If the tort system is judged as a method of compensating accident victims for their losses, it is both inefficient and unfair. Inefficient, because only half — or less — of the cost goes toward any form of compensation for victims. Unfair, because many victims receive no compensation at all.

Tillinghast Office Locations

United States

Atlanta
One Atlanta Plaza
950 East Paces Ferry Road, Suite 1100
Atlanta, GA 30326-1119
(404) 261-5420

Boston
500 Boylston Street
Boston, MA 02116-3734
(617) 638-3700

Chicago
200 West Madison Street
Chicago, IL 60606-3414
(312) 609-9000

Dallas
12377 Merit Drive, Suite 1200
Dallas, TX 75251-2223
(214) 363-2451

Denver
One Tabor Center
1200 Seventeenth Street, Suite 1200
Denver, CO 80202-5812
(303) 592-1200

Detroit
38705 Seven Mile Road, Suite 450
Livonia, MI 48152-1005
(313) 462-5800

Hartford (Life/Health)
One Commercial Plaza
280 Trumbull Street, 22nd Floor
Hartford, CT 06103-3599
(203) 727-0018

**Hartford
(Risk Management/Casualty)**
The Powder Forest
One Mill Pond Lane
Simsbury, CT 06070-2486
(203) 651-3761

Irvine
2600 Michelson Drive, Suite 900
Irvine, CA 92715-1550
(714) 553-1277

Jacksonville
IBM Building
815 South Main Street
Jacksonville, FL 32207-8186
(904) 398-5661

Kansas City
6900 College Boulevard, Suite 700
Overland Park, KS 66211-1536
(913) 451-3000

Los Angeles
1925 Century Park East, Suite 1500
Los Angeles, CA 90067-2790
(213) 551-5600

Minneapolis
8300 Norman Center Drive, Suite 600
Minneapolis, MN 55437-1097
(612) 835-4700

New York
245 Park Avenue, 17th Floor
New York, NY 10167-0128
(212) 490-3460

Philadelphia
Centre Square West
1500 Market Street
Philadelphia, PA 19102-2183
(215) 569-6000

St. Louis
101 South Hanley
St. Louis, MO 63105-3411
(314) 862-7611

San Francisco
333 Bush Street, Suite 1600
San Francisco, CA 94104-2831
(415) 362-7834

**Seattle
(Risk Management/Casualty)**
1111 Third Avenue, Suite 2185
Seattle, WA 98101-3204
(206) 622-7300

Stamford
Financial Centre
695 East Main Street, Suite 600
Stamford, CT 06901-2138
(203) 326-5400

Washington (Life/Health)
2101 L Street, N.W., Suite 400
Washington, D.C. 20037-1577
(202) 293-0138

**Washington
(Risk Management/Casualty)**
4601 North Fairfax Drive, Suite 1100
Arlington, VA 22203
(703) 527-7500

Australia

Melbourne
356 Collins Street, 6th Floor
Melbourne, Victoria 3000, Australia
61-3-600-0944

Sydney
Level 14
MLC Centre, 19-29 Martin Place
Sydney, NSW 2000, Australia
61-2-229-5555

Bermuda

Hamilton
P.O. Box HM 1359
30 Victoria Street
Hamilton HMF, Bermuda
(809) 295-8863

Canada

Montreal
1800 McGill College Avenue,
22nd Floor
Montreal, Quebec,
Canada H3A 3J6
(514) 982-9411

Toronto
250 Bloor Street East, Suite 1100
Toronto, Ontario,
Canada M4W 3N3
(416) 960-2700

Vancouver
1100 Melville Street, Suite 1400
Vancouver, British Columbia,
Canada V6E 4A6
(604) 683-8485

France

Paris
28, avenue de Messine
75008 Paris, France
33-1-42-56-47-90

Sweden

Stockholm
Narvavagen 7, 2 tr
S-114 60 Stockholm, Sweden
46-8-663-5475

Switzerland

Geneva
ICC Building C
20, route de Pré-Bois
P.O. Box 633
1215 Geneva 15, Switzerland
41-22-798-5013

United Kingdom

London
Castlewood House
77-91 New Oxford Street
London WC1A 1PX, England
44-1-379-4000

Claim File Data Analysis: Overview



ISO DATA, Inc.

Claim File Data Analysis: Overview

ISO DATA, Inc., is an advisory organization and a wholly-owned, non-profit subsidiary of Insurance Services Office, Inc.

The opinions, analyses, and conclusions in this study are those of ISO DATA, Inc., and not those of any other organizations, including individual insurers that contributed claims handling expertise or actuarial advice.

ISO DATA, INC.

175 WATER STREET NEW YORK, N.Y. 10038 (212) 487-5000

December 1988

To: Readers of the Claim File Data Analysis

During the past several years, a national debate has focused on the perceived advantages and disadvantages of tort reform. As a matter of course, insurers make available to regulators and the public vast amounts of financial and statistical information. Nonetheless, insurers, regulators, public policymakers, and others have expressed a need to obtain relevant information from claim files to assist in evaluating the complex issues associated with changes to tort law.

In 1986, ISO announced its sponsorship of two high priority claim studies. The first study, the Claim Evaluation Project, was conducted by the independent policy and management consulting firm of Hamilton, Rabinovitz & Alschuler, Inc., under ISO's sponsorship. It was completed in May 1987.

The second study, the Claim File Data Analysis, is now completed. It analyzes detailed information gathered from over 13,000 actual commercial liability claim files, submitted by 24 participating insurer groups. The study was conducted by ISO DATA, Inc., a subsidiary of Insurance Services Office, Inc.

The report contains extensive information that will help interested parties better understand the issues surrounding the ongoing public policy debate.

Among the key findings of this second study are the following:

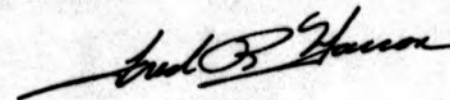
- On average, a claimant's liability insurance compensation represented several times his or her compensable economic loss.
- Insurer total claim costs are driven by a small minority of larger claims that involve more serious injury, are reported later, and characteristically require years to resolve after extended litigation.
- Current application of tort law doctrines (such as joint and several liability and the collateral source rule) contribute significantly to higher insurer claim costs.
- Plaintiffs and courts frequently treat governmental entities as "deep pockets." Governments are more likely than other insureds to make settlement payments exceeding their percentage of fault.

The types of risks any one insurer covers may vary from the average. Therefore, the aggregated results of the sample claims may not reflect any individual insurer's claim portfolio in whole or in part. Thus, although the study is based upon the best and most comprehensive information that could be collected and evaluated, the study was not designed for, nor does it result in, a pricing of tort reform.

Nevertheless, the two ISO claim studies clearly suggest that meaningful tort reform may reduce the number and dollar value of insurance losses. The size of this reduction will vary depending on the package of reforms enacted in a state and an individual insurer's book of business.

However, tort reform is only one of many events and forces that affect insurance prices. Such factors as court decisions and the responses to those decisions by claimants, lawyers, juries, and the judiciary, as well as inflation in health care costs and wage levels, interact continually to influence insurers' loss costs. Despite the enactment of tort reform by many jurisdictions in 1986 and 1987, underlying insurer claims costs have continued to rise.

The property and casualty insurance industry is highly dynamic and intensely competitive in pricing, in product, and in marketing strategies. An operational reality of the business is that anything likely to increase profitability for insurers is very soon converted by competitive pressures into reduced premium levels designed to increase or retain market share. The actual impact of tort reforms will be reflected in insurers' loss experience over time. Until then, informed judgment, supplemented by the information in this and other studies, will assist insurers in continuing to make the difficult pricing judgments necessary to estimate cost savings attributable to tort reform.



Fred R. Marcon
Chairman

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I. Background

A. Introduction

The recent problems in the liability insurance marketplace produced hardship and dislocation for some businesses, local governments, and professionals. These entities need affordable liability insurance to protect their operations. Not surprisingly, a highly charged public debate arose over the root causes of the problems, with some observers focusing on the effects of rising costs and unpredictability within the tort system—and others arguing that primary responsibility for the problems lay with the behavior of the property and casualty insurance industry itself.

A major by-product of that debate has been a surge in efforts to obtain more data about insurer claim costs. In 1986 alone, 17 states enacted a wide range of data reporting bills, with a diversity of requirements that has virtually precluded a uniform response.

Expanded interest in insurer claim cost information appears to reflect a multiplicity of forces. In some cases, the data requests indicate a desire to improve understanding of the sources of claims and the dynamics of the claim negotiation process. Other requests reflect an understandable impulse to evaluate the cost effects of traditional tort law doctrines and recently enacted and potential new tort reforms. Sometimes, the specific objectives behind the data requests are less clear. In general, the new data reporting laws seem to be based on the assumption that more information will, in some undefined way, inevitably lead to better-informed public policy.

Supporters of these laws appear to presume that the social value of more information exceeds the cost of producing that information—or that those costs are irrelevant.

Before enactment of the recent legislation, property and casualty insurers were already subject to extensive data reporting requirements. (See ISO Insurance Issues Series, *Insurance Data: A Close Look*.) The recent legislation has imposed a massive new burden on insurer data reporting and claim functions. Nonetheless, from time to time, insurers have supplemented traditional financial and statistical data with information from other sources. Where specific claim information appeared useful in enhancing public debate, insurers have undertaken claim studies, such as in the areas of medical malpractice and product liability.

To address in an effective manner the perceived needs for more data, Insurance Services Office, Inc. (ISO), sponsored two claim data studies.

The first study, the *Claim Evaluation Project*, was conducted by the independent public policy and management consulting firm of Hamilton, Rabinowitz & Alschuler, Inc., under ISO's sponsorship. It was completed in May 1987. The study involved the evaluation by experienced claims personnel of six typical, but hypothetical, claim situations. The *Claim Evaluation Project* provided an early look at the direction and relative size of the effects of various tort reforms on bodily injury indemnity costs. The study identified the likely effects of major tort reforms in the claim situations tested. In the opinion of the experts who participated in the *Claim Evaluation Project*, the qualifications and exceptions incorporated into many of the tort reform statutes largely eliminated the effects of those tort reforms in reducing claim costs. The study also concluded that enactment of a three-point program¹ of rela-

tively straightforward tort reforms would produce significant cost reductions in virtually all of the claim situations tested.

This Overview presents key findings from the second study, the *Claim File Data Analysis* (hereafter, "the study").

B. Study Objectives and Limitations

The *Claim File Data Analysis* is a longer-term analysis by ISO DATA, Inc., of 13,316 actual commercial liability claim files submitted by 24 insurer groups. In the aggregate, the participating insurers write a significant portion of the general liability coverage written in the United States. A Technical Analysis of the study is also available from ISO DATA, Inc., for those seeking a more complete understanding of the issues highlighted in this Overview. The Technical Analysis presents an in-depth review of the findings and includes presentations of 14 major groups of reports.

Because the requests for more insurer claim data have been motivated by a variety of concerns, this study sought to meet a wide range of objectives. The study represents the broadest survey of commercial liability claim files ever undertaken, and thus the most detailed picture ever produced of the commercial liability compensation process. The study includes the first claim file analysis of claims against governmental and municipal insureds. It also contains a broad-based analysis of the effects on insurer claim costs of several important tort law doctrines, including joint and several liability, the collateral source rule, and punitive damages.

The *Claim File Data Analysis* addresses a series of important issues—compensation levels relative to claimant losses, the size distribution of claims, the effects of litigation

¹The three-point program consisted of the abolition of the rule of joint and several liability, relaxation of the collateral source rule (including set off of collateral benefits), and establishment of a ceiling of \$250,000 on awards of non-economic damages.

tion on the length of time a claim is open, and others. These topics are critical for understanding the workings of the insurance mechanism and evaluating tort law policy. The commercial liability claims universe is not monolithic—large and small claims, for example, exhibit sharply different characteristics—and the study delineates such distinctions.

The objective of this study is not to present the case for or against any particular policy initiative. Rather, the goal is to assist interested parties in making difficult judgments about tort law policy issues. ISO DATA, Inc., hopes the study will encourage a more informed public policy debate and avoid the need for further, less useful, but expensive state and federal government demands for data.

Any claim file study must be reviewed in light of the limitations of such studies. A complete discussion of the availability, uses, and limitations of claim file information can be found in *The Report of the Statistical Information Advisory Committee to the NAIC Legal Liability Insurance (D) Task Force*, dated December 1986. These limitations include the following:

- Information needed to study public policy issues may not be available in the claim file, or may be available only when a claim actually goes to verdict.
- Claim studies contain information only from primary insurers in the admitted market.¹

- Claim file information does not measure trends or changing conditions or the effects of future change. A claim study is a "snapshot" at one point in time.

These limitations, inherent to all claim studies, put certain constraints on the uses of the *Claim File Data Analysis*.

First, the study is about claim costs, not prices. The study provides no information on premium collected or on exposures insured. Both elements are necessary to measure the appropriateness of premiums. More important, during periods when tort laws are in great flux, a claim file study can never yield precise quantitative judgments about current prices.

Current insurance prices reflect judgments about future claim costs—specifically, the costs of paying the claims expected in the years ahead under a policy written today. But commercial liability losses "mature" slowly. That is, the higher-valued claims producing the preponderance of insurer claim costs tend to be litigated and settled years after they are first reported. Therefore, claims that have actually closed are predominantly those reported years in the past. To the extent that the tort system is in ferment, this study could not capture information on the recent changes that will determine future claim costs.

Second, even at a single point in time, a study like the *Claim File Data Analysis* cannot produce a precise, definitive finding on the effects of particular tort law reforms. Insurer claim costs are, by definition, the best measure of the effects of tort law trends on insurer costs. And over time, the aggregate effects of tort law changes—increased valuations of injury or expansion of liability that raise costs or meaningful tort reforms that reduce costs—are reflected in insurer claim cost data regularly submitted to regulators.

In settling claims, however, insurers do not typically calculate how claim payments would have differed if some tort law element had been different. Insurers, claimants, and attorneys negotiate settlements on the basis of existing law within a jurisdiction; they do not make a record of what the settlement would have been had the law been different, nor do they specify how particular doctrines of existing law contributed to their final settlement figure. The best a claim file study can do in measuring the impact of specific tort law changes is to ask claims professionals to offer a subjective estimate of how the outcome of a multifaceted negotiation might change if one or more elements of the law were different.

C. Scope of the Study

The usual insurance claims survey is a study of closed claims, in which all outstanding contractual obligations of the insurance company have been satisfied. Analysts value closed claim studies because all payment information is fully developed, and closed claims present a composite picture of claims that have been resolved. But cases settle slowly—it may take a decade or more to resolve a disputed commercial claim—and the data collected in many case files may be stale by the time the claims for a given period of time have all closed. This problem is compounded by the effects of a dynamic environment, in which law, social attitudes, scientific knowledge, and, as a result, claim frequency and severity change rapidly. To minimize this problem, the *Claim File Data Analysis* looked at three separate samples of claims, as described below.

¹The *Claim File Data Analysis* did collect information from the surplus lines subsidiaries of the participating insurer groups, but they are a minority of the non-admitted market.

Professional claims personnel from a sample of insurers representing at least 50% of the premium volume in each of the 27 states filled out a detailed questionnaire for each eligible claim. A complete description of the specifications and scope of the study can be found in the Technical Analysis of the *Claim File Data Analysis*. See Section IV of this Overview for lists of the participating insurers, states surveyed, and lines of business included.

Study Part 1—Policy Year 1983 Claims of \$25,000 or More

To allay the concern about old claims in a dynamic environment, Study Part 1 surveyed claims—both open and closed—that arose out of policies written during 1983. This is a relatively recent policy year, considering that a long settlement process is common for large commercial liability claims. The study collected information on all eligible commercial liability claims (other than medical malpractice) with a bodily injury indemnity of \$25,000 or more. The evaluation date for these claims was December 31, 1986. Claims closed before July 1, 1985, were excluded, because the claim files were too old or too difficult to locate. Claims reported after January 1, 1986, that were still open were also excluded, because they were too immature to produce meaningful information. Thus, this sample does not represent all claims from policies written during 1983.

These requirements permitted the collection of information on recent large claims, yet assured that the claims were mature enough to permit meaningful analysis.

Study Part 2—August 1987 Closed Claim Sample

Small claims in general close quickly, and the information required for this study might not be routinely maintained in

claim files. Therefore, a retrospective study of small claim files may not provide as much meaningful information as a study conducted as the claims close—while the information is still fresh in the minds of the claims handlers.

Thus, Study Part 2 examined all commercial liability bodily injury claims (other than medical malpractice) that closed during the first week of August 1987, regardless of size, date of accident, or when the underlying policy was written. The survey forms were completed as the claims closed or soon thereafter.

Study Part 3—Policy Year 1983 Governmental Claims under \$25,000

A key policy concern has been the availability of liability insurance to governmental entities at an affordable cost. Therefore, Study Part 3 collected information on identifiable bodily injury claims under \$25,000 against governmental entities that arose from policies written during 1983. (Governmental claims of \$25,000 or more were reported in Study Part 1, with the non-governmental claims.) Both open and closed claims were surveyed with the same exceptions as noted above for Study Part 1.

D. NAIC Review

Once the initial study design was prepared, ISO DATA, Inc., invited the National Association of Insurance Commissioners (NAIC) to review the technical specifications and methodology of the *Claim File Data Analysis*. On January 5, 1987, the NAIC sponsored a meeting in Washington, D.C., at which 13 organizations reviewed the study specifications. As a consequence of that review, ISO DATA, Inc., made various modifications in the survey form. The NAIC confirmed that the study specifications met its concerns and those of the organizations that participated in its review. In addition, to assure that the study would gain broad acceptance, the Illinois Department of Insurance engaged the independent public accounting firm of Ernst & Whinney to review the study.

The objective and scope of Ernst & Whinney's review, as defined by the Illinois Department of Insurance and the NAIC, was to determine whether the data collection process had been performed in a manner sufficient to provide a reasonable degree of assurance that the compiled data was free of material errors or irregularities. To accomplish this objective, Ernst & Whinney:

- reviewed a random sample of survey forms and compared the data to the participating insurer's claim files
- performed a general computer controls review as related to the inputting, editing, processing, and output of the study data
- recomputed the study's output processing for a sample of output reports

Based on the procedures performed, Ernst & Whinney reported to the Illinois Department of Insurance and the NAIC that nothing came to their attention that caused them to believe that the compiled data was not collected in a reasonable manner within the *Claim File Data Analysis* specifications.

II. Major Findings

A. Adequacy of Compensation

For the vast majority of claimants in the study, liability insurance compensation covered at least their fault-adjusted economic loss (such as medical costs, past and future wage losses, and rehabilitation costs). On average, claimants received several times their compensable economic losses.

These findings suggest that many claimants received substantial compensation for non-economic damages, including such intangible injuries as pain and suffering, mental distress, and loss of consortium.

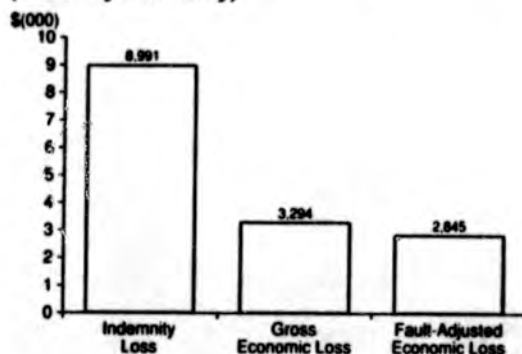
Since non-economic damages are intangible, a quantitative analysis cannot say whether compensation for non-economic damages is adequate or inadequate. Therefore, the *Claim File Data Analysis* focuses on whether claimants received compensation greater or less than their economic losses. Specific findings include the following:

- Over 90 percent of claimants were compensated for at least their fault-adjusted economic loss. (Fault-adjusted economic loss is the claimant's economic loss reduced by the estimated percentage of fault attributable to the claimant.) On average, in Study Part 2 (closed claim sample), claimants received more than 3 times their fault-adjusted economic loss. Even when not fault-adjusted, claimants received an average of 2½ times their economic loss.
- Claimants with small claims received, on average, several times their fault-adjusted economic loss. The tendency toward compensation exceeding economic loss declined as the level of economic loss increased.

Figure 1

Average Compensation Compared to Economic Loss

Study Part 2 - Closed Claim Sample
(With Payment Only)



- The great majority of claimants had relatively small medical, wage, and "other" economic losses. Medical expenses predominated at the lower levels of economic loss, and lost wages predominated at the higher levels.

The real compensation received by many plaintiffs may be overstated because plaintiffs' legal fees were not reflected. Although many small claims did not involve an attorney, almost all large claims did.

On the other hand, the findings understate the total recovery received by many claimants. Claimants often received payments from collateral sources (such as health insurance, Workers' Compensation, and no-fault insurance) as well as reimbursements from other liability policies (such as excess and umbrella policies) and direct payments from the liable parties (because of self-retentions, settlements exceeding policy limits, and payments from non-insureds). However:

- Considering known collateral source payments (with no lien attached) as well as liability compensation, claimants, on average, received a total recovery several times their level of fault-adjusted economic loss. In Study Part 1 (claims of \$25,000 or more) claimants received a total average recovery of 2½ to 3 times their fault-adjusted economic loss. In Study Part 2 (closed claim sample), reflecting all claim sizes, the average multiplier was about 4 times the fault-adjusted economic loss.

An example will clarify these findings. Assume that a claimant suffered a \$10,000 economic loss (\$5,000 in medical costs and \$5,000 in lost wages) and that the claimant was 25 percent responsible for his or her own injury. The claimant's fault-adjusted loss was 75 percent of \$10,000, or \$7,500. Assume that the claimant received \$20,000 in liability compensation and \$10,000 from collateral sources, for a total recovery of \$30,000. The multiplier of total recovery (excluding legal fees) to fault-adjusted economic loss was \$30,000 divided by \$7,500, or 4 to 1.

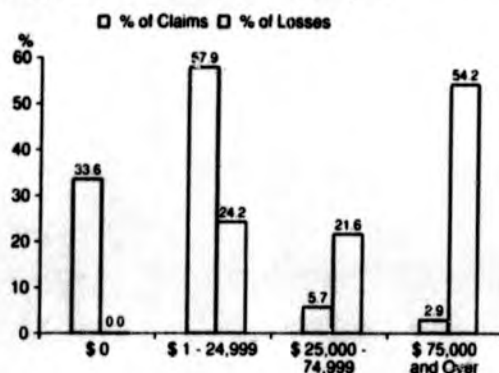
B. Claim Size Distribution

The claims in the study can be divided into two groups—large claims and small claims. The study found that these groups exhibited very different characteristics.

The vast majority of claims were relatively small. In Study Part 2 (which had a size-of-loss distribution similar to the overall commercial liability bodily injury claims universe), more than 90 percent of the claims were settled for less than \$25,000.

Figure 2

**Size of Loss Distribution by Percentage
Of Claims and Percentage of Losses**
Study Part 2 - Closed Claim Sample



A relatively small number of large claims accounted for the vast preponderance of total liability insurance compensation dollars. In Study Part 2, claims of \$25,000 or more accounted for only 9 percent of the claims but 76 percent of all compensation paid. Fewer than 3 percent of the largest claims were responsible for 54 percent of the total compensation paid. In Study Part 1 (claims of \$25,000 or more), the same pattern held. Claims of \$150,000 or more accounted for only 16 percent of all Study Part 1 claims but represented 51 percent of total Study Part 1 compensation.

Table 1 displays the size distributions of claims and average loss levels.

Table 1

Average Losses by Study Part

	Number of Claims	Average Loss per Claim*	Average Loss per Incident*
Study Part 1—Policy Year 1983—			
Claims of \$25,000 or More	6,707	\$91,026	\$128,114
Study Part 2—Closed Claim Sample			
No Payment	1,965	0	0
Payment under \$25,000	3,390	4,495	4,646
Payment of \$25,000 or More	499	95,394	109,817
Study Part 3—Policy Year 1983—			
Governmental Claims under \$25,000	755	6,903	13,748

* Throughout this study, a claim refers to a demand for compensation from a particular insured. Thus, if two parties who were injured in a single event each seek compensation from each of three insureds, there are six claims. An incident refers to the number of injured parties seeking compensation, regardless of the number of insureds. Thus in the prior case there are two incidents.

The fact that a small number of large claims drive total insurer claim costs has several implications:

- The frequency of litigation involving small claims is less critical in determining total insurer claim costs than the frequency of litigation and award levels in the larger cases.
- Tort reforms that target the high-cost cases can play a critical role in determining total insurer claim costs.
- To the extent that liability doctrines continue to change while the larger claims remain subject to years of litigation before settlement, insurers will confront a systemic problem of unpredictability in gauging future claim costs.

Just as the claims in this study do not fully reflect total compensation received by claimants, neither do they provide a full picture of insurer costs. The study was limited to bodily injury claims and excluded claims for property damage. While the study did examine allocated loss adjustment expenses (insurer legal expenses and other expenses that can be allocated to a specific claim), these costs are not included in Table 1. Also the study did not include some types of claims referred to in the Institute of Civil Justice report, *Trends in Tort Litigation: The Story Behind the Statistics*, such as some high-stakes personal injury suits (for example, medical malpractice) and mass tort class action suits. Had such high-cost claims been included, the phenomenon of large claims playing a prominent role in driving total insurer costs would have been even more evident.

C. Settlement Patterns and the Role of Litigation

An analysis of claim settlement patterns and the frequency of litigation extends and reinforces the striking picture of two very different worlds within the commercial liability claims universe.

Most claims involved relatively modest sums of money, minor injuries, and a single insured. By and large, smaller claims were reported shortly after the accident, did not produce litigation, and were settled quickly.

By contrast, a small minority of larger claims accounted for the overwhelming preponderance of total liability insurance compensation dollars. These claims generally involved more serious injuries and often had multiple defendants. They tended to be reported more slowly, usually led to litigation, and were resolved slowly. Indeed, even among litigated claims, those involving the largest sums of money were resolved the slowest.

The study's findings on settlement patterns and litigation include the following:

- Within a year of the accident, more than 90 percent of all claims were reported, but claims reported later involved higher levels of compensation.
- In Study Part 2 (closed claim sample), 56 percent of the claims were closed within a year of the first report, but those claims accounted for only 14 percent of the total liability compensation insurers ultimately paid. Three years after the first report, only 12 percent of all claims remained open, but they represented 40 percent of the liability compensation that insurers ultimately paid. Looked at another way, average compensation for claims closed within 6 months of the first report was about \$2,000. By contrast, average compensation for claims closed 3 to 4 years after the first report was \$58,000.

Figure 3

Average Compensation by Time from Accident to First Report Study Part 2 - Closed Claim Sample (With Payment Only)

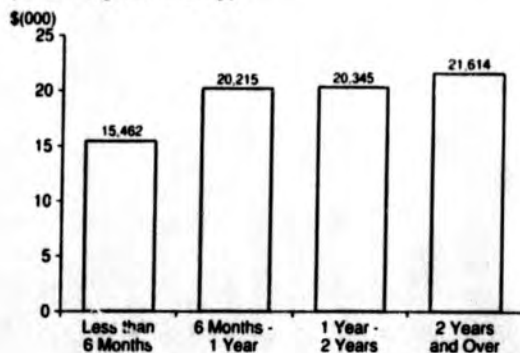
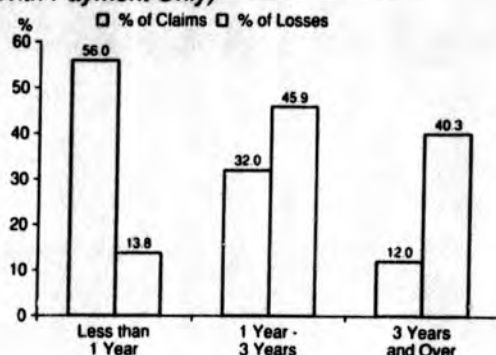


Figure 4

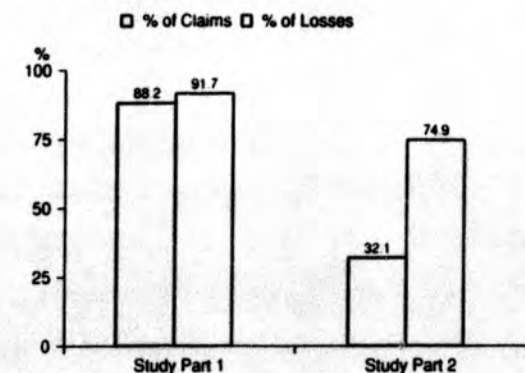
Percentage of Claims and Losses by Time From First Report to Case Closed Study Part 2 - Closed Claim Sample (With Payment Only)



- Within Study Part 1 (claims of \$25,000 or more), 88 percent of all claimants filed lawsuits. But in Study Part 2 (closed claim sample), where 90 percent of the claims were under \$25,000, only 32 percent filed lawsuits. Those claims accounted for 75 percent of the total liability compensation ultimately paid. Similarly, while 98 percent of all Study Part 1 claimants were represented by an attorney, only 64 percent of Study Part 2 claimants had an attorney.
- In commercial automobile accident cases, claims involving a lawsuit remained open twice as long after the accident date as claims without a lawsuit. In "all other liability" cases, claims with a lawsuit remained open almost three times as long. Moreover, longer periods of litigation corresponded to higher claim costs ultimately being paid. The average compensation rose from \$12,000 for claims closed within 6 months after the suit was filed to \$77,000 for claims closed from 48 to 60 months after the suit was filed. Claims involving multiple defendants and greater severity of injury understandably took longer to settle than simpler cases. The consequences for insurers were higher legal costs and delay in determining claim costs.
- Fewer than 2 percent of the claims went all the way to verdict.

Figure 5

Percentage of Claims and Losses With Lawsuit Filed



Study Part 1 - Claims of \$25,000 or More
Study Part 2 - Closed Claim Sample (with Payment Only)

Figure 6

Average Time from Accident Date to Case Closed

Study Part 2 - Closed Claim Sample (With Payment Only)

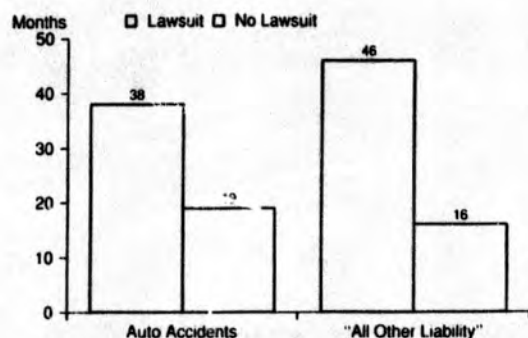


Figure 7

Average Compensation by Time from Suit Filed to Case Closed
Study Part 2 - Closed Claim Sample (With Payment Only)



These findings have significant implications for insurers and for the tort law policy debate. Some observers have discounted the effects of recent tort law trends on the insurance mechanism by making two assertions. First, some have said that, while tort awards for serious injuries may be rapidly rising, median tort awards for typical, small tort actions have remained relatively constant. Second, some have noted that, as a practical matter, most claims are settled through negotiations rather than through litigation.

In fact, the study suggests that tort trends producing increased dollar valuations of serious injury cases will have a very real effect on the insurance mechanism. The litigated claims constitute the majority of insurer claim costs and thus drive the insurer claim cost base. The vast preponderance of those litigated claims are indeed settled before verdict, but the parties reach their settlements in the context of lawsuits. The litigants' expectations of how those claims would be resolved if the suits went to verdict have a strong influence on the amounts of the settlements. In short, the study indicates that insurer claim costs will be largely determined by tort law trends affecting the crucial minority of cases involving serious injuries and large awards or settlements.

Because the claims driving insurer claim costs typically take many years to close, an analysis of recent policy years cannot quantify external factors that may change total claim costs. The lengthy claim settlement process described by this study constitutes a severe obstacle to efforts to quantify the costs of tort reforms in advance or to predict future claim cost levels with precision.

D. Implications of Tort Doctrines

The study provides evidence that current applications of some tort law doctrines contribute to higher claim costs. This section examines three tort law issues and related findings of the *Claim File Data Analysis*.

1. Joint and Several Liability

Under the traditional rule of joint and several liability, a plaintiff injured by more than one defendant may seek and receive full payment of any court award from any liable defendant, regardless of the share of the fault assigned by the court to that defendant. Critics assert that it is unfair to force a defendant who played a minor role in causing an injury to pay all or most of a large judgment. As an alternative, these observers have suggested—and several states have adopted—a rule of several liability only. Under such a rule, each defendant is liable only for the percentage of the total award corresponding to that defendant's percentage of fault.

The study does not assess the merits of any side in the policy debate over joint and several liability. Rather, the study provides a firmer factual basis for that debate. Specifically, the study addresses the issue of how often defendants pay a percentage of the total settlement larger than their indicated percentage of fault. The study also identifies some of the key characteristics of multi-defendant claims, including their cost implications.

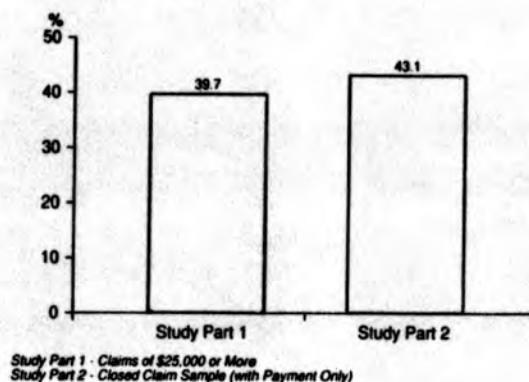
In addition, the study addresses the extent to which claimants are responsible for their own injuries, an issue arising in the context of both single- and multi-defendant claims.

The study's findings on joint and several liability and claimant fault include the following:

- Insureds in multi-defendant situations frequently paid a larger percentage of the settlement than their percentage of fault. The insured's estimated percentage of the settlement was larger than the insured's estimated percentage of fault in about 40 percent of the multi-defendant cases.

Figure 8

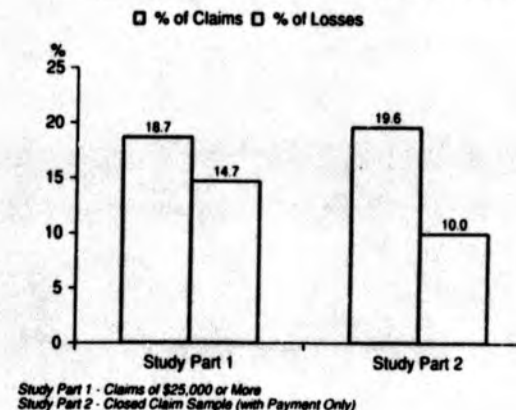
Percentage of Multi-defendant Cases in Which Insured's Percentage of Settlement Exceeded Percentage of Fault



- In both Study Part 1 (claims of \$25,000 or more) and Study Part 2 (closed claim sample), the claimant was estimated to be 50 percent or more responsible for his or her own injury in almost 20 percent of the claims. In Study Part 1, 15 percent of the total liability insurance costs went to claimants who were estimated to be 50 percent or more responsible for their own injuries. The average compensation for those claims was more than \$70,000.

Figure 9

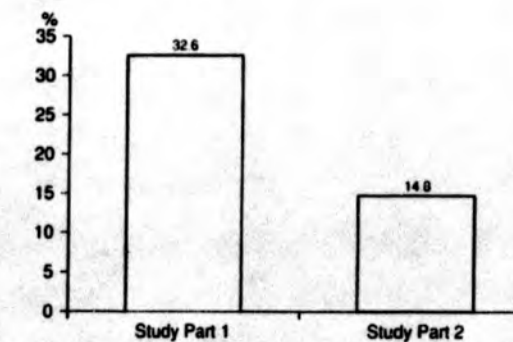
Percentage of Claims and Losses With Claimant 50% or More Responsible



- Average compensation in multi-defendant cases significantly exceeded compensation in single-defendant cases. About one third of the larger claims (Study Part 1) were multi-defendant cases, whereas only about 15 percent of the Study Part 2 claims, mostly small claims, were multi-defendant cases. In Study Part 1, insurers paid an average of 2.4 times more in multi-defendant cases than in single-defendant cases. In Study Part 2, insurers paid an average of 3.7 times more in multi-defendant cases than in single-defendant cases.
- Multi-defendant cases also generated disproportionately higher legal costs than single-defendant cases. When allocated loss adjustment expenses (insurers, legal costs, and other claim expenses) were calculated as a percentage of compensation paid to claimants, those expenses were more than 75 percent greater in multi-defendant cases than in single-defendant cases.

Figure 10

Multi-defendant Cases As Percentage of All Cases



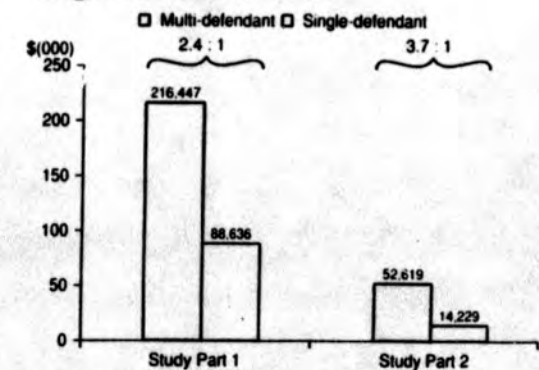
Study Part 1: Claims of \$25,000 or More
Study Part 2: Closed Claim Sample (with Payment Only)

2. Collateral Sources

Under the collateral source rules in effect in most jurisdictions, the fact that a claimant has received—or is entitled to receive—benefits from a collateral source (such as no-fault or private health or disability insurance) does not reduce any settlement or court award. Indeed, in many jurisdictions, the availability of collateral source payments may not even be introduced as evidence at trial. Critics say that it is unfair for some claimants to recover twice for the same injuries. In some jurisdictions alternatives to these rules have been proposed or enacted. These alter-

Figure 11

Ratio of Average Losses in Multi-defendant Cases to Average Losses in Single-defendant Cases



Study Part 1: Claims of \$25,000 or More
Study Part 2: Closed Claim Sample (with Payment Only)

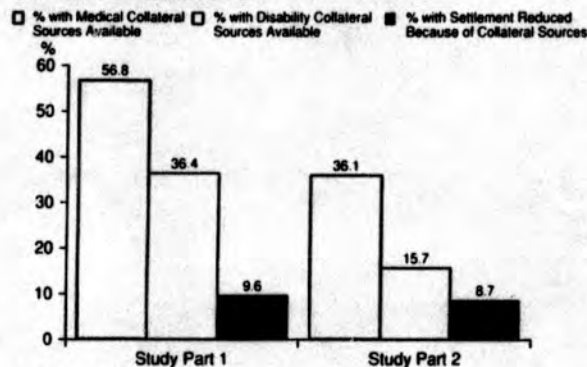
natives either permit collateral source benefits to be introduced as evidence or more directly mandate that the amount of the settlement or court award be reduced by the amount of collateral benefits already received by the claimant.

The *Claim File Data Analysis* sheds light on a number of issues related to collateral sources:

- Many claimants did, in fact, receive recoveries from collateral sources as well as from liability insurance. In Study Part 1 (claims of \$25,000 or more), 57 percent of the claimants were reported to have medical collateral sources available and 36 percent of the claimants were reported to have disability collateral sources available. In Study Part 2 (closed claim sample), claimants were reported to have medical collateral sources available in 36 percent of the cases and disability collateral sources in 16 percent of the cases.
- The study also indicated the potential for cost reduction that the relaxation of the traditional collateral source rule would permit. Despite the wide availability of collateral source benefits, only 9 percent of all claims in both study parts had settlements or court verdicts reduced because of the availability of collateral sources.

Figure 12

Percentage of Claims with Collateral Sources Available and Percentage with Settlement Reduced Because of Collateral Sources



Study Part 1 - Claims of \$25,000 or More
Study Part 2 - Closed Claim Sample (with Payment Only)

- In cases where collateral sources did reduce the settlement or court awards, the dollar effect was significant. In Study Part 1 (claims of \$25,000 or more), in claims that were reduced because of collateral sources, the average reduction was 20 percent. In Study Part 2 (closed claim sample), the average reduction was 28 percent for affected claims.
- For Study Part 1, Workers' Compensation was the most prevalent collateral source of benefits reported. Almost 40 percent of Study Part 1 claimants who had a collateral source reported and almost 20 percent of Study Part 2 claimants who had a collateral source reported had Workers' Compensation benefits. This is consistent with the proportion of claimants whose injuries were related to their employment. Among the employed claimants in Study Part 1, 41 percent of the injuries were work-related, and among the employed claimants in Study Part 2, 16 percent of the injuries were work-related.

Figure 13

Distribution of Claims by Type of Collateral Source
Study Part 1 - Claims of \$25,000 or More

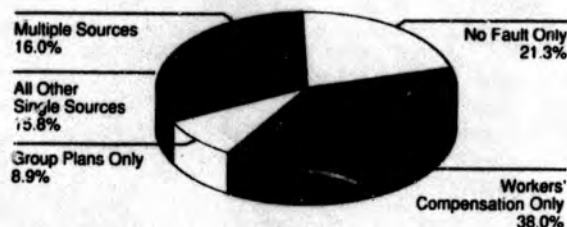
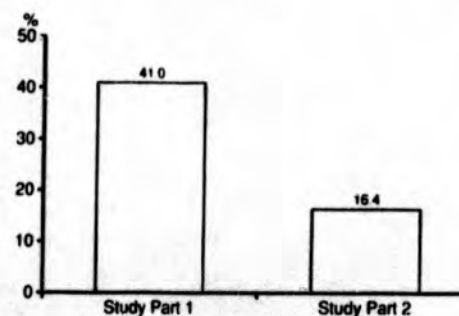


Figure 14

Work-Related Injuries as Percentage of Employed Claimants



Study Part 1 - Claims of \$25,000 or More
Study Part 2 - Closed Claim Sample (with Payment Only)

- In Study Part 2, no-fault was the most prevalent collateral source reported, covering over 30 percent of all claimants who had a collateral source reported.

Because of difficulties in collecting collateral source data, the study probably understated the significance of collateral sources. Claimants are generally not required by law to disclose collateral sources—either to insurers or to the courts—and the process of negotiating settlements strongly discourages plaintiffs from volunteering this information.

Figure 15

Distribution of Claims by Type of Collateral Source
Study Part 2 - Closed Claim Sample
(With Payment Only)



Thus, collateral source benefits were probably far more widely available than the study found. For example, in 1983, 80 percent of all Americans had private health insurance for hospital expenses, 76 percent had coverage for surgical expenses, and 73 percent had coverage for physicians' expenses. Over 134 million Americans belonged to some form of employer- or union-provided group coverage plan. (See U.S. Bureau of the Census, *Statistical Abstract of the United States: 1987* (107th edition) Washington, DC, 1986, p. 89)

3. Punitive Damages

Awards for punitive damages are not designed to compensate for injury but to penalize the defendant for conduct that a court finds to be beyond ordinary negligence. The standards vary from state to state. Some jurisdictions provide damages for gross negligence, others for reckless misconduct, and others for conduct deemed wanton, willful, or malicious.

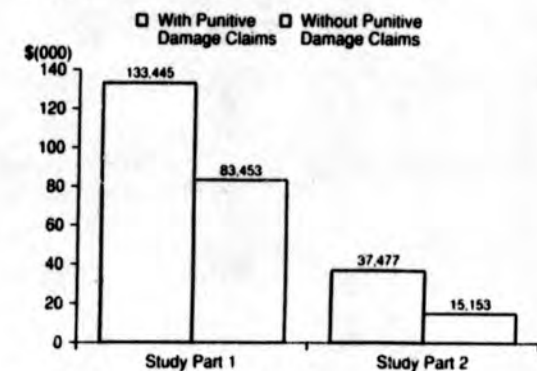
Since a very small minority of claims actually go to verdict, many observers have argued that award levels as such do not reveal the primary effect of punitive damages. Instead, their main effect comes in the upward ratcheting of settlements negotiated with a threat of potentially large punitive damage awards. In effect, to protect insureds against the risk of large punitive awards, insurers are agreeing to bigger settlements than they would without the threat of punitive damages. The *Claim File Data Analysis* makes an effort to quantify this "shadow effect" of punitive damages awards on actual claim settlements. The relevant findings include the following:

- On average, respondents reported that claim settlements rose about 10 percent when claimants sought punitive damages. In Study Part 1 (claims of \$25,000 or more), where claimants sought punitive damages, survey participants reported that the punitive damage claims influenced the settlement in 13 percent of the cases. Among that 13 percent, the respondents reported that compensation would have been 55 percent lower on average if the claimants had not sought punitive damages.

- In Study Part 1, claim settlements where claimants sought punitive damages were about 60 percent higher than those where claimants did not seek punitive damages (\$133,000 compared with \$83,000). In Study Part 2 (closed claim sample), claim settlements where claimants sought punitive damages were nearly 150 percent higher than those where claimants did not seek punitive damages (\$37,000 compared with \$15,000). Much of the difference in claim settlement value between claims with and without the threat of punitive damages may have resulted from the inherent characteristics of these claims, rather than the threats. Nevertheless, as the respondents reported, punitive damage claims do have some effect on claim settlements.

Figure 16

Average Losses with and without Punitive Damage Claims



Study Part 1 - Claims of \$25,000 or More (Closed Claims Only)
Study Part 2 - Closed Claim Sample (with Payment Only)

E. Governmental and Municipal Claims

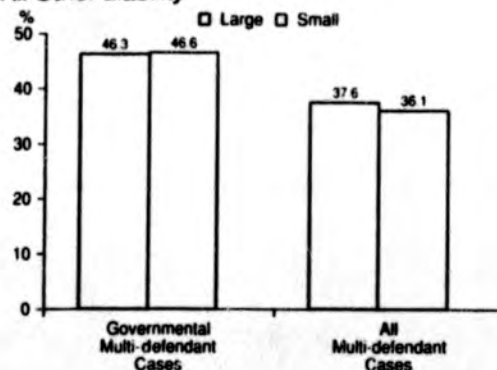
State and local governments have asserted that changes in the legal climate have, in effect, converted governments into "deep pockets" for potential claimants. The study, which collected information on approximately 1,000 claims against local governments and municipalities, suggests that this contention has merit. The study found that governmental entities were more likely than other insureds to make settlement payments in excess of their percentages of fault. Claimants against governmental entities were more likely than other claimants to sue and to receive compensation greater than their economic losses.

Specifically for the "all other liability" claims:

- In multi-defendant cases, when the insured was a municipal or governmental entity, the insured's estimated percentage of settlement exceeded its estimated percentage of fault in 46 percent of the cases, compared with 36 percent of the cases for all multi-defendant cases.
- Claimants filed suits in the vast majority of governmental claims—in 75 percent of the small governmental claims and in 88 percent of the large governmental claims. By contrast, in the general claim population, claimants filed suits in only about one third of the claims. The frequency of suits against governmental and municipal entities may be attributable in part to the tight statutory time limits for filing suits against such public entities. Claimants are forced to sue early in the claims process or forgo the right to sue later.

Figure 17

Percentage of Cases in Which Insured's Percentage of Settlement Exceeded Percentage of Fault
"All Other Liability"



- The tendency for the insurance payment to exceed the claimant's economic loss was significantly stronger for claims against governmental entities than for the general claims population. For governmental claims, average compensation was 3.4 times the average fault-adjusted economic loss, while for the general claim population, compensation was only 2.4 times the fault-adjusted economic loss.

The study may not have captured a representative sample of governmental and municipal claims because of two limitations. First, insurers that participated in the study were not necessarily the ones that wrote the majority of governmental business during the sample periods. And second, many companies did not segregate claims against governmental entities in their claim files.

Figure 18

Percentage of Cases with Lawsuit Filed
"All Other Liability"

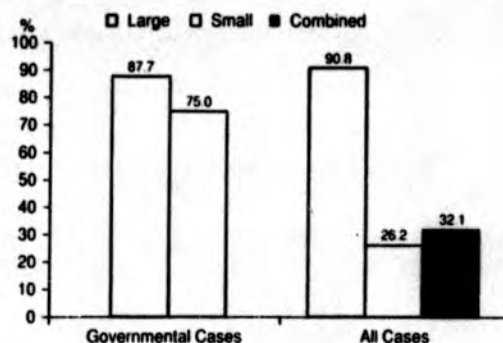
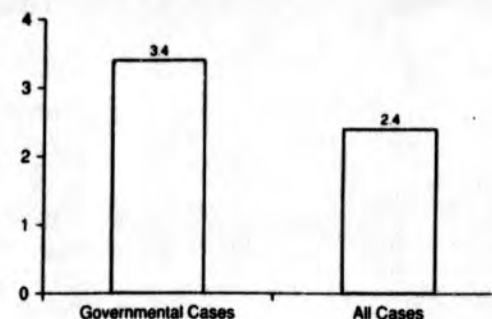


Figure 19

Ratio of Compensation to Fault-Adjusted Economic Loss
"All Other Liability"



F. Reserving Practices

Insurer reserving practices have been an issue in the recent public debate over the availability and affordability of liability insurance. The study does not address the adequacy of current insurer reserves. It does, however, review differences between initial case reserves and the ultimate payments made by insurers.

Insurers continually review and update their case reserves as better information becomes available. In addition to the individual case reserves, insurers have "bulk" reserves for the expected development of open claims and for claims that have been incurred but have not yet been reported, known as incurred but not reported, or IBNR. Those "bulk" reserves are not included in this analysis.

Findings on reserving practices include the following:

- In the aggregate, Study Part 2 (closed claim sample) claims were initially under-reserved by 26 percent. About 61 percent of the claims were over-reserved by a total of more than \$16.9 million. (Of these claims, about half were closed without payment.) For some claims (11 percent), the initial case reserves exactly equaled the ultimate insurance loss. The remaining 28 percent of claims were under-reserved by a total of more than \$33.3 million.

Table 2

Adequacy of Initial Reserves *Study Part 2—Closed Claim Sample*

	<u>% of Claims</u>	<u>Initial Reserve minus Ultimate Insurance Loss</u>
Reserve > Loss	60.7%	\$16,995,988
Reserve = Loss	11.4	0
Reserve < Loss	27.9	(33,332,663)
Total	100.0%	\$(16,336,675)

III. Tort Reform Opinion Survey

In addition to the analysis outlined in Section II, the study also collected the opinions of the participating claims professionals on the effects of tort reforms enacted in recent years.

A. Scope of Survey and Methodology

The opinion survey covered 24 states that enacted some form of tort law change. Each participant was given a description of the relevant tort reforms enacted in the state. The participant was then asked to indicate separately for each statutory provision whether the provision would affect the claim and, if so, to estimate the dollar effect within a broad range.

B. Objectives and Limitations

A full understanding of the conclusions and limitations of the opinion survey requires a reading of Chapter V of the underlying study. Briefly, the objective of the opinion survey was to determine the relative effect and direction of the states' tort law changes on bodily injury indemnity losses and allocated loss adjustment expenses. The study analyzed the percentage of claims estimated to be affected by each tort reform in each state and the estimated dollar effect on individual affected claims.

No attempt was made to quantify a precise dollar impact of each reform. The primary reasons for this are the lack of statistical credibility caused by the small number of claims in most states, the variation in results that could be caused by the presence or absence of a few large claims in a state, and the subjective nature of the judgments requested in the survey forms. The only overall opinions quoted in the study about the effect on total bodily injury indemnity losses are for a few states and tort reforms with a reasonably credible number of claims affected.

Because of the enormous variations in the tort reform laws enacted in the different states, the opinion survey does not permit countrywide generalizations. In addition, in most of the states surveyed, the data is limited and is not credible for drawing precise conclusions.

Nonetheless, particularly when viewed in conjunction with the findings from the *Claim Evaluation Project*, this opinion survey provides valuable insights. The survey represents the first quantitative measure of the percentage of claims likely to be affected by the recent tort reform legislation. Moreover, the term "tort reform" has taken on generic meaning and has come to cover an extraordinary variety of actions. This survey and its predecessor can help distinguish reforms likely to have a powerful effect from those likely to have little effect. Finally, different tort reforms affect different sectors of the claims universe. This survey helps delineate those different effects.

Studies of this nature should help deepen awareness that no simple mathematical formula can calculate the prospective cost implications of tort law changes.

C. Findings

In the aggregate, the study participants estimated that nearly 15% of the claims studied would have been affected by the enacted tort reforms. Moreover, for each category of tort reform—joint and several liability, collateral source rule, and others—at least some states enacted a variant that would have had a meaningful effect in a substantial number of cases. For example, in seven of the states that amended the collateral source rule, 20 percent or more of the large claims studied would have been affected. Furthermore, while the study does not quantify the cost reductions associated with each tort reform, the participants' responses suggest that in claims that would have been affected, the potential cost reduction often would have been substantial.

These findings, coupled with an analysis of the percentages of claims affected, carry several implications. First, the study reinforces the finding of the 1987 *Claim Evaluation Project* that many of the legislative actions falling under the category of tort reform were heavily encumbered by exceptions and qualifications. Whatever their public policy merits, these exceptions and qualifications limit the cost effects of the reforms. Second, while certain classes of tort reform can influence indemnity levels across a broad spectrum of claims, others may have a

powerful effect in a limited range of cases. Certain tort reforms may play an insignificant role in the typical small claim situation—for example, modifications of joint and several liability, restrictions on punitive damages, and ceilings on non-economic damages. However, these same reforms may have greater force in the larger claims, where cost predictability is a special problem for insurers.

The opinion survey indicates that the enacted tort reforms generally would have had a greater effect on large claims (Study Part 1) than on small claims. That disparity was less pronounced in connection with reforms aimed at modifying the collateral source rule. The survey found that changes in the collateral source rule produced the broadest effect in the largest number of states. This finding does not imply that modifications of the collateral source rule are inherently the most powerful tort reform tool for reducing indemnity costs. The survey did not address which hypothetical tort reforms might have produced the greatest cost reductions.

Among the large claims, tort reforms in the area of joint and several liability had powerful effects in two states that repealed the doctrine outright. In those two states, Colorado and Wyoming, participants found that over 15% of all Study Part 1 claims would have been affected.

In most instances, the caps on non-economic damages and restrictions on punitive damages, as enacted, would have affected relatively fewer cases, although in some individual cases the dollar effects appeared potentially large.

The findings about limitations to punitive damages illustrate why aggregate data on the percentage of claims influenced by a given tort reform can understate the effect of the reform. The participants estimated that the enacted punitive damage provisions would have affected only a small sliver of the total claims studied. In the large claim sample (Study Part 1) for the two states reporting the greatest effects, Iowa and Montana, respondents estimated that under 10% of all claims would have been affected. However, claimants sought punitive damages in 10% of the Study Part 1 closed claims. So the projected effects of the recent legislation appear far more impressive. In short, in the states that enacted strong laws on punitive damages, the opinion survey finds powerful effects among the small, but important, minority of claims where punitive damages are an issue.

IV. Additional Study Specifications

A. Participating Insurer Groups

Listed below are the 24 insurer groups whose submissions make up the data base underlying this study.

Aetna Life & Casualty
American International Group, Inc.
Chubb Group of Insurance Companies
CIGNA Property and Casualty Companies
CNA Insurance Companies
Continental Insurance
Crum & Forster Insurance Companies
Fireman's Fund Insurance Companies
General Accident Insurance Company of America
Great American Insurance Company
The Hartford Insurance Group
Home Insurance Company
Imperial Casualty and Indemnity Company

The Kemper National Property and Casualty Companies
Liberty Mutual Insurance Company
Lincoln National Corporation
Nationwide Insurance Companies
(including Wausau Insurance Companies)
The Reliance Insurance Companies
Royal Insurance U.S.A.
St. Paul Companies
State Farm Insurance Companies
The Travelers Insurance Company, Inc.
United States Fidelity & Guaranty Company
Zurich American Insurance Group

B. States Surveyed

Listed below are the 27 states surveyed in this study. During 1986, 24 of the states enacted some modification to their tort laws affecting the settlements of commercial liability claims other than medical malpractice. Three states—Kansas, Massachusetts, and South Dakota—were surveyed to balance the geographic mix of states.

Alaska	Iowa	New York
California	Kansas	Ohio
Colorado	Louisiana	Oklahoma
Connecticut	Maryland	South Carolina
Florida	Massachusetts	South Dakota
Georgia	Michigan	Utah
Hawaii	Minnesota	Washington
Illinois	Montana	West Virginia
Indiana	New Hampshire	Wyoming

C. Lines of Business Included

The study included all direct business, including, but not limited to, monoline, package, national accounts, and surplus lines written by the 24 participating insurers. Umbrella and excess policies were excluded. The bodily injury liability portions of the following lines of insurance were examined: premises/operations (e.g., OL&T, M&C, Businessowners), product liability, and commercial automobile.

Civil Litigation Project

**PROCEDURAL REFORM
OF THE CIVIL JUSTICE SYSTEM**

**A STUDY
CONDUCTED BY
LOUIS HARRIS AND ASSOCIATES**

**Commissioned By:
Foundation for Change**

FOUNDATION FOR CHANGE THE CIVIL LITIGATION PROJECT

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Chevron, USA

Anthony Roisman
Cohen, Milstein & Hausfeld

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FOUNDATION FOR CHANGE THE CIVIL LITIGATION PROJECT

Available evidence suggests that the cost of litigating a major civil suit has skyrocketed in the past decade. The Foundation for Change, in its Civil Litigation Project, has undertaken three endeavors to study various procedural improvement and reform options designed to reduce litigation "transaction costs" — the total costs incurred by all parties to civil litigation, excluding any liability or settlement — in our nation's civil justice system: (1) Louis Harris and Associates was commissioned to conduct an independent survey of federal trial judges and of the various segments of the federal litigating bar; (2) the Brookings Institution in Washington, D.C. has convened a series of one-day conferences, cosponsored by the Foundation for Change, on civil justice reform; and (3) the Rand Corporation's Institute for Civil Justice is serving as technical consultant to the Project to assemble and interpret the relevant empirical data available.

*Organizations * for identification purposes only.

INTRODUCTION

The Foundation for Change commissioned Louis Harris and Associates to undertake this survey, unprecedented in its comprehensiveness and scale, of federal trial judges and the various segments of the federal litigating bar. The objective was to determine the degree of consensus among the judiciary and litigating bar about seemingly high federal civil litigation transaction costs and about delays in litigating federal civil cases, and to determine whether a consensus exists on procedural reform of the civil justice system.

Transaction costs are the total costs incurred by all parties to civil litigation, excluding any ultimate liability or settlement.

The study was based on in-depth telephone interviews, averaging 25 minutes in length, with:

- 250 private litigators who represent plaintiffs;
- 250 private litigators who represent defendants;
- 100 public interest litigators;
- 300 corporate general counsel of companies selected from the 5,000 largest corporations in America (based on annual sales revenue); and
- 147 federal district court judges.

Briefly stated, the interviews focused on perceptions and attitudes about whether increasing litigation transaction costs and delay in the federal civil justice system are a problem, and, if so, to assess the magnitude of that problem, its probable causes and a broad range of possible solutions. All interviewing was conducted by Harris Executive Interviewers from their on-premise, centralized interviewing facility. The interviewing began on August 17, 1988, and concluded on October 27, 1988.

Louis Harris and Associates is fully responsible for the design and execution of this study. The Foundation for Change and an expert team it assembled helped the Louis Harris team fully understand the issues and gave specific suggestions and guidance in developing items and issues to be examined.

All references are to tables in the report prepared by Louis Harris and Associates. Copies of the report are available from the Foundation for Change.

PROCEDURAL REFORM OF THE CIVIL JUSTICE SYSTEM

The past several years have witnessed a growing chorus of voices expressing concern about high transaction costs and undue delays associated with federal civil litigation. This problem has widespread implications and casts doubt on whether the civil justice system continues to meet its basic objective as specified in Rule 1 of the Federal Rules of Civil Procedure — the “just, speedy and inexpensive” resolution of disputes.

Accordingly, the Foundation for Change commissioned Louis Harris and Associates to conduct an objective, in-depth assessment of the transaction costs issue. Transaction costs serve as a measure of the efficiency and fairness of the civil justice system. According to the relevant literature, high and increasing litigation transaction costs indicate that greater amounts of our nation’s resources are being expended in resolving civil disputes between parties. Increasing transaction costs also mean, according to numerous experts, that a lower percentage of each dollar expended in the civil justice system is actually paid in compensation.

THE RESULTS:

The survey found that transaction costs are, indeed, perceived to be a problem. There is widespread agreement that excessive transaction costs lead to unequal justice. Discovery abuse is considered the most important cause of the problem. Inadequate judicial case management is also cited as a principal cause of inflated costs. There is very strong support for specific proposals designed to reduce discovery conflicts and to enhance judicial case management. Finally, it is widely believed that it would be possible to introduce procedural improvements and reforms, such as changes in the discovery process and changes in the way judges manage cases, that would “significantly reduce” litigation costs.

THE MAJOR FINDINGS:

I. TRANSACTION COSTS ARE PERCEIVED TO BE A PROBLEM.

More than half of the federal judges, corporate counsel and public interest litigators surveyed characterize the costs of litigating civil cases today as a “major problem.” Even among private litigators, 4 out of 10 admit as much about current costs. And among the various respondents, more than 7 out of 10 characterize transaction costs as at least a “moderate problem.” (Table 1.6)

- There is general agreement that in “high stakes” cases, such as product liability, malpractice or complex litigation, transaction costs are “excessive.” While there is some ambivalence, many agree that transaction costs are excessive in a typical personal injury case, a typical contract dispute and in “mass latent injury” tort cases (such as asbestos or Dalkon Shield). (Table 3.0)
- Those who have litigated abroad perceive U.S. litigation costs to be substantially higher than costs in foreign countries. (Table 5.0)

II. JUDGES AND LAWYERS AGREE THAT EXCESSIVE TRANSACTION COSTS LEAD TO UNEQUAL JUSTICE.

A majority agree that transaction costs unreasonably impede the use of the civil justice system by the ordinary citizen and that the civil justice system today gives an unfair advantage to "large interests" with greater legal resources. (Tables 4.1 and 4.2)

III. DISCOVERY ABUSE IS CONSIDERED THE MOST IMPORTANT CAUSE OF THE PROBLEM.

The most important cause of high transaction costs or delays that increase these costs is perceived to be lawyers who abuse the discovery process. (Table 6.2)

- Lawyers who "over-discover" cases rather than focus on controlling issues and lawyers and litigants who use discovery as an adversarial tool or tactic to raise the stakes for their opponents are the most frequently cited causes of high transaction costs. (Table 7.1)
- Corporate counsel and private litigators estimate that nearly 60% of their total transaction costs are discovery costs in a typical federal court case. (Table 7.2)
- Private litigators who previously litigated on behalf of the government report that they use more discovery and spend more time on their cases in their present positions than they did when they litigated for the government. (See page 19.)

IV. INADEQUATE JUDICIAL CASE MANAGEMENT IS ALSO BLAMED FOR INFLATED COSTS.

A majority of the lawyers and federal judges believe that the "failure of judges to control the discovery process" is another principal cause of inflated transaction costs.

- Substantial numbers also consider the failure of judges

to hold early substantive conferences, to use the rules and discretion that they are granted and to set early, firm trial dates as major factors contributing to excessive costs. (Table 9.1)

V. THERE IS VERY STRONG SUPPORT FOR SPECIFIC PROPOSALS DESIGNED TO REDUCE DISCOVERY CONFLICTS AND TO ENHANCE JUDICIAL CASE MANAGEMENT.

- There is near unanimous support for proposals that emphasize early, pretrial efforts among the parties to reduce discovery conflicts, (Table 11.2.1) including:
 - requiring counsel to negotiate discovery conflicts among themselves before seeking court resolution;
 - requiring the parties to arrive at a final discovery plan well before the pretrial conference; and
 - requiring discovery conferences soon after the case is filed.
- Nearly 8 out of 10 attorneys surveyed favor "setting an 18-month limit on discovery, with provisions for exceptional circumstances." (Table 11.2.1)
- More than 8 out of 10 judges and lawyers surveyed favor increasing the role of federal judges as active case managers. (Table 12.1) Specifically, there is very strong support for two procedures:
 - more active use of pretrial and status conferences to monitor and limit discovery; and
 - scheduling early and firm trial dates. (Table 12.2)
- Nearly all lawyers surveyed, as well as 8 out of 10 federal judges, favor introducing a system that places cases on different "tracks" based on complexity. The less complex a case, the more accelerated the track. (Table 12.4)

VI. IT IS WIDELY BELIEVED THAT CERTAIN PROCEDURAL IMPROVEMENTS AND REFORMS, IF IMPLEMENTED, WOULD SIGNIFICANTLY REDUCE LITIGATION COSTS.

Nine out of 10 corporate counsel, 3 out of 4 private litigators and public interest litigators and 7 out of 10 federal judges believe that if changes in the discovery process and in the manner in which judges manage cases were implemented, transaction costs would be "significantly" reduced. (Table 17.2)

OTHER IMPORTANT FINDINGS:

VII. JUDGES AND LAWYERS CITE COSTS AND DELAYS AS THEIR MOST SERIOUS CRITICISMS OF THE CIVIL JUSTICE SYSTEM TODAY.

When asked to identify their most serious criticism of the federal civil litigation process today, the litigating bar most often volunteered: (Table 2.0)

- delays in reaching court, exacerbated by clogged dockets;
- discovery abuses, resulting in expensive, time consuming and unnecessary discovery; and
- the costs of civil litigation.

VIII. NEARLY ALL ACKNOWLEDGE THAT TRANSACTION COSTS HAVE INCREASED DURING THE PAST DECADE AND ARE LIKELY TO CONTINUE INCREASING.

While only about 1 out of 10 evaluate the process of civil litigation in the federal courts today in wholly negative terms (Table 1.3),

- nearly all acknowledged that litigation transaction costs have increased, controlling for inflation, in the past 10

years; a majority of corporate counsel and federal judges think that they have increased "greatly" (Table 1.1); and a majority feel that delays in disposing of civil cases have also increased. (Table 1.2)

- eight out of 10 anticipate that transaction costs will continue to increase during the next decade; 1 out of 3 corporate counsel, 1 out of 4 public interest litigators, and 1 out of 5 private litigators and federal judges believe that these costs will increase "greatly." (Table 1.4)

IX. MOST BLAME BOTH PLAINTIFF'S AND DEFENSE COUNSEL FOR DISCOVERY ABUSE.

The blame for discovery abuse is generally seen as shared equally by plaintiff's and defense attorneys. Plaintiff's attorneys and federal judges, however, blamed defense attorneys with some frequency, while corporate counsel often blamed plaintiff's attorneys. (See page 27.)

X. MANY FEEL THAT JUDGES ARE NOT FORCEFUL ENOUGH IN THEIR CASE MANAGEMENT.

The prevalent view is that the judge most controls the pace of litigation. (Table 9.3) About 3 out of 4 corporate counsel, 7 out of 10 public interest litigators, the majority of plaintiff's attorneys and a near majority of defense attorneys feel that judges are not forceful enough in their case management. More than 4 out of 10 federal judges agree, although nearly half feel that judicial case management is "about right." (Table 9.2)

XI. THE INCREASING COMPLEXITY OF LITIGATION AND HAVING TOO FEW JUDGES FOR THE CASELOAD ARE ALSO SEEN AS CONTRIBUTING TO THE HIGH COST OF LITIGATION. (TABLE 10.1.1)

- Ineffective case management by corporate counsel, however, is not seen as a major cause of high costs. (Table 10.1.1)
- A majority believe that the "time value of money" (that is, the ability to earn interest on funds over time) is often a major motive for not settling earlier. (Table 10.2)

XII. THERE WAS STRONG SUPPORT FOR OTHER PROCEDURAL IMPROVEMENTS AND REFORMS.

- More than 8 out of 10 federal judges and corporate counsel, and 3 out of 4 private litigators, favor:
 - limiting the number of interrogatories and depositions in certain types of cases;
 - establishing a set of standing orders on discovery that instruct the bar how to proceed; and
 - granting judges the discretion to impose some or all discovery costs on the requesting party. (Table 11.2.1)
- Eight out of 10 public interest lawyers favor the establishment of standing orders, but to a lesser extent favor limiting interrogatories and depositions (67% favor), and granting judges the discretion to impose discovery costs on the requesting party (59% favor). (Table 11.2.1)
- A majority of corporate counsel favor the "allocation of discovery costs to the losing party in disputes between solvent corporations." Indeed, this proposal is favored by a majority of all surveyed, except public interest lawyers (49% favor). (Table 11.2.2)
- A majority of all litigators and judges surveyed support means to foster judicial accountability by requiring the

publishing of judicial statistics. (Table 12.3)

- A majority favor the use of alternative dispute resolution (ADR) mechanisms. (Tables 13.1 and 13.2)
- About 7 out of 10 attorneys, and 8 out of 10 judges, who have participated in bifurcated trials feel that bifurcation had a positive impact on reducing transaction costs. (Table 14.1)
- There are mixed views about the use of court-appointed expert witnesses. (Table 16.0)

CONCLUSION

During the past several years, a lot has been said and written about the transaction costs of hearing and disposing of federal civil cases. The Foundation for Change commissioned Louis Harris and Associates to conduct, for the first time, an independent, objective and large-scale study of this issue. The survey measured the views of 250 litigators who represent plaintiffs, 250 litigators who represent defendants, 100 public interest litigators, 300 corporate general counsel and approximately 150 federal trial judges. In sum, there is widespread agreement that while transaction costs are a problem, it would be possible to introduce procedural improvements and reforms in the areas of discovery and judicial case management that would "significantly reduce" transaction costs.

FOUNDATION FOR CHANGE

The Foundation for Change is a nonprofit corporation organized to foster, promote and directly participate in research, study and educational programs on a variety of complex public policy issues. The Foundation's objective is to involve itself in complicated issues where there is a need for experts to study and consider various policy options. Each of the Foundation's areas of focus will be an emerging issue of the next decade in which policy changes are needed or will inevitably occur.

The Foundation intends to research and study initially: (1) civil justice issues; (2) a national anti-drug strategy, particularly the need for private sector initiatives to combat drug abuse; and (3) U.S.-European relations in the 1990s, especially the appropriate U.S. policy response to the European Commission's 1992 Plan for economic integration.

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Tort reform:

Past, present, and future

by Brad Cohn, MD, FAAP, San Francisco, CA

Tort law affects virtually every practicing physician. Therefore, the more that we as individual practitioners, as well as members of organized associations, know regarding the way in which our profession is governed in civil law, the better we can right the imbalances existing within the system today.

The objectives of tort reforms

The purpose of tort law is to enact measures that serve to ameliorate inequities in the application of civil law to contemporary actions. In cases of alleged professional negligence, a variety of tort reform measures have been viewed as inequitable or outdated.

Some of the various reforms that have been suggested in numerous jurisdictions across the United States are limitations on noneconomic damages and on contingency fees for the plaintiff's attorneys. There also have been requests for the abolition of collateral source payment, of the *ad damnum* clause, of the methods for claiming punitive damages, and of joint and several liability. Additional provisions that have been proposed include periodic payments of awards rather than one lump sum; reversionary trusts, in which unneeded funds are returned to the carrier; reduction in the statute of limitations; review panels and certificates of merit to screen out nonmeritorious or frivolous lawsuits; and arbitration as an alternative mechanism to resolve disputes.

In general, there are eight major areas of concern with regard to tort reform. These are as follows:

1. To ensure that the injured party receives the funds awarded in a negligence action. It is estimated that only 20 percent of the payment ever reaches the injured person.
2. To expedite the process. Many years may pass before any disposition of a case is made.
3. To encourage a reasonable settlement of the case, so that liability is clearly resolved, payments are determined, and transaction costs are kept to a minimum.

A tort is defined as a wrongful act for which a civil action will lie except one involving a breach of contract.

The standard of care in tort law is to possess and employ such reasonable skill and care as are commonly possessed and exercised by reputable persons of similar training and ability in the community at that point in time. This is a legal duty and obligation a physician has to a patient.

The four elements comprising the tort of medical malpractice are as follows: (1) There has been a breach of standard care. (2) That breach was the proximate cause of the injury. (3) The injury produced measurable damage. (4) It was foreseeable that the outcome would have been less injurious to the patient if the physician had conducted a different course. The burden of proof is on the plaintiff by virtue of a "preponderance of evidence."

4. To provide equity in awards in order to achieve similar settlements for conditions of like severity and circumstances.

5. To permit the defendant the opportunity for an unencumbered defense.

6. To conserve finite resources available through the insurance carrier, which should assist in the stabilization of professional liability premiums.

7. To identify and eliminate incompetent physicians from the system through the development of loss prevention and quality assurance mechanisms that should serve to reduce patient injury.

8. To differentiate cases of maloccurrence from those of malpractice.

Table 1 Comparison of premium rates for three physician groups from 1986-1988			
Annual Premium Rates			
Physician Group	1986	1987	1988
Internal medicine			
Florida	\$14,034	\$17,402	\$21,143
Michigan	10,477	10,845	19,279
New York	15,168	16,533	18,169
Alaska	6,760	11,256	11,898
Arizona	6,108	8,248	10,430
Georgia	4,370	5,825	7,050
Hawaii	5,792	7,628	7,628
California	5,572	5,908	5,908
General surgery			
Florida	\$70,736	\$91,730	\$99,503
Michigan	36,176	41,603	73,961
New York	45,255	49,328	54,209
Alaska	24,324	40,520	42,830
Arizona	25,388	34,272	40,750
Georgia	21,473	28,623	34,066
Hawaii	20,847	27,456	27,456
California	20,048	21,260	21,260
Obstetrics and gynecology			
Florida	\$117,891	\$152,881	\$185,739
Michigan	55,443	70,135	124,685
New York	77,025	83,957	92,264
Alaska	45,948	76,536	80,899
Arizona	40,272	57,068	66,440
Georgia	35,434	47,233	56,157
Hawaii	39,377	51,860	51,860
California	37,868	40,756	40,156
*Through July 1988			

The components of tort reform

During the liability crisis in 1975, California enacted one of the most comprehensive tort reform packages at that time—the Medical Injury Compensation Reform Act (MICRA). It is doubtful that a sweeping reform of this magnitude could ever be enacted under present conditions. It is also unlikely that such a reform would be passed by the federal government in the foreseeable future. As a result, many physicians have recognized that coordinated long-term projects can and need to be attempted on a state level.

Certain components are necessary to make such efforts viable. First, state medical groups need money. The California Medical Association raised about \$3 million toward its goal in 1975. Another requirement is expertise. People who are experienced, competent lobbyists are needed to help legislators draft responsible bills and to offer sound legal advice. It also is very important that the lobbyist have factual information. Anecdotal accounts do not persuade legislators or voters.

Another way to gather political momentum is to form coalitions with other groups that are adversely affected by the current tort system. Coalitions such as these enhance resources and conserve energy.

Because public support is such a key element, voter surveys are extremely helpful in gauging where the sentiments of the voters lie. These data can then be used to design provisions that will have backing from the sector in subsequent referendums.

Commitment, of course, has to come from every rank and file member of the medical constituency. Dedicated efforts from the leaders cannot carry the entire movement for reform. Finally, the stabilizing ingredients that go into these endeavors are a few parts each of time, patience, endurance, and luck.

The rewards of tort reform

As predicted, the 1975 provision of MICRA underwent constitutional challenges based on federal and state equal protection clauses. What ensued was a long, drawn-out process that culminated after a nine-year period. Finally, all court challenges were answered, and the constitutionality of the act was upheld.

Since 1985, MICRA has been the legal standard in California, and data have been accumulated across a number of states for comparative purposes. As chairman of the board of a physician-owned profes-

sional liability insurer, the Medical Insurance Exchange of California (MIEC), I can offer some of the information that we have obtained from the states whose physicians we insure. In addition to California, these states include Idaho, Hawaii, Nevada, and Alaska. Of these, only California has the MICRA legislation.

In 1975, California had the highest premium among the states in which we offer coverage. Because our underwriting, claims handling, and loss prevention efforts are uniform, we can reasonably claim that the subsequent reversal in premium trends could be ascribed most notably to the benefits accrued from MICRA.

Table 1 on page 14 shows the premium rates for three physicians' groups in eight states from 1986

through July 1988. Figure 1 on this page displays graphically the same premium rates for general surgeons only at that time. The average premium for a general surgeon in California in 1988 was \$21,000. In Florida, the rate was as high as \$99,500 (in the Miami area); in New York, the average premium was \$54,000. Even in a state that has been regarded as relatively "low risk," such as Georgia, the average rate was more than \$30,000.

It is my impression that California's MICRA is the reason for this difference in rates. Each of these states has stable, professional liability companies with experienced management, advanced risk management techniques, and pools of insured physicians who represent surgeons of similar training, experience, and ability.

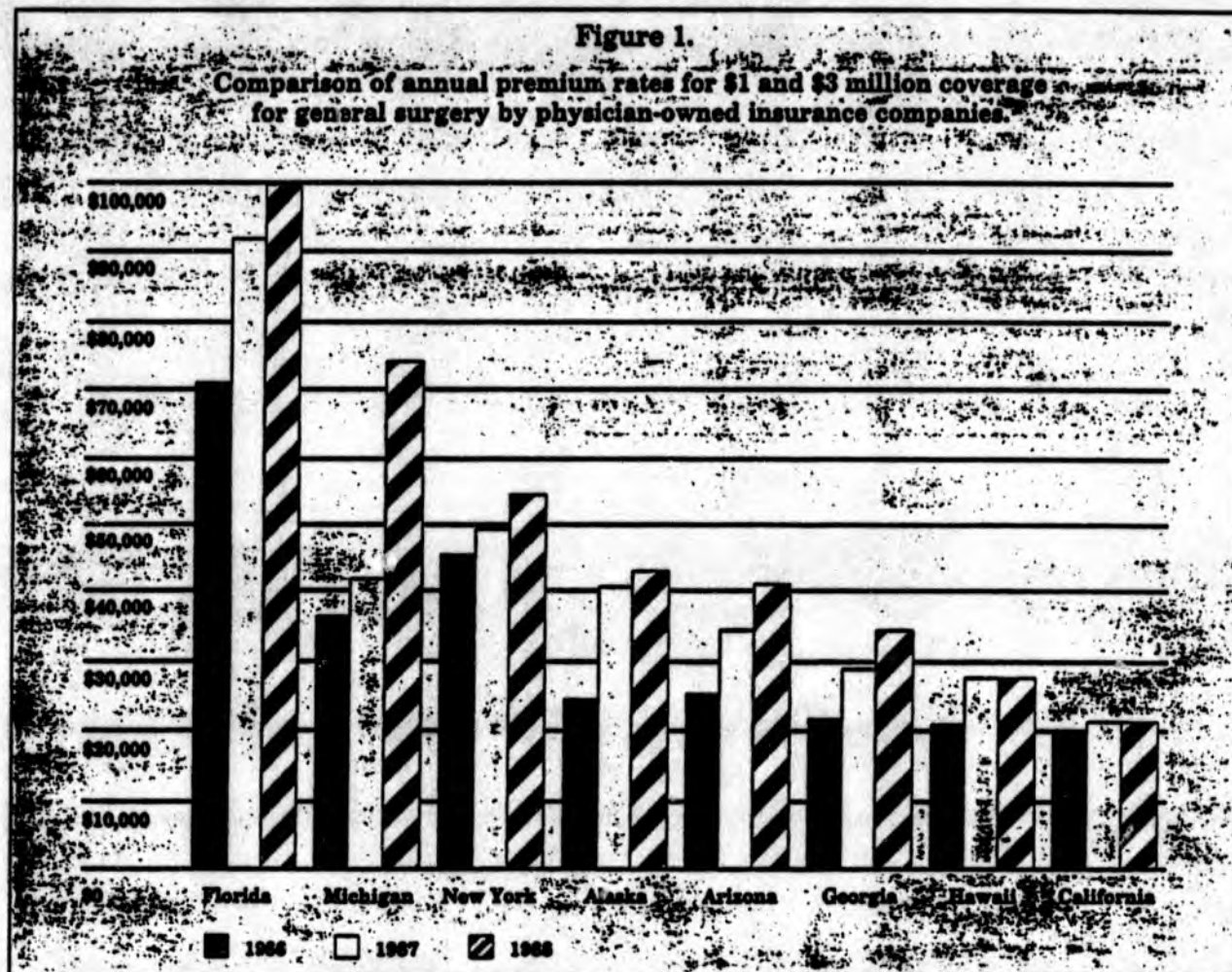


Table 2 on page 17 compares premium rates for the five states covered by MIEC from 1981 through July 1988. The rates in California for general surgery (Figure 2, on this page) are only slightly higher than those in Idaho. When the percentage of annual increases are compared across these five states (Figure 3, on page 17), the difference between California and the other states is even more remarkable.

The rate of increase is 5.2 percent in California compared with 9.4 percent in Idaho and 17.4 percent in Hawaii. These data demonstrate the impact that tort reform in California has had in alleviating the considerable burden of professional liability on the medical profession. Although it appears that the tort system may not be replaced, it is dynamic and can be modified to provide equitable and fair settlements to both the injured party as well as to the professional.

Most certainly tort reform is not the only solution, but it deserves attention and should be considered. Of course, there will be some jurisdictions where it may prove unattainable, even in part. That is why other alternative systems for dispute resolution are being reviewed. Fault-based administrative plans have been formulated by the American Medical Association in conjunction with 32 medical specialty societies and by the Physician Insurers Association of America. A Harvard-based task force also is reevaluating the no-fault concept.

In conclusion, whatever changes are formulated and promoted, our first duty as physicians is, as always, the unalterable doctrine of *primum non nocere*. The care of our patients is our ultimate concern.

Although it may appear that the tort reform system has gone awry and is in desperate need of

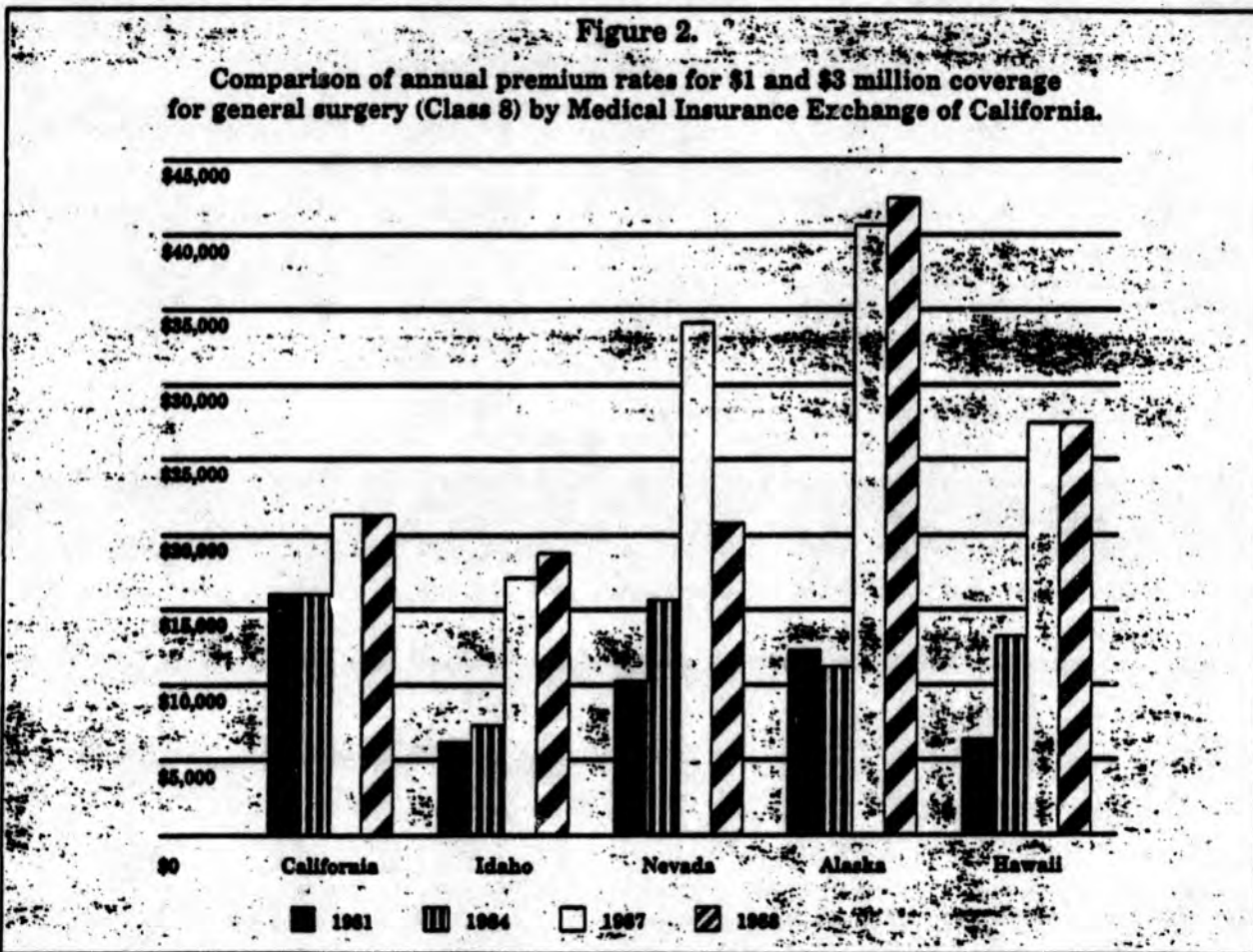
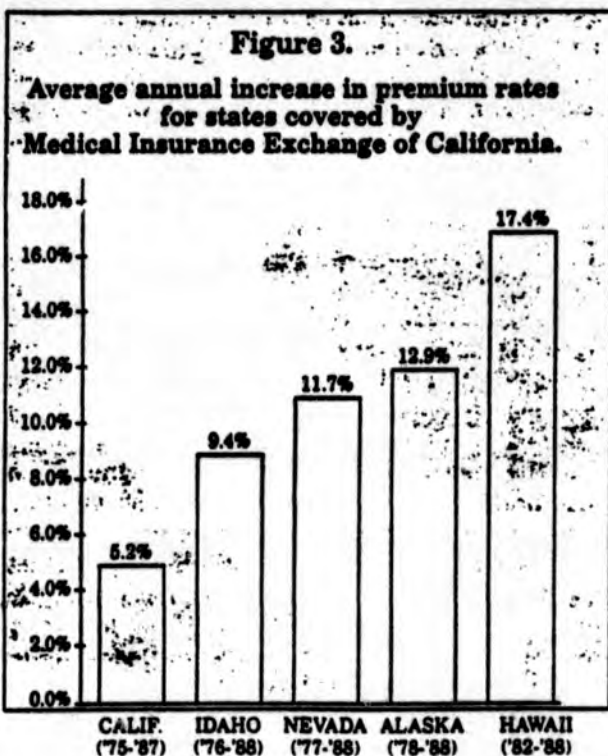


Table 2 Comparison of premium rates for three physician groups from 1981-1988 Annual Premium Rates				
Physician Group	1981	1984	1987	1988
Internal medicine				
California	\$4,996	\$4,996	\$ 5,908	\$ 5,908
Idaho	1,888	2,284	4,740	5,156
Nevada	3,524	4,864	9,480	8,532
Alaska	3,864	3,480	11,256	11,900
Hawaii	1,355	2,828	7,628	7,628
General surgery				
California	\$15,868	\$15,868	\$21,260	\$21,260
Idaho	5,996	7,252	17,052	18,556
Nevada	11,188	15,436	34,120	30,712
Alaska	12,264	11,032	40,520	42,832
Hawaii	6,248	13,008	27,456	27,456
Obstetrics and gynecology				
California	\$24,988	\$27,487	\$40,156	\$40,156
Idaho	9,440	12,562	40,260	43,804
Nevada	17,620	26,739	64,448	58,012
Alaska	19,304	19,114	76,536	80,904
Hawaii	9,840	22,537	51,860	51,860

Through July 1988



reform, we must ensure that our patients continue to be protected at all times and to the best of our ability. Even if our adversaries are reluctant to release what they perceive as a golden goose, we must make our patients the primary beneficiaries. This standard, after all, is what distinguishes medicine as a time-honored profession. [1]

Bibliography

1. American Medical Association Special Task Force on Professional Liability and Insurance: Professional liability in the '80s. Chicago, IL: American Medical Association, 1984.
2. American Medical Association Special Task Force on Professional Liability and Insurance: Response of the American Medical Association to the Association of Trial Lawyers of America statement regarding the professional liability crisis. Chicago, IL: American Medical Association, August 1985.
3. Cohn B: A crisis around the corner—professional liability. *California Physician*, January 1985, pp 15-17.
4. Danzon PM: The frequency and severity of medical malpractice claims. Santa Monica, CA: Rand, The Institute for Civil Justice, 1983.
5. Neupauer R: Large loss trend study. Oakland, CA: Medical Insurance Exchange of California, written communication, 1988.
6. PIAA Data Sharing Project. Lawrenceville, NJ: Physician Insurers Association of America, January 1989.
7. Report of the California Citizens' Commission on Tort Reform. Los Angeles, CA: 1977.

Dr. Cohn is a practicing pediatrician in San Francisco. He is also chairman of the board, Medical Insurance Exchange of California, Oakland, CA, and vice-president, Physician Insurers Association of America, Lawrenceville, NJ.



Medical Malpractice and the Tort System

Peter D. Jacobson, JD, MPH

FEW TOPICS in health care policy generate more contentious commentary than medical malpractice. To some, the recent trend of increasing liability awards and malpractice insurance premiums is a major crisis that affects the organization and practice of medicine. To others, it is a sign that the medical profession has not yet developed adequate controls to sanction deviations from standard practice. In either case, the escalation in medical professional liability awards raises important public policy issues concerning the underlying reasons for the awards and the potential effects on medical practice and service delivery.

See also p 3291.

While the full dimension of the crisis is difficult to specify, rising malpractice insurance premiums and increased claim frequency and award severity have been, until recently, its primary manifestations. Various explanations for these trends have been proposed, with little agreement as to the nature or causes of the problem.¹⁻⁴

Although lawyers, the legal system, the medical profession, and the insurance industry have all been "blamed" for the current medical professional liability situation, there is a growing perception that something is wrong with the manner in which the tort system assesses liability and awards compensation in medical malpractice cases. Many physicians contend that the entire claim-settlement process fails to distinguish between negligent and nonnegligent behavior in assessing liability^{5,6} and thus exposes them to liability for adverse outcomes as well as for negligent medical practice. Large jury verdicts and relatively easy access to the court system contribute to these perceptions.

In response, much of the recent debate has focused on reforming the tort system as a solution to the recurring malpractice crisis.⁷ It is more likely, however, that this crisis results from complex interactions between the medical, legal, and insurance industries and cannot be blamed on any one source. Rising health care costs, for instance, contribute to

larger jury verdicts, which in turn contribute to increased medical malpractice insurance premiums. As such, medical malpractice is not one problem but a series of interrelated problems that involve the regulation and social control of medical practice, quality of care, insurance markets, and the consistent assessment of liability by the courts.

To provide a broader context for the malpractice debate, this article will evaluate changes in legal doctrine and practice over time. The tort system operates to provide compensation to an injured party, to provide incentives for reducing the risks and costs of injuries (that is, deterrence), and to provide accountability for injurious conduct. Although this system has been criticized as being an economically inefficient regulatory mechanism whose costs vastly exceed its benefits, this article is neither an analysis of the tort system's strengths and weaknesses in resolving medical malpractice disputes⁸ nor a broad critique of tort law.

Instead, I will analyze how evolutionary changes in legal doctrine and practice have contributed to increased claim frequency and award severity. I conclude that these changes do not provide a full explanation for the continued rise in awards and that no single doctrinal change has led to recent malpractice liability problems. Thus, changes in legal doctrine alone are not likely to reverse current trends, although tort reforms will help to stabilize and moderate award severity. Effective medical professional peer review, risk management, and the continued development of standards to define appropriate medical intervention are needed to reduce the incidence of substandard medical care.

The first part of this article is a review of medical professional liability data trends during the past 20 years. In the next section, I discuss legal trends during this period, focusing on several hypotheses that might explain the data. Finally, I suggest several public policy measures that might be undertaken in response to these trends.

MEDICAL PROFESSIONAL LIABILITY DATA TRENDS

General Trends

Assembling data to analyze empirically recent trends in medical malpractice cases can be difficult. For the most part, malpractice data are not systematically collected and analyzed, making it difficult to estimate the scope of the malprac-

From the Behavioral Sciences Department, The RAND Corp, Santa Monica, Calif. The conclusions expressed in this article are those of the author and do not necessarily reflect those of The RAND Corp. Reprint requests to the Behavioral Sciences Department, The RAND Corp, 1700 Main St, PO Box 2138, Santa Monica, CA 90404-2138 (Mr Jacobson).

tice problem.⁷ We know very little about the incidence of negligent iatrogenic injuries, the relationship between quality of care and tort awards, or why people seek recovery through the tort system. Other gaps in available information include the deterrent effects of malpractice liability on medical practice, the effects of malpractice insurance premium increases on the availability of services for high-risk patients, and the effects of risk-management or loss-prevention programs on claim frequency and award severity.

Regardless of these gaps, the trend in claim frequency and award severity is unmistakable. No one disputes that from the 1970s until the mid-1980s, medical malpractice award severity and claim frequency increased sharply and without interruption. Nor is there much dispute that, although there is considerable unexplained variation, awards are systematically related to injury severity, and for permanent injuries, to life expectancy.^{1,10,11}

The available data suggest that malpractice liability is not randomly distributed in the physician population,¹² but varies according to specialty and practice location. It does not appear, however, that only a "few" physicians are responsible for a disproportionate share of malpractice tort awards. Certain specialists (particularly surgeons and obstetricians and gynecologists) have a much higher risk of being sued and of being subjected to higher awards than other physicians,^{1,13} although there is no reason to suspect that they are more negligent than other physicians. In all likelihood, this occurs because certain procedures have a higher probability of producing adverse outcomes in the absence of error. Also, errors in these specialties are more detectable and can result in more severely injured patients than in most other areas of medical practice.

It is also generally agreed that the proportion of potentially compensable malpractice incidents that reach the claim-settlement process or tort system is low.^{8,17,18} According to the widely cited study by Mills¹⁷, only 1 in 10 legitimate malpractice incidents reaches the tort system. From this perspective,

the problem is that too few, rather than too many, cases reach the tort system or claim-settlement process.^{12,19} Of the cases in which a claim is filed, available data suggest that the tort system overcompensates those with modest losses while undercompensating those with very serious injuries and large losses.¹ In some cases, the tort system fails to compensate a negligently injured patient; in other cases, compensation may be awarded to someone who was not injured through substandard medical care.²⁰

Claim Frequency and Award Severity

Looking first at the frequency of filed claims, Fig 1 shows sharp increases from the 1970s to the mid-1980s, with reductions occurring in the late 1980s. Between 1975 and 1985, claims per 100 physicians more than doubled,²¹ while between 1976 and 1981, claims against obstetricians and gynecologists tripled.²² Because the proportion of incidents that results in claims is very low, claim filing could show major increases over time without suggesting any increase in substandard medical practice if the percentage of claims from legitimate malpractice incidents filed rises even slightly.

For the time being, the rise in claim frequency appears to have moderated, as some recent studies have indicated a drop or leveling in both claim and paid-claim frequency.^{14,23-26} In Florida, for instance, Nye et al¹⁴ suggest that claim filing peaked in 1984. Major medical malpractice insurers report similar trends beginning in 1986.²⁶ It is too soon to determine whether this is a statistical aberration, a leveling before new increases, the increased costs of litigating marginal claims, or the long-term effects of state tort reforms, hospital risk-management efforts, and enhanced professional sanctions.

With regard to award severity (Fig 2), median awards have increased steadily over time in medical malpractice cases,^{1,10,27} but the average verdict has soared.^{1,28} Between 1975 and 1984, average medical malpractice verdicts increased at nearly twice the rate of the consumer price index.¹ In one study,²⁷ the average expected medical malpractice

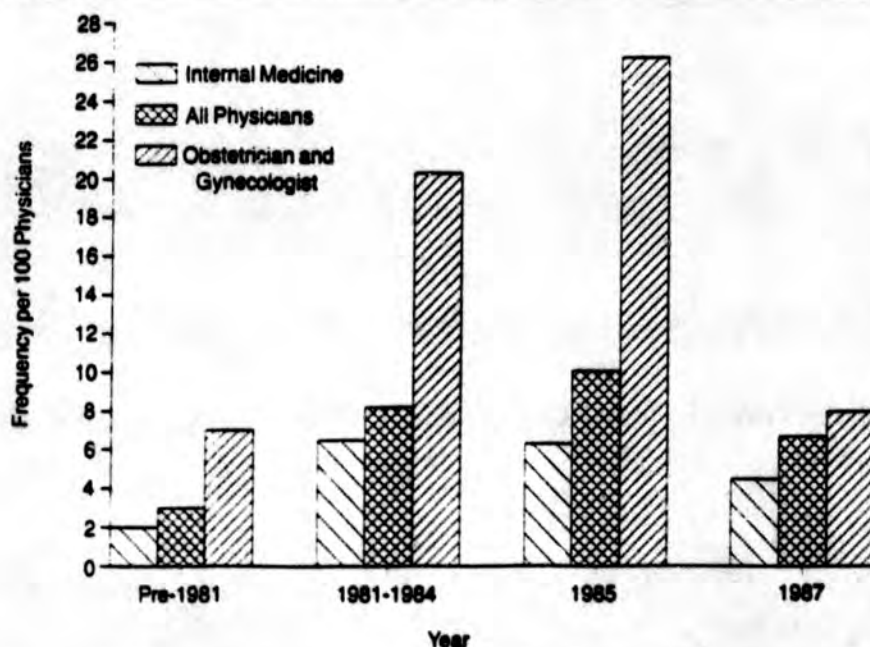


Fig 1.—Malpractice claim frequency. Data from the American Medical Association, Socioeconomic Monitoring System.

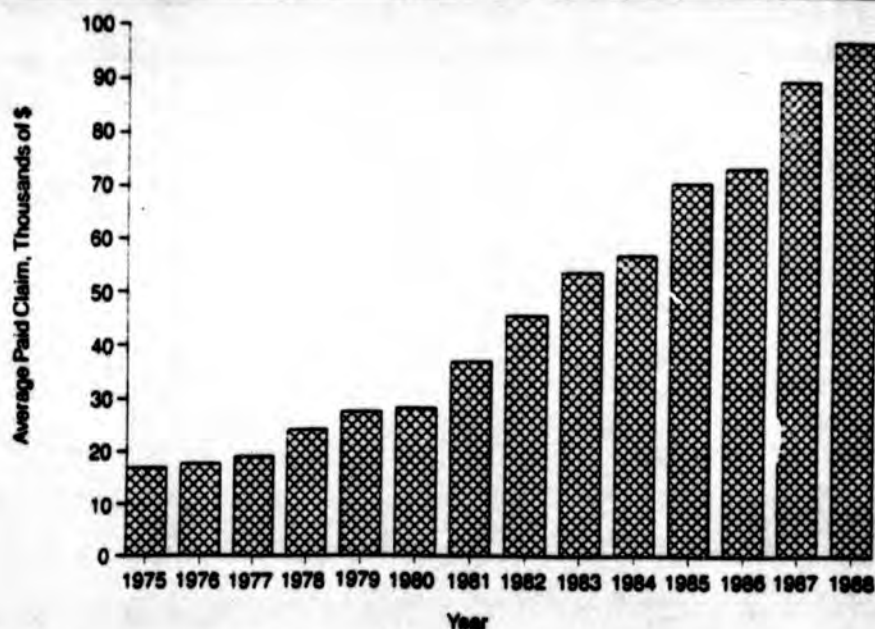


Fig 2.—Trends in medical malpractice paid claims. Data from the St Paul (Minn) Fire and Marine Insurance Company.

verdict in two jurisdictions was compared during two time periods, 1975 to 1979 and 1980 to 1984, showing a threefold rise in San Francisco, Calif, and a fivefold rise in Cook County, Illinois. Likewise, Nye et al¹ found that between 1975 and 1986 inflation-adjusted mean paid claims rose fivefold, while inflation-adjusted median paid claims rose nearly threefold. Average yearly increases reflect these trends.² In real terms, Nye et al¹ found that the average cost of a paid claim in Florida increased at a compound rate of 7.6% per year from 1975 to 1986.

Even with fewer claims, neither median nor average awards have yet declined, although the steep rise in average awards seems to have moderated. Thus, recent malpractice insurance premium reductions appear to result from declining total paid claim dollars rather than from declining median or average awards. Despite a reduced claim-filing rate, the average award paid by St Paul (Minn) Fire and Marine Insurance Company (a major underwriter of medical malpractice insurance) increased by 16% from 1986 to 1987 and by 6% from 1987 to 1988.³ As with the decline in claim frequency, it is too soon to determine whether continuing tort reforms will ultimately result in reduced median and average awards, although local variations may result in greater reductions in certain areas.

The award severity data reflect a skewed distribution, attributable to an increase in large outlier awards. In the 1980s, million-dollar awards accounted for a disproportionate share of tort indemnity awards generally, and of medical malpractice awards in particular.^{1,4,5,27} Recent data, however, suggest that the frequency of million-dollar awards has declined. If this trend continues, average award severity may also decline.

It seems likely that birth-injury cases have an inordinate effect on malpractice statistics. In 1984, according to the General Accounting Office,¹ obstetricians accounted for 10% of total claims, but 27% of total indemnity. The St Paul Fire and Marine Insurance Company²⁸ reports that birth-related injuries have replaced anesthesia-related injuries as the most

costly claims. One study of California claims²⁹ found that by excluding birth-injury cases, average indemnity of reported large losses (verdicts and settlements of more than \$50 000) would have declined by 23% from 1983 to 1986.

Finally, most claims are settled without any payment and defendants win most of the litigated cases. A recent survey in three largely rural states reported that the defense prevailed in 81% of the litigated cases.³⁰ Data from the 1987 American College of Obstetricians and Gynecologists survey³¹ indicate that defendants won 68% of all claims adjudicated by arbitration or jury verdict, although this was down from 81% reported in the 1985 American College of Obstetricians and Gynecologists survey.³² At least in urban areas, however, plaintiffs may be winning a higher percentage of medical malpractice verdicts than 20 years ago. Peterson²⁷ reports that plaintiffs' victories in medical malpractice cases increased during a 20-year period from 27% to 53% in San Francisco, Calif, and from 25% to 49% in Cook County. This is consistent with other findings showing that urbanization is an important predictor of award severity.^{3,33}

Data Constraints

In evaluating these data, some important limitations must be considered. Aside from major gaps in available data, the reported data cannot be compared easily. Each data-reporting system uses a different standard for defining the principal allegations of negligence, and each system uses different assumptions and numerical bases for data reporting. Some report data from all claims and expenses (ie, defense costs), including settlements and those in which no indemnity was paid. Others report averages only on a claims-paid basis or by looking at nonzero jury awards alone. Because many of the claims filed result in no indemnity payments, how those are incorporated into the figures makes a major difference in the apparent scope of the problem.

One result of these different approaches is that estimates of average verdicts vary widely (Fig 3), and statements about averages need to be scrutinized. As an example, Jury Verdict

Research¹² reports that the annual average medical malpractice verdict rose from approximately \$400 000 in 1980 to \$1.4 million in 1986. Since this report only includes averages for initial jury verdicts (unadjusted for posttrial reductions), it provides a misleading picture in view of indications that large jury awards are often substantially reduced in posttrial proceedings. In medical malpractice cases, for instance, Shanley and Peterson¹³ found an average posttrial reduction of 33%. They also found that reductions were disproportionate to large awards, with medical malpractice awards between \$1 million and \$10 million reduced by an average of 39%. Broder¹⁴ found similar reductions. Thus, if the data regarding award severity disregard the effects of posttrial reductions, the averages misstate the dimension, although not the seriousness, of the medical malpractice problem.

Given the rise in health care costs over an equivalent period, it is not surprising that jury verdicts are higher. The soaring economic cost for treating permanent and total disabilities is no doubt a factor in many of these large verdicts. General rising salaries may also account for some portion of larger economic losses (*New York Times*, January 31, 1988:sect 3:2). This raises the question of what proportion of these large verdicts is for noneconomic damages. If most of a large verdict is for injury severity, as expressed through economic damages, and liability is accurately assessed over a range of cases, the rise in award severity may be a function of factors beyond control of the tort system. Unfortunately, the data are inconclusive on this issue, and further research is needed to isolate the effects of noneconomic damages on increased award severity relative to economic loss.¹⁴

LEGAL TRENDS

The rise in claim frequency and award severity has occurred during a period of continued advances and improvements in medical care. It thus seems unlikely that a general deterioration in medical practice standards accounts for these trends. Nor is there any reason to believe that individual physicians are less skillful today than they were 20 years ago.^{15,16}

What factors, then, account for the trends described previously? Whatever external factors may also be involved, such as increases in medical costs, it is appropriate to analyze changes in the tort system during the past two decades. Have standards for assessing liability changed so that physicians are now held to higher practice standards? Are courts and juries confusing adverse outcomes with physician error? If not, what other explanation might be explored? The following sections evaluate various hypotheses that link the rise in award severity to changes within the tort system.

Are Physicians Now Held to Higher Practice Standards?

One hypothesis often used to explain trends in medical malpractice liability is that courts and juries are holding physicians to higher liability standards, amounting to strict liability, instead of the traditional fault-based negligence standard of care. If this hypothesis were true, it could certainly explain much of the increase in claim frequency and award severity, as well as suggesting reasonable solutions.

In *strict liability*, a physician could be held liable for adverse outcomes regardless of fault. For a plaintiff to recover in *negligence*, he or she must show that the physician was at fault by failing to maintain the customary standard of care owed to the patient. *Customary care* is typically defined as the degree of care and skill ordinarily used under similar circumstances by members of the profession. In medical malpractice, the applicable standard of care is established by the medical profession itself through expert medical testimony.¹⁷

Little evidence exists in the reported cases to confirm the strict liability hypothesis. In fact, a perusal of numerous medical malpractice cases decided within the past 20 years indicates considerable stability in the general common-law rules. The standard of liability remains what it has always been; a fault-based determination of whether the physician maintained the applicable standard of care.

Technological Change.—A possible explanation for the perception of strict liability is that although the standard of

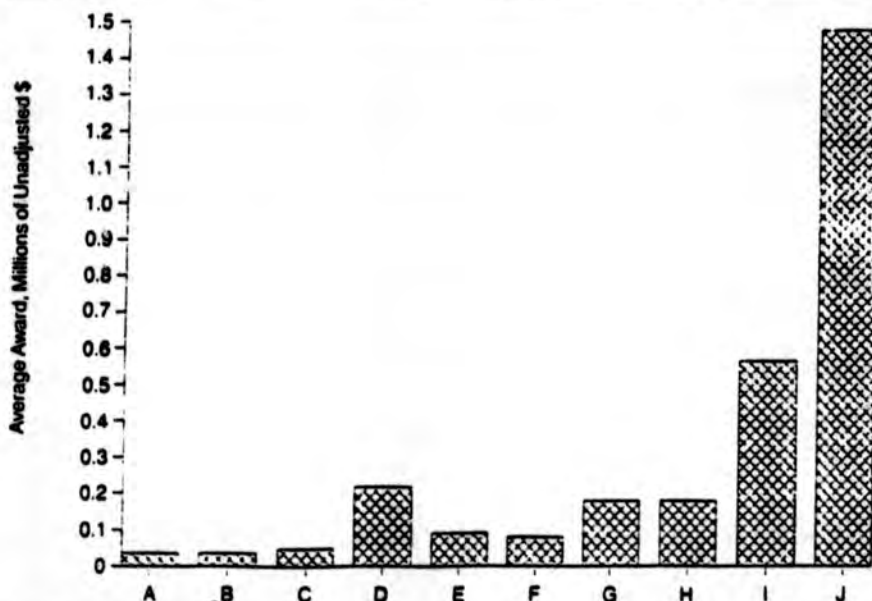


Fig 3.—Ways of computing average awards. A indicates St Paul, Minn, 1986, all claims; B, General Accounting Office (GAO) 1984, paid obstetrician and gynecologist; C, St Paul 1981 to 1985, paid obstetrician and gynecologist; D, GAO 1984, paid obstetrician and gynecologist; E, St Paul 1985, average paid losses; F, GAO 1984, paid claims; G, American College of Obstetricians and Gynecologists 1985, average claim; H, all California 1980 to 1984, expected award; I, San Francisco, Calif, and Chicago, Ill, 1980 to 1984, expected award; and J, Jury Verdicts Research 1986, verdict only.

care has not changed, how it operates in practice and what is necessary to meet the standard may have shifted over time. In large part, this change in how the standard operates is driven by advances in technology, improvements and changes in medical practice, and changes in legal organization and practice. As technology changes, medical standards change, and what constitutes a minimum standard of care also changes. Although difficult to quantify, it is likely that the introduction of new technology has raised what is considered to be customary care to much higher levels, giving the appearance of meeting a higher standard in court.

Along with opportunities for improved health care, technological advances create more opportunities for error, either in diagnosis or treatment, and those errors may result in more visible and more severe adverse outcomes. The availability of new technology is a particular problem for obstetric and gynecologic practice because much of it is controversial and may not add to improved health care,^{3,8} while paradoxically contributing to a higher operating standard of care. Some technologies, such as genetic testing, electronic fetal monitors, and ultrasonography, carry the risk of increased liability either through failure to use in certain situations or for improperly interpreting the results.^{3,8} Technological advances may have also helped to create an environment of perhaps unrealistic patient expectations that every neonate (or indeed any medical outcome) will be perfect. The ability to save a severely injured low-birth-weight infant, when that same infant would not have survived 20 years ago, carries with it the potential for litigation that blames the obstetrician for the injuries.

Expert Testimony.—In addition, with the demise of the locality rule, which virtually limited testimony to the standard of care in the defendant's practice area, plaintiffs have access to a wider array of previously unavailable testimony from experts outside the local area. This moves the changing standard down to the practitioner much faster, particularly since out-of-state or academic experts may practice a different, that is, higher standard of care than practiced locally. However, this does not mean that a *de facto* strict liability standard has replaced the negligence standard. The question is how quickly these changes should be adopted by the average practitioner at a time when changes occur very rapidly.

Defensive Medicine.—Another possible explanation for the perception of a higher standard of care is that the familiar problem of defensive medicine also operates to raise the standard of care. To the extent that physicians order additional tests as protection against subsequent liability, the added tests become part of the changing standard of care. This may, however, be as much a reaction to new practice standards as a cause of them. It is also difficult to distinguish defensive practices from those that are beneficial and would have occurred anyway,^{3,8} and there appear to be no data that link them to increased claim frequency or award severity.

Jury Generosity

A second hypothesis is that "jury generosity" is a major reason for these trends. To be sure, it is possible that juries systematically confuse adverse outcomes with substandard care, disregard judicial instructions, and hold "deep pocket" defendants to a higher standard of care, or even confound the notion of liability with damages.⁴⁰ Individual juries may hold

defendants in medical malpractice cases to a higher standard of conduct than would be applicable to an individual defendant. More broadly, critics of the tort liability system often allege that juries may view themselves as an instrumentality for redistributing wealth.

However, since there is very little systematic evidence regarding jury behavior, it is speculative to blame juries for not following the law when defendants win most of the litigated cases. Indeed, Danzon⁴ concluded that available data refuted the assertion that juries disregard fault when assessing liability, and judges have the authority to overrule juries that clearly disregard either the evidence or the judge's instructions.⁴¹ No doubt, some courts and juries assess liability incorrectly, but it has not been shown that courts or juries systematically assess liability improperly or impose an improper standard of care on physicians.

When evaluating jury behavior in medical malpractice cases, two interrelated issues should be considered. The absence of definitive research on appropriate outcomes from medical procedures (that is, the distribution of outcomes that can reasonably be expected from medical intervention) makes it difficult to establish whether the outcome in any given situation results from inappropriate care (negligence) or bad luck.⁴² Confounding this problem is the equally difficult issue, particularly in birth-injury cases, of attributing an adverse outcome to a particular cause. Scientific notions of causation (established through probabilistic reasoning) are very different from the legal determination of proximate cause and can be difficult to reconcile in an individual case.

While a detailed discussion of the causation issue is beyond the scope of this article, one example might illustrate the problem. According to epidemiologic research, the incidence of newborns who have cerebral palsy has remained stable at anywhere from 1.3 to 2.7 per 1000 live births.⁴³ However, the etiologic factors that lead to cerebral palsy are not well understood and can rarely be predicted on the basis of perinatal events.⁴⁴ It is thus difficult to attribute an outcome of cerebral palsy to a preventable perinatal event or, in other words, to observed substandard medical care.⁴⁵ Nonetheless, a jury must decide what happened to an individual victim during the birthing process (based on the best available scientific evidence), hardly an easy task.

Juries may well be more sympathetic to a severely injured newborn in attributing causation to physician error,⁴⁶ but there is insufficient empirical or case support for that conclusion.⁴⁷ A review of reported obstetric and gynecologic cases is inconclusive on this point, and insurance company data are not available to confirm or refute this. Once again, the legal rule itself seems to be stable over time⁴⁸; whether it operates differently in practice is harder to determine from the reported cases.

For example, it is possible that reduced standards of evidence make it easier for plaintiffs to show a causal connection, or that the availability of expert testimony allows "causation" cases to go forward. Perhaps a greater percentage of causation cases are now reaching the courts, resulting in larger verdicts. A researchable hypothesis, for example, is that courts are seeing different types of cases, raising more difficult notions of causation, than those that were presented 20 years ago. If so, the trends described previously may be a function of judging a different class of issues rather than the unpredictability or randomness of jury verdicts.

Substantive Changes in the Law

Despite the previous discussion, the law has not remained static during the past 20 years; far from it. A third hypothesis is that there have been considerable proplaintiff substantive changes in the law that may affect claim frequency and award severity. Many changes have indeed been proplaintiff, such as the abolition of the locality rule, abolition of charitable immunity, expansion of informed consent, and expansion of *respondeat superior* (that is, employer liability for employee wrongdoing).

Proplaintiff Reforms.—One of the unanswered empirical questions is the extent to which each change has contributed to changes in aggregate tort liability awards. Danzon⁸ found statistically significant effects on claim frequency and award severity in jurisdictions that adopted the four proplaintiff doctrines listed previously, but the effects peaked in 1976 and then declined. In an analysis of data from the American Medical Association, Adams and Zuckerman⁹ found that none of these doctrines had a statistically significant effect on claim frequency. Although the doctrine of informed consent in particular has generated considerable critical commentary and attention, it does not appear to have had a significant impact on award severity. The study by Adams and Zuckerman⁹ indicates that informed consent had a statistically significant relationship to increased claim frequency between 1976 and 1981, but their study did not address award severity. Danzon,⁸ however, found the effects of informed consent to be larger on claim frequency than on award severity. If so, this may add to the transaction costs of defending such cases (hence, increasing aggregate costs for insurers), but may not add that much to average award severity.

In view of these findings, it is unlikely that the proplaintiff changes are a major cause of the current malpractice crisis, although they may contribute to the rising percentage of plaintiffs' victories.¹⁰ To be sure, these changes could also contribute to larger aggregate payouts if more claims are successful, even those of modest value.

Prodefendant Reforms.—In reaction to the proplaintiff reforms, a "counterreformation" set in during the mid-1970s (and continued into the 1980s) as several prodefendant tort reforms were enacted. These included caps on noneconomic damages, mandatory collateral offset (that is, any award is net of other benefits), shorter statutes of limitation (the time period in which litigation must be initiated), and the use of arbitration panels. These reforms apparently have reduced award severity from levels they otherwise might have reached.¹¹ While the long-term effects of state tort reform efforts are still not fully known,¹² recent evidence suggests that the counterreformation is introducing greater stability and predictability on average. Over time, tort reforms are likely at least to limit the rate of increase in award severity and claim frequency. These reforms will perhaps reduce average or median awards, but will not reduce the underlying rate of medical malpractice incidents.

Liability Expansions.—Finally, the types of cases in which liability might be determined have expanded during the past two decades. One example is the ability to recover emotional damages without showing a physical impact (although not adopted in all jurisdictions). Another example is recovery for loss of a chance of survival. Where the alleged medical malpractice reduces a chance of survival to an even

lower probability, the injured victim may recover to the extent the malpractice reduced the chances of survival. For two reasons, however, this is unlikely to have a major effect on aggregate trends: first, the doctrine is not accepted in all jurisdictions; and second, awards are not likely to be large in any event because recovery is limited to damages that directly result from the premature death, such as lost earnings and additional medical expenses.^{13,14}

An area of new liability that may be extremely troublesome to obstetricians and gynecologists is the tort of wrongful life or wrongful birth. Most jurisdictions deny liability for wrongful life (that is, a claim for damages brought by an impaired child's parents who allege that but for defendant's negligence the child never would have been born), but a growing number of jurisdictions allow recovery for wrongful birth (which is the parents' claim for damages that result from a prenatally detectable severe birth defect).^{15,16} As discussed previously, the technological ability to save infants, albeit in imperfect condition, who would not have survived 20 years ago carries with it the potential for extensive liability awards. Genetic screening tests, although not now a liability problem, also have the potential for large indemnity awards if erroneous test results are imputed to physician error.

At the same time, there are indications that courts are beginning to restrain further expansions. Recent cases in New York, have denied separate compensation for loss of enjoyment of life by an unconscious medical malpractice plaintiff. Such rulings may not reduce current award levels, but they may place upper bounds on aggregate award severity.

Changes in Procedural Rules

Beyond these changes in substantive law, there have been significant procedural changes (that is, the rules of evidence that govern how trials are conducted) that may also affect trial outcomes. Little is known empirically about the relationship between procedural changes and trial outcomes, but it is reasonable to expect that procedural changes can affect both claim frequency and award severity. By the mid-1970s, most state courts had adopted the more flexible federal rules of discovery and federal rules of evidence. These rules allow plaintiffs' lawyers greater opportunities for pretrial discovery and, hence, an expanded ability to discover and introduce into evidence factors that may either prove liability or increase a case's monetary value. In addition, courts have come to rely more heavily on expert witnesses, particularly economists, to estimate future health care costs. With access to a wider array of previously unavailable expert testimony, plaintiffs are able to present stronger cases and damage estimates to juries.¹⁷ Such changes operate to facilitate the plaintiffs' burden of proof and allow any number of cases, which otherwise might not have gone very far, to achieve a positive settlement or to be decided by a jury.

The use and importance of expert witnesses is an aspect of medical malpractice litigation in need of further research. Like other procedural changes, the changing use and reliance on expert witnesses may be an important determinant of large awards, particularly in estimating future health care costs of neurologically impaired infants.

Changes in Legal Practice

An additional explanation for the data trends is that changes in the organization and practice of law may influence

jury behavior²⁷ and certainly influence the types of cases brought to trial. Lawyers' courtroom presentations and tactics may be more sophisticated (shared information, better pretrial discovery, expert witnesses), so that their trial presentation is more convincing. For example, the use of videotapes and other litigation tools that show a day in the life of an injured patient enables a plaintiff's attorney to present a case more graphically to the jury than before.²⁸ Juries may also be hearing stronger cases since lawyers may be more selective in cases taken to a jury.

This further suggests that there has been an important shift during the past 20 years in the balance between plaintiff and defense attorneys. Just as the practice of medicine has become increasingly specialized, so has the practice of law, mirroring trends throughout society (*New York Times*, September 9, 1988; sect A:19). In all probability, greater specialization permits larger capital investment in malpractice cases, sharing of knowledge and training with other specialists, and better preparation for litigation. Access to computer databases and institutional support mechanisms increases the likelihood of litigating the "right" cases for substantial awards. One consequence of this is to provide greater access to the tort system for injured patients (at least for those cases where the expected value exceeds the costs of litigation).

Ongoing changes in the organization and practice of law are not likely to affect outcomes to the same extent as changes in legal doctrine or procedure, but they can affect what types of cases reach a jury and how a jury might respond. More research is necessary to determine the extent to which these organizational and practice changes have affected trial outcomes.²⁹ When taken together, however, these changes provide a clearer picture of the legal system's role in explaining recent trends.

PUBLIC POLICY RESPONSES

If changes in the tort system over time are inadequate to explain fully the rise in claim frequency and award severity, then tort reform alone is unlikely to solve the malpractice problems faced by physicians. Indeed, focusing exclusively on tort reform is likely to obscure the inherent complexity underlying the malpractice conundrum and the need to develop broader approaches for ameliorating the problem.

At a time when demands for changing the tort system are increasingly articulated, the empirical basis for making sound policy decisions is inadequate. Nonetheless, it is quite possible, if not likely, that demands for change will not wait for the extensive research needs cited previously. Assuming that recent reductions in malpractice premiums provide a "window of opportunity" for further debate, several measures can be taken to better inform the policy process, regardless of what mechanism is used to resolve medical practice disputes.

First, and most important, the medical profession should expand work that has already begun to define what constitutes appropriate medical intervention and what the appropriate outcomes are from medical intervention.³⁰ Defining the range and probabilities of appropriate outcomes will provide a sounder basis for juries to differentiate between adverse outcomes from the natural course of disease and substandard medical care. In conjunction with appropriateness standards, the medical profession should also expand the use of medical practice protocols similar to the one developed for anesthesiology.³¹

Second, to the extent that the problem begins with substandard practice, the burden is on the medical profession to reduce the incidence of negligent iatrogenic injury.^{32,33} The medical profession should continue to improve its sanctioning and risk-management and loss-prevention mechanisms. In the past, these have not been used effectively, and substandard medical practice has often not been punished.³⁴ As a result, the tort system has imposed certain social controls as a deterrent to substandard medical care. The burden should be shifted back to the medical profession to reduce injury costs through effective monitoring and sanctions. An important research question is the extent to which these self-policing mechanisms operate to reduce injury and litigation costs.

To assist the medical profession, states need to enact legislation that insulates peer review activity from liability except in cases that involve gross negligence or recklessness. In conjunction with the Health Care Quality Improvement Act of 1986, such legislation should provide sufficient protection to encourage active peer review.

Third, policymakers should consider whether cases that involve probabilistic causation, such as with neurologically impaired infants, should be removed from the tort system and resolved under a separate compensation mechanism similar to vaccine injuries. In cases where medical intervention is less likely to alter observed outcomes, such as cerebral palsy, it may be appropriate to spread the risk of birth injury through a separate compensation fund rather than trying to reconcile probabilistic and legal causation in an individual case. This would address a difficult problem facing physicians without undermining the tort system's general deterrence value. As the Virginia legislation dealing with neurologically impaired infants suggests, however, this is not an easy task.

Fourth, in conjunction with the previously mentioned measures, malpractice data need to be collected and arrayed in a more consistent and comprehensive manner to avoid comparability problems and to provide better information for injury prevention. In particular, insurance companies should take the lead in reporting disaggregated data by primary allegation (such as specific birth injury) and alleged treatment error (such as what caused a missed diagnosis). This would allow aggregate trends to be broken down into more discrete injury categories for closer evaluation. While initially more expensive, doing so should assist in reducing injury costs. Insurers should also report median awards and settlements (because they are more representative of the expected result than average awards),³⁵ and all claims (including claims with no payment and verdicts for the defense) as adjusted for post-trial reductions and increases in medical care costs.

CONCLUSION

As is so often the case when commenting on medical malpractice problems, more questions have been raised than answered. No single explanation of the medical professional liability crisis is likely to answer all questions. Changes in the tort system over time may help explain some of the reasons for increased claim frequency and award severity and may clarify the policy options for reforming the tort system. Tort reform by itself, however, is unlikely to be a panacea without an invigorated response from the medical profession. In the absence of effective sanctions from the medical profession, the tort system is likely to remain the dominant mechanism for monitoring injury prevention.

At best, the tort system is an imperfect instrument for allocating risk and resolving medical practice disputes between physician and patient. No-fault and other alternative compensation systems are promising reforms, but whether they are superior alternatives to the tort system remains to be demonstrated.

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References

1. Medical Malpractice: Characteristics of Claims Closed in 1984. Washington, DC: General Accounting Office; 1987. Publication GAO/HRD-87-55.
2. Report of the Task Force on Medical Liability and Malpractice. Washington, DC: Dept of Health and Human Services; 1987.
3. The Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability. Washington, DC: Dept of Justice; 1986.
4. Bovbjerg RR, Havighurst CC, eds. Medical malpractice: can the private sector find relief? *Law Contemporary Problems*. 1986;49:1-348.
5. American Medical Association and Specialty Society Medical Liability Project. A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based Administrative System. Chicago, Ill: American Medical Association; 1986.
6. Nye DJ, Gifford DG, Webb BL, Dewar MA. The causes of the medical malpractice crisis: an analysis of claims data and insurance company finances. *Georgetown Law J*. 1988;76:1485-1561.
7. Reynolds RA, Rizzo JA, Gornes ML. The cost of medical professional liability. *JAMA*. 1987;257:2776-2781.
8. Danson PM. *Medical Malpractice: Theory, Evidence and Public Policy*. Cambridge, Mass: Harvard University Press; 1986.
9. The Medical Malpractice Crisis in Obstetrics: The Economic, Medical and Health Policy Implications. Cambridge, Mass: Harvard University; 1987.
10. Cheney FW, Poerner K, Caplan RA, Ward RJ. Standard of care and anesthesia liability. *JAMA*. 1989;261:1599-1608.
11. Abraham KS. Medical liability reform: a conceptual framework. *JAMA*. 1988;260:68-72.
12. Bovbjerg RR. Medical malpractice on trial: quality of care is the important standard. *Law Contemporary Problems*. 1986;49:321-348.
13. Danson PM. *The Disposition of Medical Malpractice Claims*. Santa Monica, Calif: The RAND Corp; 1990. Publication R-3822-RCFA.
14. Broder I. *Analysis of Million Dollar Verdicts*. Washington, DC: American Trial Lawyers Association; 1986.
15. Rolph JE. Some statistical evidence on merit rating in medical malpractice insurance. *J Risk Insurance*. 1981;48:247-300.
16. Physicians' & Surgeons' Update, 1988. St Paul, Minn: St Paul Fire & Marine Insurance Co; 1988.
17. Mills DH. Medical insurance feasibility study. *West J Med*. 1978;128:300-308.
18. Meyers AR. 'Lumping it': the hidden denominator of the medical malpractice crisis. *Am J Public Health*. 1987;77:1544-1548.
19. Abul RL. The crisis in injuries, not liability. In: Olson W, ed. *New Directions in Liability Law*. New York, NY: Academy of Political Science; 1988:31-41.
20. Physicians' & Surgeons' Update, 1985. St Paul, Minn: St Paul Fire & Marine Insurance Co; 1985.
21. Adams EK, Zuckerman S. Variation in the growth and incidence of medical malpractice claims. *J Health Polit Policy Law*. 1984;9:475-488.
22. Neupauer R. 1987 California Large Loss Trend Study/Malpractice. Oakland: Medical Underwriters of California; 1988.
23. Professional Liability Insurance and its Effects: Report of a 1987 Survey of ACOG's Membership. Washington, DC: Opinion Research Corp; 1988.
24. Hatch MA. *Medical Malpractice Claim Study: 1982-1987*. St Paul: Minnesota Dept of Commerce; 1989.
25. Physicians' & Surgeons' Update, 1989. St Paul, Minn: St Paul Fire & Marine Insurance Co; 1989.
26. Shanley MG, Peterson MA. *Posttrial Adjustments to Jury Awards*. Santa Monica, Calif: The RAND Corp; 1987. Publication R-3511-ICJ.
27. Peterson MA. *Civil Justice in the 1980s: Trends in Jury Trials and Verdicts in California and Cook County, Illinois*. Santa Monica, Calif: The RAND Corp; 1987. Publication R-3486-ICJ.
28. Kakalik JB, Pace NM. *Costs and Compensation Paid in Tort Litigation*. Santa Monica, Calif: The RAND Corp; 1986. Publication R-3391-ICJ.
29. Neupauer R. 1986 California Large Loss Trend Study/Malpractice. Oakland: Medical Underwriters of California; 1987.
30. Needham, Porter, Novelli. *Professional Liability Insurance and its Effect: Report of a Survey of ACOG's Membership*. Washington, DC; 1986.
31. Danson PM. *New Evidence on the Frequency and Severity of Medical Malpractice Claims*. Santa Monica, Calif: The RAND Corp; 1986. Publication R-3410-ICJ.
32. *Current Award Trends, 1988 Edition*. Solon, Ohio: Jury Verdict Research; 1988.
33. Brook RH, Brutoos RL, Williams KN. The relationship between medical malpractice and quality of care. *Duke Law J*. 1975;1179-1231.
34. Prosser WL. *Handbook of the Law of Torts*. 4th ed. St Paul, Minn: West Publishing Co; 1971.
35. Dobson T. Medical malpractice in the birthplace: resolving the physician-patient conflict through informed consent, standard of care, and assumption of risk. *Nebraska Law Rev*. 1989;65:651-685.
36. Glick MG. Electronic fetal monitoring: physician liability and informed consent. *Am J Law Med*. 1984;10:31-40.
37. Heland KV. The professional liability crisis in obstetrics: can the causes suggest solutions? *Quality Rev Bull*. 1986(special issue):12-19.
38. *Walker v United States*, 600 F Supp 195 (D DC 1985).
39. Zuckerman S. Medical malpractice: claims, legal costs, and the practice of defensive medicine. *Health Aff*. 1984;3:122-132.
40. MacCoun RJ. *Getting Inside the Black Box: Toward a Better Understanding of Civil Jury Behavior*. Santa Monica, Calif: The RAND Corp; 1987. Publication R-3571-ICJ.
41. *Rutherford v Zoroff*, 272 SE2d 225 (Va 1980).
42. Williams AP. *Malpractice, Outcomes, and Appropriateness of Care*. Santa Monica, Calif: The RAND Corp; 1988. Publication P-7445.
43. Sokol RJ. Perinatal risk and cerebral palsy. *JAMA*. 1984;251:1988-1989.
44. Nelson KB, Ellenbogen JH. Obstetric complications as risk factors for cerebral palsy or seizure disorders. *JAMA*. 1984;251:1848-1849.
45. Kitchen WH, Doyle LW, Ford GW, Richards AL, Lissenden JV, Ryan MM. Cerebral palsy in very low birth weight infants surviving to 2 years with modern perinatal intensive care. *Am J Perinatol*. 1987;4:29-36.
46. Niswander K, Elbourne D, Radman C, et al. Adverse outcome of pregnancy and the quality of obstetric care. *Lancet*. 1984;2:827-831.
47. *Hippocratus Mortar v 73rd Corp*, 470 NY2d 792 (NY Ct App 1984).
48. *Seattle First National Bank v Rankin*, 567 P2d 885 (Wash 1982).
49. *Long v Johnson*, 381 NE2d 98 (Ind 1978).
50. *Carter v Shirley*, 488 NE2d 16 (Mass 1985).
51. Danson PM. *The Frequency and Severity of Medical Malpractice Claims*. Santa Monica, Calif: The RAND Corp; 1986. Publication R-3570-ICJ/RCFA.
52. Carroll SJ. *Assessing the Effects of Tort Reform*. Santa Monica, Calif: The RAND Corp; 1987. Publication R-3554-ICJ.
53. *Herskovits v Group Health*, 664 P2d 474 (Wash 1983).
54. King JH. Causation, valuation, and chance in personal injury torts involving preexisting conditions and future consequences. *Yale Law J*. 1981;90:1353-1397.
55. Louisell DW, Williams H. *Medical Malpractice*. New York, NY: Matthew Bender & Co Inc; 1982.
56. *Trevino v United States*, 804 F2d 1512 (9th Cir 1986).
57. *Enos v Wilson*, 519 So2d 1244 (Ala 1987).
58. Eichhorn JH, Cooper JB, Cullen DJ, Meier WR, Phillip JH, Seaman RG. Standards for patient monitoring during anesthesia at Harvard Medical School. *JAMA*. 1986;256:1017-1020.
59. Julian TM, Brooker DC, Butler JE et al. Investigation of obstetric malpractice closed claims: profile of event. *Am J Perinatol*. 1985;2:320-324.
60. Dubois RW, Brook RH. Preventable deaths: who, how often, and why? *Ann Intern Med*. 1982;109:582-589.
61. Kussnerow RP, Handley EA, Yessan MR. An overview of state medical discipline. *JAMA*. 1987;257:230-234.
62. *Medical Malpractice: A Framework for Action*. Washington, DC: General Accounting Office; 1987. Publication GAO/HRD-87-78.
63. Localio AR. Variations on 8002 238: the misuse of data on medical malpractice. *Law Med Health Care*. 1985;13:126-127.

THE ALASKA SUPREME COURT SYSTEM

THEIR RULES, EFFECTS, AND COSTS

TO THE GENERAL PUBLIC

PREPARED BY

A.L. TAMAGNI SR.

PENSION SERVICES LTD.

The Purpose of this report is to review from the Alaska Constitution, how efficiently, fairly and effectively the Supreme Court operates its systems. What public process is imputed into it's rule making for Civil Rules, Rules of the Court, and Alaska Bar Association rules.

The effect of it's rules regarding the costs to society, the costs of backlog cases, and the comparison of equal treatment of criminal cases vs civil cases.

We will also review some major studies and survey's that have been conducted regarding the Federal Civil Justice system and how many of their suggested changes may have a beneficial effect on the Alaska Court system, which is operated by the Alaska Supreme Court.

RULE 82 AND PREJUDGMENT INTEREST

Prejudgment Interest is statutorily set at 10.5% and is effective from the date of filing a legal court action. The purpose of this outline is to demonstrate the accruing interest and case cost when cases lag in the Judicial system. Then the application of Rules 82 Attorney fees. We have averaged current Rule 82 to be at an average rate of 10% of the recovery. (SEE Exhibit A)

CASE FACTORS

Prejudgment Interest = 10.5% simple

FINAL SETTLEMENT = \$400.000

RULE 82 = 10%

<u>YEAR</u>	<u>AMOUNT</u>	<u>P.J. INT</u>	<u>TOTAL RECOVERY</u>	<u>RULE 82</u>	<u>TOTAL</u>
1	\$400,000	\$ 42,000	\$442,000	\$44,200	\$486,200
2	\$400,000	\$ 84,000	\$484,000	\$48,400	\$532,400
3	\$400,000	\$126,000	\$526,000	\$52,600	\$578,600
4	\$400,000	\$168,000	\$568,000	\$56,800	\$624,800
5	\$400,000	\$210,000	\$610,000	\$61,000	\$671,000
6	\$400,000	\$252,000	\$652,000	\$65,200	\$717,200
7	\$400,000	\$294,000	\$694,000	\$69,400	\$763,400
8	\$400,000	\$336,000	\$736,000	\$73,600	\$815,800
9	\$400,000	\$378,000	\$778,000	\$77,800	\$855,800
10	\$400,000	\$420,000	\$820,000	\$82,000	\$902,000

ATTORNEY FEE CALCULATION
ALASKA BAR RULE 35

SEE Exhibit B

Contingency fee = 40% of Recovery
Year Recovered = Year 4 from previous chart
Costs and Expenses = \$50,000
This calculation is assuming costs and expenses are not deducted prior to contingency fee calculation.

1. Amount of Recovery = \$624,800
2. 40% Contingency = \$249,920
3. Less costs and expenses = \$ 50,000
4. Net to Client = \$324,880
5. % to Attorney = 47.95%
6. % to Client = 52.05%

The following is the same outline as above except costs are subtracted before the contingency fee:

1. Amount of Recovery = \$624,800
2. Less costs and expenses = \$ 50,000
3. 40% Contingency fee = \$229,920
4. Net to Client = \$344,880
5. % to Attorney = 44.81%
6. % to Client = 55.19%

The Question of Rule 82 Attorney fees and whether they should be part of the recovery upon which the Attorney's contingency fee is based, needs to be clarified either by statute or Rule. The purpose of Rule 82 is to partially reimburse the prevailing party for his Attorney costs. Thus if Rule 82 were not allowed as a part of the recovery and using the previous assumptions, The following would be in order. We have also assumed costs would be deducted before the contingency fee is calculated:

1. Amount of Recovery	= \$624,000
2. Less costs and expenses	= \$ 50,000
3. Less Rule 82 fees	= \$ 56,800
4. 40% Contingency fee	= \$206,880
5. Net to Client	= \$423,920
6. % to Attorney	= 32.07%
7. % to Client	= 67.93%

These are a few elements that should be reviewed as to fairness. Costs effectiveness, and efficiency of the legal delivery system.

I

THE ALASKA CONSTITUTION

Their are parts of the Alaska Constitution that are a part of this review. That will be outlined and critique rendered as how they are being applied and recommendations that may be effected for their benefit to the General public under a Democratic process.

II

A

ARTICLE I

DECLARATION OF RIGHTS

SECTION 1 - INHERENT RIGHTS.

This constitution is dedicated to the principles that all persons have a natural right to life, liberty, the pursuit of happiness, and the enjoyment of the rewards of their own industry; that all persons are equal and entitled to equal rights, opportunities, and protection under the law; and that all persons have corresponding obligations to the people and to the State.

B

SECTION 2 - SOURCE OF GOVERNMENT.

All political power is inherent in the people. All government originates with the people, is founded upon their will only, and is instituted solely for the good of the people as a whole.

C

SECTION 7 - DUE PROCESS.

No person shall be deprived of life, liberty, or property, without due process of law. The right of all persons to fair and just treatment in the course of legislative and executive investigations shall not be infringed.

D

SECTION 11 - RIGHTS OF ACCUSED.

In all criminal prosecutions, the accused shall have the right to a speedy and public trial, by an impartial jury of twelve except that the legislature may provide for a jury of not more than twelve nor less than six in courts not of record. The accused is entitled to be informed of the nature and cause of the accusation; to be released on bail, except for capital offenses when the proof is evident of the presumption great; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the assistance of counsel for his defense.

E

SECTION 15 - PROHIBITED STATE ACTION.

No bill of attainder or ex post facto law shall be passed. No law impairing the obligation of contracts, and no law making any irrevocable grant of special privileges or immunities shall be passed. No conviction shall work corruption of blood or forfeiture of estate.

F

SECTION 16 - CIVIL SUITS; TRIAL BY JURY.

In civil cases where the amount in controversy exceeds two hundred fifty dollars, the right of trial by a jury of twelve is preserved to the same extent as it existed at common law. The legislature may make provision for a verdict by not less than three-fourths of the jury and, in courts not of record, may provide for a jury of not less than twelve.

Comments: The following Exhibits "C" and "D" outline the aging of civil cases in the Anchorage Superior Court.

The committee should determine why civil cases are not processed equally and fairly under the Constitution by the court system keeping in mind the Buildup of Interest Cost and Rule 82 Fees. It would appear that the system is not operating within the scope of its own Civil Rule No 1.

III

ARTICLE IV

THE JUDICIARY

SECTION 1 - JUDICIAL POWER AND JURISDICTION.

The judicial power of the State is vested in a supreme court, a superior court, and the established by the legislature. The jurisdiction of courts shall be prescribed by law. The courts shall constitute a unified judicial system for operation and administration. Judicial districts shall be established by law.

A

SECTION 4 - QUALIFICATIONS OF JUSTICES AND JUDGES.

Supreme court justices and superior court judges shall be citizens of the United States and of the State, licensed to practice law in the State, and possessing any additional qualifications prescribed by law. Judges of other courts shall be selected in a manner, for terms, and with qualifications prescribed by law.

B

SECTION 8 - JUDICIAL COUNCIL.

The judicial council shall consist of seven members. Three attorney members shall be appointed for six-year terms by the governing body of organized state bar. Three non attorney members shall be appointed for six-year terms by the governor subject to confirmation by a majority of the members of the legislature in joint session. Vacancies shall be filled for the unexpired term in like manner. Appointments shall be made with due consideration to area representation and without regard to political affiliation. The chief justice of the supreme court shall be ex-officio the seventh member and chairman of the judicial council. No member of the judicial council, except the chief justice, may hold any other office or position of profit under the United States or the State. The judicial council shall act by concurrence of four or more members and according to rules which it adopts.

C

SECTION 9 - ADDITIONAL DUTIES.

The Judicial council shall conduct studies for improvement of the administration of justice, and make reports and recommendations to the supreme court and to the legislature at intervals of not more than two years. The judicial council shall perform other duties assigned by law.

D

SECTION 10 - COMMISSION ON JUDICIAL CONDUCT.

The Commission on Judicial Conduct shall consist of nine members, as follows: three persons who are justices or judges of state courts, elected by the justices and judges of state courts; three members who have practiced law in this state for ten years, appointed by the governor from nominations made by the governing body of the organized bar and subject to confirmation by a majority of the members of the legislature in joint session; and three persons who are not judges, retired judges, or members of the state bar appointed by the governor and subject to confirmation by a majority of the members of the legislature in joint session. In addition to being subject to impeachment under Section 12 of this article, a justice or judge may be disqualified from acting as such and may be suspended, removed from office, retired, or censured by the supreme court upon the recommendation of the commission. The powers and duties of the commission and the basis for judicial disqualification shall be established by law. [Amendment approved August 27, 1968 - Effective October 11, 1968; Amendment approved November 2, 1982 - Effective December 24, 1982]

E

SECTION 15 - RULE- MAKING POWER.

The supreme court shall make and promulgate rules governing the administration of all courts. It shall make and promulgate rules governing practice and procedure in civil and criminal cases in all courts. These rules may be changed by the legislature by two-thirds vote of the members elected to each house.

F

SECTION 16 - COURT ADMINISTRATION.

The chief justice of the supreme court shall be the administrative head of all courts. He may assign judges from one court or division thereof to another for temporary service. The chief justice shall, with the approval of the supreme court, appoint an administrative director to serve at the pleasure of the supreme court and to supervise the administrative operations of the judicial system. [Amendment approved August 25, 1970 - Effective October 10, 1970]

IV

CIVIL RULE NO 1

PART I. SCOPE OF RULES
CONSTRUCTION - ONE FORM OF
ACTION

RULE 1. Scope of Rules-Construction.

The procedure in the superior court and so far as applicable, in the magistrate courts, shall be governed by these rules in all actions or proceedings of a civil nature - legal, equitable, or otherwise. These rules shall be construed to secure the just, speedy and inexpensive determination of every action and proceeding.

(Adopted by SCO 5 October 9, 1959)

VII

ALASKA RULES OF COURT

RULE 68. Offer of Judgment.

(A) At any time more than 10 days before the trial begins, either the party making a claim or the party defending against a claim may serve upon the adverse party an offer to allow judgment to be entered in complete satisfaction of the claim for the money or property or to the effect specified in the offer, with costs then accrued. The offer may not be revoked in the 10 day period following service of the offer. 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, either party may then file the offer and notice of acceptance together with proof of service, and the clerk shall enter judgment. An offer not accepted within 10 days is considered withdrawn and evidence of the offer is not admissible except in a proceeding to determine costs. The fact that an offer is made but not accepted does not preclude a subsequent offer.

(B) If the judgment finally rendered by the court is not more favorable to the offeree than the offer, the prejudgment interest accrued up to the date judgment is entered shall be adjusted as follows:

(1) if the offeree is the party making the claim, the interest rate will be reduced by the amount specified in AS 09.30.065 and the offeree must pay the costs and attorney's fee incurred after the making of the offer (as would be calculated under Civil Rules 79 and 82 if the offeror were the prevailing party). The offeree may not be awarded costs or attorney's fee incurred after the making of the offer.

(2) if the offeree is the party defending against the claim, the interest rate will be increased by the amount specified in AS 09.30.065.

(C) When the liability of one party to another has been determined by verdict or order or judgment, but the amount or extent of the liability remains to be determined by further proceedings, 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 10 days prior to the commencement of hearings to determine the amount or extent of liability.

(Adopted by SCO 5 October 9, 1959; amended by SCO 818 effective August 1, 1987)

Annotations

Cases

- I. In General
- II. Payment of Costs
 - A. Construction
 - B. Prejudgment Interest

I. In General

A payment document which in itself did not have the criterion of an offer of judgment and could at most be considered as a deposit in the superior court made under the provisions of Civil Rules 67 (A). was by virtue a stipulation of the parties as reasonably construed converted into an offer of judgment which plaintiffs accepted under the stipulation. *Albritton v. Estate of Larson*, Op. No 413, 428 P2d 376 (Alaska 1967).

The purpose of this rule is to encourage settlement of civil litigation as well as to avoid protracted litigation. *Miklautsch v. Dominick*, Op. No. 538, 452 P2d 438 (Alaska 1969).

RULE 79. Costs taxation and Review.

(A) Cost Bill -- Notice -- Waiver.

Within 10 days after the date shown in the clerk's certificate of distribution on the judgment, a party entitled to costs shall serve on each of the other parties to the action or proceeding a cost bill, together with a notice of the date and time of the cost bill hearing at which the clerk will tax costs. The date and time of the hearing shall be scheduled with the clerk's office and shall be not less than 3 nor more than 7 days from the date of the notice. The cost bill shall distinctly set forth each item claimed in order that the nature of the charge can be readily understood. It shall be verified by the oath of such attorney, stating that the items are correct, that the services have been actually and necessarily performed, and that the disbursements have been necessarily incurred in the action or proceeding. Failure of a party to serve a cost bill and notice as required by this subdivision shall be construed as a waiver of his right to recover costs.

(B) Items Allowed as Costs.

A party entitled to costs may be allowed premiums paid on the expenses of posting, undertaking, bonds or security stipulations, where the same have been furnished by reason of express requirement of law or on order of the court; the necessary expense of taking depositions for use at trial and producing exhibits; and the expense of service and publication of summons or notices, and postage when the same are served by mail; filing fees and other charges made by the clerk of the court and fees for transcripts required in the trial of a case in the superior court. In addition to the items allowed as costs by law and in these rules, a party shall be allowed any other expenses necessarily incurred in order to enable a party to secure some right accorded him in the action or proceeding.

(C) Taxing of Costs by Clerk.

(1) At the time specified in the notice, any party may present his objections to the cost bill, either orally or in writing. He shall specify each item to which objection is made on the ground of the objection. The parties may file affidavits of other documentary evidence to support their respective positions.

(2) The clerk shall thereupon proceed to tax the costs, and shall allow the items specified in the cost bill which are proper. Within 2 days after the costs have been taxed, the clerk shall insert the amount of the same in blank space left in the judgment or order for that purpose, and shall make a similar insertion in the copies and docket of the judgment or order. The taxing of costs by the clerk shall be final, unless modified on review as provided in this rule.

(D) Review by Court.

The action of the clerk in taxing costs may be reviewed by the court at the instance of any party upon motion and notice served not later than five days after the costs have been taxed by the clerk. When notice is served, the motion shall particularly designate each ruling of the clerk to which objection is made. Matter not so designated will not be considered by the court. The motion will be heard upon the same papers, affidavits and other documentary evidence used before the clerk, and upon such memoranda as the court may require. The court shall promptly rule on the motion.

(Adopted by SCO 5 October 9, 1959; amended by SCO 56 effective November 1, 1963; by SCO 258 effective November 15, 1976; and by SCO 554 effective April 4, 1983)

We are in the process of Gathering the consumer costs that are built into the Rates of Insurance Carriers to find the effects of Rule 82. These factors will apply to Automobile, Homeowners, and Business Policies. The Data is difficult to obtain although we are pursuing our sources. There have been previous Estimates of These Charges in the amount of \$16.00 per Automobile Policy and \$12.00 on Homeowners Policy. There have also been lower estimates in the ranges of \$6.00 and \$4.00 respectively. There have also been estimates on Commercial Policies ranging from \$20.00 to \$2,000 + Dollars. We hope that we can gather this factual data for a later Report.

We would like to emphasize, this additional consumer cost is a direct result of Rule 82. In Essence a tax was imposed by the Judiciary without any public hearings, and due process. The Argument for Rule 82 is that it helps settle cases faster. If one reviews Civil Rule 68, and it's purposes with annotations then Rule 82 is just fluff with no public purpose benefit, and definitely a cost to all of society.

Exhibit "A"

RULE 82. Attorney's Fee.

(A) Allowance to Prevailing Party.

(1) Unless the court, in its discretion, otherwise directs, the following schedule of attorney's fees well be adhered to in fixed such fee for the party recovered an money judgement therein:

ATTORNEY'S FEES IN AVERAGE CASES

		Contested	Without Trial	Non Contested
First	\$ 25,000	20	18	10
Next	\$ 75,000	10	8	3
Next	\$400,000	10	6	2
Over	\$500,000	10	2	1

Should no recovery be had, attorney's fees may be fixed by the court in its discretion in a reasonable amount.

(2) In actions where the money judgment is not an accurate criteria for determining the fee to be allowed to the prevailing side, the court shall award a fee commensurate with the amount and value of legal services rendered. An application for attorney's fees in a default case exceeding \$50,000 must specify actual fees.

(3) The allowance of attorney's fees by the court in conformance with the foregoing schedule is not to be construed as fixing the fees between attorney and client.

(4) Attorney's fers upon entry of judgment by default shall be determined by the clerk. In all other matters the court shall determine attorney's fees. Awards not pursuant to the schedule set forth in subparagraph (1) of this Rule shall be made only upon motion.

(B) Allowance in Mental Cases.

In proceedings under the Mental Health Act, the attorney appointed to represent the patient shall be allowed and paid a fee of \$25.00, unless the judge, in his discretion, orders otherwise. A lay advisor appointed in such proceedings shall be allowed and paid a fee of \$10.00, unless the judge, in his discretion, orders otherwise.

(Adopted by SCO 5 October 9, 1959; amended by SCO 497 effective January 18, 1982; by SCO 921 effective January 15, 1989)

NOTE: AS 10.06.435 as enacted by ch. 166 § 1, SLA 1988, amended Civil Rule 82 by changing the the criteria for awarding attorney fees to the plaintiff in a shareholder derivative action. AS 10.06.580(E), as enacted by ch.166 § 1, SLA 1988 amended Civil Rules

Exhibit A Continued

NOTE: AS 10.06.435 as enacted by ch. 166 § 1, SLA 1988, amended Civil Rule 82 by changing the criteria for awarding attorney fees to the plaintiff in a shareholder derivative action. AS 10.06.589(E), as enacted by ch.166 § 1, SLA 1988 amended Civil Rules 82 by changing the criteria for awarding attorney fees in an action to determine the value of dissenting shareholder's interest in a corporation.

NOTE: See Civil Rule 23.1(j) concerning attorney fees in shareholder derivative actions.

NOTE: Ch. 139 § 8. SLA 1986, provided that AS 09.60.010, enacted by ch. 139 § 4 SLA 1986 amended Civil Rule 82 by prohibiting the award of attorney fees in certain civil actions based on fault, unless allowed statute of by agreement of the parties or unless the civil action is contested without trial of fully contested.

Sec. 09.60.010. Costs and attorney fees allowed prevailing party. The supreme court shall determine by rule or order the costs, if any, that may be allowed a prevailing party in a civil action. Unless specifically authorized by statute of by agreement between the parties, attorney fees may not be awarded to a party in a civil action for personal injury, death of property damage related to or arising out of fault, defined in AS 09.17.900, unless the civil action is contested without trial, or fully contested as determined by the court. (§ 5.14 ch 101 SLA 1962; am § 4 ch 139 SLA 1986)

Annotations

Cases

- I. In General
- II. Prevailing Party
- III. Review
 - A. Standard
 - B. Abuse of Discretion of Error
- IV. Fee Schedule

I. In General

The common law did not permit allowance of attorney's fees as costs to the prevailing party, but in Alaska such allowance is of relatively ancient origin and prior to attainment of statehood the matter was regulated by statute. *McDonough v. Lee*, Op. No. 378, 420 P2d 459 (Alaska 1966).

The purpose of this rule is to encourage settlement or civil litigation as well as to avoid protracted litigation. *Miklautsch v. Dominick*, Op. No. 538, 452 P2d 438 (Alaska 1966).

Exhibit "B"

**RULE 35. Fee for Legal Services;
Agreement.**

(A) Basis or Rate of an Attorney's Fee.

An attorney's fee will be reasonable. The factors to be considered in determining the reasonableness of a fee including the following:

- (1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to properly perform the legal services;
- (2) the likelihood that the acceptance of the particular employment will preclude other employment by the attorney;
- (3) the fees customarily charged in the locality for similar legal services;
- (4) the amount involved and the results obtained;
- (5) the nature and length of the professional relationship with the client;
- (6) the time limitations imposed by the client or by the circumstances;
- (7) the experience, reputation, and ability of the attorney of attorneys performing the services; and
- (8) whether the fee is fixed or contingent.

(B) Written Fee Agreement.

When the attorney has not previously or regularly represented a client, the basis or rate of the fee to be charged, including any fee of retainer or initial deposit, should be communicated to that client in writing, before commencing the representation of within a reasonable time thereafter. In the absence of a written fee agreement, the attorney must present clear and convincing evidence that the basis or rate of fee exceeded that amount alleged by the client.

(C) Contingent Fees.

A fee may be contingent on the outcome of the matter for which the service is rendered, except in a matter in which a contingent fee is prohibited by Section (D) of this rule, or by other law of court rules or decision. A contingent fee agreement will be in writing and will state the method by which the fee is to be determined, including:

- (1) the percentage or percentages that shall accrue to the attorney in the event of settlement trial or appeal; provided, however, fees on appeal may be left to later negotiation;

Exhibit B Continued

(2) litigation and other expenses are to be deducted from the recovery; and

(3) whether such expenses are to be deducted before the contingent fee is calculated.

Upon conclusion of a contingent matter, the attorney will provide the client with a written statement reporting the outcome of the matter and, if there is recovery, showing the amount of the remittance to the client and the method of its determination.

(D) Prohibited Attorney Fee Agreements.

An attorney will not enter into an arrangement for, charge, or collect:

(1) any fee in a domestic relations matter, the payment of which is contingent upon the securing of a divorce or upon the amount of alimony or support, or property settlement on lieu thereof, except an action to collect past - due alimony or support payments; or

(2) a fee contingent upon the outcome of a criminal case.

(E) Fee Divisions Between Attorneys.

A division of fee between attorneys who are not in the same law firm may be made only if:

(1) the division is in proportion to the services performed by each attorney or, by written agreement with the client, each attorney assumes joint responsibility for the representation;

(2) the client is advised of and does not object to the participation of all the attorneys involved; and

(3) the total fee is reasonable.

(Old Rule 35 [SCO 176] deleted and new Rule 34 added by SCO 780 effective March 15, 1987)

Exhibit "C"

V

ANCHORAGE SUPERIOR COURT
PENDING GENERAL CIVIL CASES
EXCLUDING DOMESTIC RELATIONS & PROBATE CASES
AS PROVIDED BY COURT SYSTEM ON 10/04/89

LIST OF CASES AGED BY DATE OF
FILING OR RE-FILING

<u>YEAR FILED</u>	<u>NUMBER OF CASES</u>	<u>CASES OF WHICH NO JUDGE HAS BEEN ASSIGNED</u>
1976	X 1	1
1977	0	0
1978	0	0
1979	0	0
1980	1	1
1981	5	1
1982	11	3
1983	7	0
1984	14	5
1985	162	133
1986	424	296
1987	616	114
1988	1234	79
1989	<u>1233</u>	<u>126</u>
TOTAL	3708	759

X NOTE: This is case NO. 3AN- 76-03000V, That is a 1976 case that was filed in Superior Court in 03/31/87. This may be an appeal from District Court or a re-filing of a Superior Court case.

Exhibit "D"

VI

ALASKA SUPREME COURT

Pending cases including civil merit appeals, Petition for review (Interlocutory) Original proceeding (Attorney Discipline and Judge Discipline) and petition for hearing on criminal cases. List of cases by filing at supreme court, not date filed with lower court. These cases were provided by supreme court system on 11/02/1989.

<u>YEAR FILING</u>	<u>NUMBER OF CASES</u>
1985	1
1986	4
1987	22
1988	151
1989	<u>269</u>
TOTAL	447

Breakout of Total =

APPEALS = 377
PETITIONS= 70

Exhibit "E"

SUPERIOR COURT CIVIL CASES

1981 Statistics

Cases Reported = 64

85% Defense Verdicts

Defense Verdicts = 17

15% Plaintiff Verdicts

Plaintiff Verdicts = 3

Cases settled prior trial = 44

1982 Statistics

Cases Reported = 65

40% Defense Verdicts

Defense Verdicts = 10

60% Plaintiff Verdicts

Plaintiff Verdicts = 15

Cases settled prior to trial = 40

1983 Statistics

Cases Reported = 58

48% Defense Verdicts

Defense Verdicts = 10

52% Plaintiff Verdicts

Plaintiff Verdicts = 11

Cases settled prior to trial = 37

Source: James J. Leyden Comapany
P.O. Box 3-057-ECB
Anchorage, AK 99501

The following Report Commissioned
by the foundation for change is enclosed for your review and
considerations some of it's recommened changes may be applied to the
Alaska Court System.