

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672  
1719 SCOMM 69: HOUSE LIABILITY INSURANCE TASK FORCE, 1989-1990 87

Thirdly, Board policy changes could be encouraged for increased use of lesser penalties (probation and/or censure) combined with written guidelines for increased monitoring of physicians disciplined under these actions. L.D. 1407 requires yearly reporting of such activities to the Legislature.

#### HOSPITAL RESPONSES TO MALPRACTICE:

In order for a hospital to be accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO), a number of policies and procedures must be in place relative to risk management. These include hospital licensure, physician credentialing procedures, ongoing quality assurance programs, morbidity and mortality reviews, and other educational programs.

##### A. Credentialing:

Each hospital establishes its own methods of credentialing physicians on its staff. These are usually administered by a committee which depends on recommendations from subcommittees specific to individual specialties such as internal medicine, OB/GYN, family practice, and surgery. Training, past hospital experience, and procedures are reviewed. When approved by the Credentials Committee, recommendations are then reviewed by the medical staff and the executive board.

The increased supply of physicians, especially in more populous areas of Maine, has allowed this process to become more rigorous. In most hospitals, board certification in the appropriate specialty is required for active hospital privileges. Policies currently regulate the extent of privileges (surgical/invasive procedures) as well as steps to rescind privileges. Hospitals are required to report suspension or required reduction in privileges to the licensing Board. The threat of such action often results in voluntary reduction or relinquishing of privileges neither of which is required to be reported. This approach may be seen as either facilitating quality control, (avoiding legal entanglements and allowing hospitals to negotiate rather than formalize removal) or as a loophole which may result in moving the physician to another locale without addressing competence issues. New JCAHO requirements will require physicians to report such voluntary actions when applying for new or renewed privileges.

##### B. Quality Assurance Activities:

Traditionally, hospitals have focused on how care was delivered. Only recently have they begun to measure the impact of that care on patient outcomes. Currently, hospitals are mandated by the JCAHO, as well as Federal and State government, to monitor the quality of care they provide and must document these activities. In Maine, each hospital must have a quality assurance plan with written policies and procedures. These are locally developed and thus vary by institution. Generally, committees are set up to monitor specific aspects of care such as medical record review

(ensure appropriate documentation), tissue committee, infection control, and tumor board. The committees meet periodically and review findings. Proposals for changes in policies or procedures are submitted to the administration or Medical Directors.

Hospitals must also submit to a review of Medicare services conducted by the Maine Professional Review Organization (PRO) which includes utilization reviews (Are people being appropriately hospitalized?) as well as quality reviews (Are appropriate antibiotics being used?). Hospitals receive a summary of findings and physicians are given individual performance profiles. If received by the hospitals, these individual physician reports might provide useful information highlighting patterns of inappropriate care since potential quality problems can be identified such as patients with unplanned return to surgery during a single admission, multiple blood transfusions during a surgical stay, and hospital-acquired infections to name a few.

In general, quality assurance activities are most effective in terms of affecting provider performance if the providers themselves are involved in setting the quality standards. In-hospital quality assurance activities are limited, however, by the time and money required to effectively monitor care.

#### C. Morbidity/Mortality Reviews:

Medical staff departments of hospitals (surgery, internal medicine, family medicine) conduct periodic meetings at which each death and any unusual morbidity are discussed. While these have been criticized as ineffective (see Millman, 1983)<sup>1</sup>, they theoretically create an opportunity for peer review and continuing education. Such meetings can result in medical record review by the Chief of Service and can lead to a peer review hearing if deemed appropriate. Hospitals are not required to report such hearings unless they result in a disciplinary reduction in privileges.

#### D. Other Educational Activities:

Hospitals host educational sessions for their medical staffs in a variety of formats usually including case conferences, noon presentations by internal and external experts, and other variations.

#### E. Risk Management Plans:

In addition to these activities, hospitals have risk management plans which range in scope and quality from patient advocate/complaint departments to more comprehensive monitoring of problems and early intervention. Some critics see these as mostly public relations, but insurers are attracted to these approaches to anticipating problems.

#### OPTIONS FOR STRENGTHENING HOSPITAL REVIEW:

Hospitals could receive individual physician as well as aggregate data from Medicare PRO reviews. This would allow closer monitoring and might lead to earlier identification of problem providers. Discovery issues in cases of disciplinary action need to be considered.

Secondly, each hospital staff could develop practice standards and use hospital quality assurance staff to compare actual care against such standards. It is thought that Statewide standards would be less likely to be adhered to and thus have less likelihood of having an impact on actual performance.

#### PROFESSIONAL STANDARDS:

There is a great deal of activity taking place at the National level as well as at various state levels relative to health care in general and the accessibility, cost, and quality of health care in particular. The National Leadership Commission on Health Care in its 1989 Report, For the Health of a Nation, indicates that there is insufficient information on the quality and outcomes of medical services and insufficient means of monitoring the quality of care and fostering its improvement. Citing studies showing large regional variations in the use of medical services that seem not to be based on medical need as well as stories of unnecessary and equivocal care in the use of inappropriate and excessive procedures, the Commission reports that this is not an isolated problem, but is generic to the whole health care system. In their words, the nation's quality control systems are at best rudimentary. Patients particularly have few tools to help them assess the quality and appropriateness of their treatment.

As part of the Commission's proposal to respond to the serious problems of quality health care, and others, in this country, it sets forth a nine point strategy which includes specific recommendations relevant to professional standards of care. Five recommendations out of the nine in this Report are included herewith which may impact on quality of care and malpractice issues:

1. Greatly increase research on the appropriateness, effectiveness, and quality of care and publicize the results widely to help patients, provider, and payers assess treatment.
2. Control costs by reducing the amount of inappropriate care as a result of the expanded research and National guidelines.
3. Develop a strong public-private partnership to improve quality and control costs by coordinating the expanded research on appropriateness and quality and disseminating the results through health professional and other appropriate organizations.

4. Develop and continually update National guidelines to enable practitioners, patients, and payers to make more informed decisions.
5. Promote nationwide the current, promising State reforms in malpractice and consider new Federal initiatives if necessary.

In addition to this call by a broadly-based group of distinguished leaders to establish National guidelines for health care, the Physician Payment Review Commission, created by law in 1986 to advise government on the reform of Medicare's physician payment methods, recommends that "the federal government actively encourage the development and dissemination of practice guidelines so that they are incorporated into physicians' practices, made available to patients, and used as the basis for coverage and payment, and for medical-review criteria by hospital medical staffs, carriers, and PROs." (Inglehart, 1989)

In Maine, if the intent is to improve quality with a National or community standard, educational research in medical settings indicates that a method which directly involves each practitioner would be the most effective. The Maine Medical Assessment Foundation (MMAF) has created a model program using exactly this type of local data collection and review process. (Wennberg, et al, 1988) In creating quality standards for hospital care, issues of the overall cost and effectiveness of standards appropriate to each institution's setting and population must also be considered. It would, therefore, seem appropriate to continue to encourage activities such as MMAF's which are both statewide and locally-based and have the capability to provide real data on which procedures are effective. This holds potential for reducing the number of procedures and ultimately malpractice risk.

Additionally, Medical Mutual Insurance Company, a physician-owned and operated malpractice insurer in Maine, has taken a statewide approach with its insured physicians by recommending guidelines of practice in three clinical areas: anesthesia, diagnosis of breast cancer, and obstetrics. The program began in January of 1988 and no data are yet available on its effects. MMIC has requested that physicians it insures and who practice in these specialties follow the proposed standards or document why they were not followed. Physicians who get sued and have not followed the standards or documented the reasons for not following them will be covered by the company, but will likely be dropped in the following year. The standards are based on those of the National organizations for each specialty. They are adopted following review (and revision) by internal MMIC physician committees. MMIC plans to adopt additional standards for other procedures and services. Physicians have, however, expressed concern about coverage if guidelines are not followed or adequately documented. Health services research studies indicate that it is impossible to rely on any one source of

information (medical record, patient report, physician report) for a valid reflection of what takes place in clinical encounters (Gerbert and Hargreaves, 1986),

#### CONCLUSIONS:

A number of ideas have been set forth for consideration relative to strengthening physician licensure procedures; monitoring and, hopefully, improving quality of care; and developing written guidelines to serve as a baseline for quality medical care. It is important to keep in mind that any approach to malpractice which attempts to be preventive, using some method of quality assurance, has multiple unresolved issues. Is quality the most cost effective care, most expensive care, best care, or usual practice? Is quality related to outcome? Despite National Medical Specialty Board promulgation of practice standards, the relationship of outcome and quality is still unclear nor has it been firmly established in many aspects of clinical care. While standard appears to be the wave of the future, any approach which relies on overly-specific protocols to be followed may lead to expensive and unnecessary care.

It may not be possible at this time to assure quality in medicine in the same way that quality is assured in a manufacturing process. It is extremely important to encourage both physicians and consumers to upgrade the integrity of the doctor/patient relationship. In so doing, physicians should be very involved in the process and assist in developing better guidelines for providing high quality care. Patients should become more informed and pragmatic relative to their expectations of what outcomes are possible and probable. Health care may be a right and a privilege, but it has to be a partnership as well.

#### REFERENCES

- Campaign for Fair Rates and Equal Justice (FAIR). Medical Malpractice and Doctor Discipline: Are We Treating the Symptoms Instead of Curing the Disease? Mimeo, 1988.
- Gerbert, B, Hargreaves, WA: Measuring Physician Behavior. Medical Care. 24(9): 838-847, 1986.
- Iglehart, John K.: Health Policy Report, The Recommendations of the Physician Payment Review Commission. NEJM, April 27, 1989, No. 17, p. 1156-1160.
- Millman, M: Medical Mortality Review: A Cordial Affair, Reprinted in Conrad, P. and Kern, R. (eds), The Sociology of Health and Illness: Critical Perspectives (second edition) New York, St. Martin's Press, 1986.
- National Leadership Commission on Health Care: For the Health of a Nation, Executive Summary, Report in Print, February 1989.
- Wennberg, J., Mulley, A., Hanley, D. et al: An Assessment of Prostatectomy for Benign Urinary Tract Obstruction: Geographic Variations and Evaluation of Medical Care Outcomes. JAMA, 259(20): 3027-3030, 1988.

X

ATTACHMENTS

- ATTACHMENT A: Physician Survey Instrument
- ATTACHMENT B: Physician Survey Analysis
- ATTACHMENT C: Attorney Survey Instrument
- ATTACHMENT D: Attorney Survey Analysis

ATTACHMENT A

MEDICAL MALPRACTICE LIABILITY STUDY  
OBSTETRICS AND MALPRACTICE IN MAINE - 1989  
PHYSICIAN SURVEY

ID#: (1-3)

1. Please indicate your primary practice specialty:

- (4) ☐ a. Family physician  
☐ b. General practitioner  
☐ c. Obstetrician/gynecologist  
☐ d. Other (please specify) \_\_\_\_\_

2. Approximately what percent of your practice is in:

- (5-6) ☐ % Obstetrics  
(7-8) ☐ % Gynecology  
(9-10) ☐ % Other (please specify) \_\_\_\_\_  
(11-12) ☐ % Other (please specify) \_\_\_\_\_

3. Please estimate how many deliveries you personally attended in:

(13-21) 1987 \_\_\_\_\_ 1988 \_\_\_\_\_ Estimated total for 1989 \_\_\_\_\_

4. If you have changed your obstetrics practice since January 1987, indicate how? (Check all that apply.)

- (22) ☐ Stopped or reduced providing care to UNINSURED patients  
(23) ☐ Stopped or reduced providing care to MEDICALLY HIGH-RISK patients  
(24) ☐ Stopped or reduced providing care to MEDICAID patients  
(25) ☐ Changed practice location  
(26) ☐ Put a limit on the number of patients accepted.  
(27-28) If yes, number per year: \_\_\_\_\_  
(29) ☐ Other (please specify) \_\_\_\_\_

5. If you have reduced/stopped (circle one) your obstetrics practice since January 1987, rank the three most important reasons why. (Please respond with 1 for most important, 2 for second most important, and 3 for third most important)

- (30) ☐ Limited back-up and consulting available for patients with high risk of a poor birth outcome  
(31) ☐ Fee limit on Medicaid reimbursement  
(32) ☐ Concern over obstetric malpractice suit  
(33) ☐ Cost of malpractice insurance premiums in obstetrics  
(34) ☐ Unavailability of occurrence type insurance coverage  
(35) ☐ Inconvenience of practicing obstetrics (on-call responsibilities, sleep deprivation, etc.)  
(36) ☐ Other (please specify) \_\_\_\_\_

IF YOU ARE NOT CURRENTLY PRACTICING OBSTETRICS PLEASE SKIP TO QUESTION 10.

6. Medicaid patients made up what percentage of your obstetrics practice during: (Please exclude those you were called on for delivery only.)

(37-42) 1987 \_\_\_\_\_ 1988 \_\_\_\_\_ Estimated for 1989 \_\_\_\_\_

7. What is your policy regarding providing total obstetrical care to Medicaid obstetric patients? (Please check one.)

- (43) ☐ a. DO NOT limit care for Medicaid obstetrical patients  
☐ b. DO NOT provide care for Medicaid obstetrical patients  
☐ c. Provide care for a LIMITED NUMBER of Medicaid obstetrical patients

(44-45) If yes, how do you choose which patients you will accept? \_\_\_\_\_

8. If you do not provide total obstetrical care to Medicaid patients, or provide care to only a limited number, please rank the 3 most important reasons why. (Please respond with 1 for most important, 2 for second most important, and 3 for third most important.)

- (46) ☐ Reimbursement is inadequate  
(47) ☐ Dissatisfaction with OHS policies.  
(48) ☐ Pregnancies are high medical risk  
(49) ☐ Fear of malpractice suit  
(50) ☐ Too much paperwork  
(51) ☐ Patients are noncompliant  
(52) ☐ Patients sue more  
(53) ☐ Other (specify) \_\_\_\_\_

9. If you plan to drop obstetrics, indicate the year this will occur:

- (54) a. 1989 \_\_\_\_\_ d. Not sure \_\_\_\_\_  
b. 1990 \_\_\_\_\_ e. No plans to drop \_\_\_\_\_  
c. 1991 \_\_\_\_\_

10. What is the current annual malpractice insurance premium for you personally (cost of liability premium per physician)?

(55-57) \$ \_\_\_\_\_/yr.

11. Please indicate who is currently paying your malpractice insurance premium.

- (59-60) ☐ a. I personally pay the premiums ☐ b. My employer (other than practice)  
☐ c. My practice pays the premiums ☐ d. My hospital  
☐ e. Other (specify) \_\_\_\_\_

12. What are your current malpractice insurance coverage limits? (case limit/total limit)

- (61) ☐ a. \$100,000/300,000 ☐ b. \$200,000/600,000  
☐ c. \$1 mil/3 mil ☐ d. Other(\$\_\_\_\_\_/\_\_\_\_\_) \_\_\_\_\_

13. Have you ever been named in an obstetrics personal injury or malpractice suit?

- (62) ☐ 1 Yes ☐ 2 No

If Yes, how many culminated in each of the following outcomes? (Provide actual number.)

- (63-64) ☐ Filed and dropped ☐ Court settlement in your favor  
(65-66) ☐ Settled out of court ☐ Court settlement for plaintiff  
(67) ☐ Still pending  
(68) ☐ Other (please specify) \_\_\_\_\_

(69-70) How many of these suits were filed by Medicaid recipients? \_\_\_\_\_

14. If a judgment was awarded for your most recent suit, please indicate the amount. \$ \_\_\_\_\_

(71-74)

Were you satisfied with this outcome?

- (75) ☐ 1 Yes ☐ 2 No

(76) a. If not, why? \_\_\_\_\_

15. In 1988, what was the total gross income to your practice per physician before deductions and taxes? \$ \_\_\_\_\_

(77-80)

In 1988, what was your net income from your practice per physician before deductions and taxes? \$ \_\_\_\_\_

(81-84)

If you were on salary in 1988, what was the total gross income before deductions and taxes? \$ \_\_\_\_\_

(85-88)

(89)

Please return in the enclosed envelope to: Ronald Deprez, Ph.D., Public Health Resource Group, Inc., P.O. Box 5068, Portland, ME 04101

THANK YOU FOR YOUR PARTICIPATION  
ATT. 2

## Attachment B

### Survey Methods and Response/Non-response Comparison

Physicians to be included in the sample were identified through the "Cooperative Health ManPower Resource Inventory", a data bank containing demographic information on all practicing Maine physicians. Physicians were included in the sample if their primary specialty was Family Practice or Obstetrics/ Gynecology, they were Osteopathic doctors, or their second or third specialty was listed as Obstetrics. Six hundred and twenty-one physicians were identified and sent surveys using this criteria. Of this number thirty surveys were returned undelivered because of the physicians death or lack of a forwarding address.

Fifty percent (300) of those surveyed returned questionnaires. There were only slight variations in percentage results between respondents and non-respondents. In addition, both the non-respondents and respondents were similar to the original pool, again only showing slight variation in some areas.

There was a slight over representation by urban physician in the respondents. Thirty eight percent of the physicians who returned questionnaires worked in urban areas, in comparison to thirty-four percent of the original sample. The opposite was found for non-respondents, with urban physicians slightly under represented with thirty percent and rural physicians slightly over represented with seventy percent.

### Physician Location

| Location | Respondents | Non Respondents | Original Sample |
|----------|-------------|-----------------|-----------------|
| Urban    | 38%         | 30%             | 34%             |
| Rural    | 62%         | 70%             | 66%             |

By age categories, the percentage of respondents and non-respondents under forty was similar to the original sample. From forty to fifty-nine there was a slight over representation by respondents when compared to the original sample. For physicians sixty and over, the original sample contained twenty-four percent. Twenty-six percent of non-respondents fell into this category while only twenty-one percent of the respondents were sixty or over, showing a slight under representation by respondents.

|          | <u>Age</u>  |                 |                 |
|----------|-------------|-----------------|-----------------|
|          | Respondents | Non Respondents | Original Sample |
| Under 40 | 33%         | 31%             | 32%             |
| 40 - 59  | 46%         | 43%             | 44%             |
| Over 60  | 21%         | 26%             | 24%             |

Seven percent of the original sample were residents. Six percent of the respondents classified themselves as residents and eight percent of nonrespondents were classified as residents.

A slightly higher percentage of respondents were male than found in the original sample and the nonrespondents sample. The opposite was found with female physicians respondents. Only twelve percent of the respondents were female while fourteen percent of the original sample and fifteen percent of non-respondents were female.

|        | <u>Sex</u>  |                 |                 |
|--------|-------------|-----------------|-----------------|
|        | Respondents | Non Respondents | Original Sample |
| Male   | 88%         | 85%             | 86%             |
| Female | 12%         | 15%             | 14%             |

A greater percentage of physicians who responded to the survey treated medicaid patients than non-respondents or than in the original sample. In addition, the percentage of blank responses found in the respondent sample was slightly lower than found in the non-respondents or original sample.

|       | <u>Treat Medicaid Patients</u> |                 |                 |
|-------|--------------------------------|-----------------|-----------------|
|       | Respondents                    | Non Respondents | Original Sample |
| Yes   | 89%                            | 81%             | 84%             |
| No    | 5%                             | 8%              | 7%              |
| Blank | 6%                             | 11%             | 9%              |

Of the four categories of physicians found in the sample, the percentage of Family Practice physicians were higher in respondents than in the original sample or the nonrespondents. Similar percentages were found for respondents, non-respondents, and the original sample for Obstetrics/Gynecology. The category Other MD's, which included all physicians whose second or third specialty was listed as Obstetrics, was slightly under represented in the respondents. The same results were found for the Doctors of Osteopathic Medicine.

#### Physician Categories

|                          | Respondents | Non<br>Respondents | Original<br>Sample |
|--------------------------|-------------|--------------------|--------------------|
| Family<br>Practice       | 55%         | 42%                | 48%                |
| Obstetric/<br>Gynecology | 16%         | 15%                | 15%                |
| Other MD                 | 12%         | 21%                | 17%                |
| Osteopaths               | 17%         | 22%                | 20%                |

Respondent physicians were slightly under represented for 36-110 deliveries per year compared to the original sample while slightly over represented for 16-35 to deliveries and 111-550 deliveries per year. The percentages of respondents, non-respondents, and original sample were similar for 0 Deliveries per year and 2-15 deliveries per year.

#### Number of Deliveries

| Per Year | Respondents | Non<br>Respondents | Original<br>Sample |
|----------|-------------|--------------------|--------------------|
| 0        | 3%          | 2%                 | 2%                 |
| 2-15     | 2%          | 3%                 | 3%                 |
| 16-35    | 8%          | 5%                 | 6%                 |
| 36-110   | 79%         | 85%                | 82%                |
| 111-550  | 9%          | 5%                 | 7%                 |

ATTACHMENT C

MEDICAL MALPRACTICE LIABILITY STUDY  
ATTORNEY SURVEY

ATTORNEY NAME: \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

FACE-TO-FACE OR TELEPHONE INTERVIEW (Circle one)

PLAINTIFF OR DEFENDANT ATTORNEY (Circle One)

PRACTICE QUESTIONS:

What Proportion of your practice/caseload are liability cases?

What types of liability cases are they? (product, medical, etc.)

How many Medical Malpractice cases have you had in the last five years?

How many Medical Malpractice cases do you have pending now?

What are they about? (type of medical  
procedures/diagnoses/???)

What is the trend in your malpractice cases compared to other personal injury cases in your practice? Are they increasing or decreasing? Are awards getting larger?

(P) What motivates malpractice case clients to seek legal assistance? (Emotional issues/cost of medical care/ ??)

(P) On average, how many reports of alleged malpractice incidents (different clients) do you consider before taking on a case?

(P) What goes into the decision to take on a malpractice case?

(D) Have you ever felt pressured by your clients (insurance co. and/or physician) to settle a case when you felt it did not have merit?

**MEDICAL MALPRACTICE LIABILITY STUDY**

**SCREENING PANEL QUESTIONS:**

How many of your cases have gone before the screening panels?

What was the result?

How many ruled in your favor?

How many reached settlement?

How many went on to a lawsuit?

How many resulted in an indemnity payment to the plaintiff?

Have you ever not adhered to the panel decision to settle and proceeded to a lawsuit? Why?

What was the outcome of the case?

How do you decide whether to use the panel for a case?  
(size of potential award? merits of the case?/???)

How do you decide when to settle a case? (what do you look for in the case that suggests a settlement is the best course of action?)

Have the availability and use of screening panels had an effect on this? How?

How much leeway do you have in the decision to settle or adjudicate a case?

How have the use of panels affected this?

Has your time involved in a case increased or decreased with the use of panels?

On average how have panels effected litigation expenses?

Have you filed more or less notice of claims since the panels have been active?

Have you ever by-passed the panels altogether? Why?

Other impressions of the panels???

## ATTACHMENT D

### ATTORNEY SURVEY SAMPLE--PRETRIAL SCREENING PANELS

#### INTRODUCTION:

An assessment of the tort law changes passed in 1986 by the Maine State Legislature was conducted as part of this study. Of the six reforms passed, two have been in effect for a sufficient time to evaluate, the prelitigation screening panels and the increased disciplinary power of the Board of Registration of Medicine. This report addresses the screening panel reform and the second reform has been addressed in Section VI

#### SCREENING PANEL PROCESS:

In Maine, the prescreening panel system is set in motion when the Clerk of the Superior Court receives a notice of claim in a medical malpractice case. The Chief Justice of the Superior Court is informed and he then appoints a retired judge to serve as panel chairman. Two or three additional panel members are then selected by the panel chair from a list of doctors, health care providers, and attorneys. (If the defendant is a health care provider, then one of the panel members would be chosen from the defendant's subspecialty if such exists.)

Discovery is the legal term used to describe all of the various pretrial procedures that are used by one party to obtain facts and information about the case from the other party in order to assist in trial preparation. In most cases, there is considerable time and expense involved at the pretrial phase. Relative to the screening panel process, there is the question of how much discovery will be allowed. This was a very important issue with all those interviewed. The law provides that if a party applies to the chairman, he/she may permit "reasonable discovery." The words reasonable discovery are vague, however, and the lawyers and Justice McCarthy are not certain how much discovery preparation for the screening panel hearing is allowed, will be allowed, and should be allowed. Since all respondents considered this such an important issue, it will be more fully discussed in the summary section of this report.

Shortly after the notice of claim, the panel chairman sets up a meeting with the attorneys and they decide upon a date when discovery must be completed and on a hearing date. The parties must agree on a timetable within twenty days of the filing of a notice of claim. The hearing date must be set within 120 days of the notice of claim.

Under Maine law, the parties may bypass the panels if they mutually agree on resolution by trial alone. The panel can only decide the legal defense of comparative negligence; it may not hear any other defense the outcome of which might ultimately decide the case. The Rules of Evidence do not apply at panel hearings, and the parties are permitted to cross examine the

witnesses against them. Further, a unanimous panel decision against either the plaintiff or the defendant as to negligence and/or causation is admissible at trial.

#### SCREENING PANEL DATA:

Superior Court Administrator, Robert Miller, has been compiling limited data as to the number of notices filed, panel hearings, and complaints filed in medical malpractice cases since the enactment of the screening panels. That data has been updated to reflect the medical malpractice caseload as of April 13, 1989. No one is responsible for keeping track of the number of panel decisions and whether the decisions are for the plaintiffs or defendants. Nor was data available prior to the screening panel system as to the number of medical malpractice complaints filed. Nevertheless, an attempt has been made to briefly summarize the data available.

For the period beginning January 1, 1987 through April 13, 1989, 232 notices of medical malpractice were filed. Of those notices, 118 were disposed of by April 13, 1989. There were 71 complaints filed, and 32 panel hearings were held during that same time period. These data are set forth in TABLE 1 which follows:

TABLE 1  
SCREENING PANEL DATA  
(through 4/13/89)

| COUNTY       | NOTICES<br>FILED | NOTICES<br>PENDING | NOTICES<br>DISPOSED | PANEL<br>HEARINGS | COMPLAINTS<br>FILED |
|--------------|------------------|--------------------|---------------------|-------------------|---------------------|
| Androscoggin | 15               | 7                  | 8                   | 1                 | 5                   |
| Aroostook    | 20               | 11                 | 9                   | 3                 | 4                   |
| Cumberland   | 57               | 27                 | 30                  | 7                 | 19                  |
| Franklin     | 0                | 0                  | 0                   | 0                 | 0                   |
| Hancock      | 10               | 4                  | 6                   | 1                 | 2                   |
| Kennebec     | 26               | 11                 | 15                  | 8                 | 8                   |
| Knox         | 6                | 4                  | 2                   | 2                 | 2                   |
| Lincoln      | 0                | 0                  | 0                   | 0                 | 0                   |
| Oxford       | 12               | 6                  | 6                   | 3                 | 5                   |
| Penobscot    | 36               | 19                 | 17                  | 6                 | 13                  |
| Piscataquis  | 2                | 2                  | 0                   | 0                 | 1                   |
| Sagadahoc    | 3                | 0                  | 3                   | 0                 | 1                   |
| Somerset     | 8                | 5                  | 3                   | 0                 | 3                   |
| Walco        | 4                | 0                  | 4                   | 1                 | 1                   |
| Washington   | 3                | 2                  | 1                   | 0                 | 0                   |
| York         | 30               | 20                 | 11                  | 1                 | 7                   |

## ATTORNEY SURVEY:

### A. Purpose:

The purpose of this survey was to obtain information from practicing attorneys relative to the effect, if any, of tort reforms passed in Maine in 1986. Specific information was gathered relative to the pretrial screening panel system which has been implemented. This is the only reform that has been in place long enough to permit some analysis. In addition, general information was elicited from the respondents relative to such things as caseload, type of cases being pursued, and suit motivation. These findings reflect only the opinions of those interviewed in this select sample, and are by no means meant to be predictive of all attorneys in Maine.

### B. Method:

Structured interviews were conducted with eight individuals involved with the medical malpractice screening panels. The survey instrument is appended. Survey respondents included three attorneys who do primarily plaintiffs' work, one attorney who does 60% defense and 40% plaintiff work (hereafter, defense/plaintiff attorney), two attorneys who do only defense work, the panel chairman who has been involved in 119 cases and presided over 20 panel hearings, and a claim manager for St. Paul Fire and Marine Insurance Company. Those interviewed were from Rumford, Augusta, Bangor, Lewiston and Portland. Of the attorney interviewed, over 50% of their practice consists of medical malpractice. The attorneys could not specify a typical type of medical malpractice that they handle. All considered medical malpractice cases to be different and could not generalize about a particular type of case. The number of cases the attorneys have had go to the panels ranges from 4 to 12. The claim manager has had 30 cases go to the panels and the panel chairman has received 119 notices of claims and presided over 20 panel hearings.

### Findings: Case Trends:

When asked about trends in the medical malpractice caseload compared to other personal injury cases, there was agreement among all four defense attorneys that the trend in their caseload suggests that the number of medical malpractice claims is decreasing while the severity of these claims is increasing. The experience of the claim manager was in agreement with the defense attorneys that the number of medical malpractice cases is decreasing, following the national trend, while the cases are becoming more complex and the damages more significant. The experience of the plaintiff attorneys, however, was that there was no particular trend in the number of claims and severity of these claims over the last five years.

#### Suit Motivation:

The plaintiff attorneys had differing views as to what motivate clients they represent to sue physicians and other health care providers. For one attorney, it was purely compensation for injury, simply to pay the hospital and medical bill. For another, compensation is a motivation in a low percentage of his cases. In his experience, medical expenses are usually covered by Medicaid or some other means. The motivation in most cases was "quality of care." He explained that the mother of a child who is completely incapable of caring for him/herself as a result of malpractice is a slave to that child for the rest of the child's life. In that type of case the mother is suing for more than just reimbursement for expenses. The third plaintiff attorney interviewed considered the motivation to sue a combination of compensation for extreme injury and a response to either a doctor's poor bedside manner or to a subsequent doctor's declaration that the former doctor caused them serious injury and pain. He felt that there are a number of motivations in many cases and added that many people want to help prevent what happened to them or their families from happening to others.

Plaintiff attorney generally spend an average of six months reviewing a medical malpractice case to determine its viability. Hospital records must be obtained, and at least one expert witness from out of state must be hired to review the case. Before a notice of claim may be filed, two determinations must be made. First, did the defendant breach an accepted standard of care and did this breach cause injury? Second, given the considerable time and expense involved in the process of litigation, are the expected damages from a case going to be high enough to justify the cost of a suit?

#### Case Disposition:

As a result of case review, many cases are dismissed as non-meritorious or cost inefficient. One attorney conducted an informal survey within his law firm and concluded that out of 20 possible medical malpractice cases, only three cases are accepted for review based on an initial interview with potential clients, and only one case out of those three results in the filing of a notice of claim. Another attorney, who has a rural practice in Rumford, turns down 90% of clients who come to him to sue for medical malpractice injury. He confirms what the other plaintiff attorneys have experienced-- that given the costs of litigation, the damages must be very high for the case to be pursued in this manner.

#### Impact of Pretrial Litigation Panels:

The plaintiff attorneys agreed that the pretrial screening panels have had an effect on their decisions to accept certain types of medical malpractice cases. The time and expense of a medical malpractice case has doubled because the attorneys must now prepare and try the case twice, once before the panel,

and once before the jury. A result is that damages must be even higher in order for a case to be economically viable and some cases that were economically viable before the screening panels were instituted are no longer.

One attorney who does 40% plaintiff work claims that he does not take the screening panels seriously and considers an adverse decision by the panel irrelevant. He does not hire an expert witness nor engage in complete discovery and preparation for the panel hearings. He feels that if he has a good case showing clear negligence and significant damages he will win at trial despite an adverse panel decision. The other plaintiff attorneys are concerned about the effect of a 3-0 panel decision against a plaintiff and thus, they fully prepare for the panel hearing. Justice McCarthy noted that most of the attorneys take the attitude that they must do whatever they can to win before the panel. He agreed, however, that if the plaintiff has a good case, a 3-0 panel decision could be explained to a jury and would not affect the trial. To date, there has not been an adverse 3-0 panel decision that has gone to trial so it is unknown what effect this type of decision will really have when admitted into evidence.

The defense attorneys believe that the screening panels have reduced the time and expense that they must put into their cases by reducing the overall number of claims, weeding out the non-meritorious claims, and encouraging early settlement. The result, they maintain, are lower fees.

The plaintiff attorneys vehemently disagreed that the screening panels have reduced the time and expense of their cases. They feel they do their own weeding out of non-meritorious cases and thus, they consider the panels to be superfluous. They point out that Rule 11 of the Maine Rules of Civil procedure, as well as the Rules of Professional Responsibility, prohibit the filing of a claim that is frivolous. The plaintiff attorneys bypass the screening panels in every case if possible because it saves them time and money. (If both parties agree they may bypass the panels). In addition, all the attorneys remarked that most of the panel decisions were in favor of the defense (3-0 or 2-1). They explained that the doctors who are on the panels are usually from the same geographical area as the defendant doctor and are almost always reluctant to rule against a fellow doctor.

There was agreement among all the attorneys interviewed that the screening panels generally help to encourage settlement. It is easier to convince a plaintiff to settle a case if the screening panel decision is adverse. Some noted, however, the reverse is sometimes true-- that when there is a 3-0 decision, the winning side becomes adamant against settling because they are convinced they have a good case.

All the attorneys interviewed are concerned about the extent of discovery being conducted to prepare for the screening panel hearings. The plaintiff attorneys believe that the defense

bar generally tries to "spend the plaintiff dry" and that unlimited discovery before the screening panel is excessive, time consuming, expensive, and must be duplicated at the trial stage. In their view, many attorneys turn the panel hearing into a minor trial which can take three to four days to complete.

Panel Chairman Justice McCarthy has developed a system to counter excessive discovery. Plaintiff and defense parties decide in advance what method of discovery they will follow. They may agree to limited discovery according to Rule 26(b)4 of the Maine Rules of Civil Procedure or they can conduct full discovery. However, if they choose to conduct full discovery they must agree that it will be used at trial so that the discovery will not be duplicated.

The excessive duration of the screening panel sessions is another issue Justice McCarthy faces. He is concerned that it is going to become increasingly difficult to attract lawyers, doctors and other health care deliverers to sit on the panels if the hearings last three to four days. He advocates the use of prepared reports as opposed to live testimony.

#### Summary:

The plaintiff attorneys felt there was little to gain from the screening panels. They will always waive the screening panel trial if the defense agrees. All of the others interviewed except one defense attorney were reserving judgment on the panels until more time has gone by. Nevertheless, they did think that the panels were weeding out some frivolous claims and encouraging early settlement in certain cases. Judge McCarthy agreed that not enough time has passed and at least eight months should be allowed before the panels can be evaluated in a meaningful way. He considers a value of the panels to be their ability to have a case dismissed against at least some of the defendants. He explains that in most medical malpractice cases the plaintiff sues four to five people or organizations. He believes the screening panels help to acquit two to three people from the lawsuit before it goes to trial. He also believes the panels help to narrow the issues for a subsequent trial.

**SCOMM**

**69:B4**

#4

# MISCELLANEOUS

- 1) Report: Analysis of the Causes of the Current Crisis of  
Unavailability and Unaffordability of Liability Insurance - May 1986
- 2) Report: Tort Cost Trends
- 3) Report: Claim File Data Analysis
- 4) Report: Tort Reform: Past, Present, Future
- 5) Report: Medical Malpractice and Tort System - Peter Jacobson
- 6) Alaska Supreme Court System
- 7) Report: Their Rules, Effects and Costs to the General Public -  
A. L. Tamagni, Sr.

**MISCELLANEOUS**

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

ACKNOWLEDGEMENT

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.

## TABLE OF CONTENTS

|                                                                                                                                                                                                                                                                                          |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| SYNOPSIS.....                                                                                                                                                                                                                                                                            | 1  |
| I. <u>INTRODUCTION</u> .....                                                                                                                                                                                                                                                             | 4  |
| II. <u>DISCUSSION</u> .....                                                                                                                                                                                                                                                              | 9  |
| <u>QUESTION #1:</u> <u>IS THE PROPERTY-CASUALTY INSURANCE</u><br><u>INDUSTRY IN TERRIBLE STRAITS</u><br><u>FINANCIALLY?</u> .....                                                                                                                                                        | 9  |
| <u>CONCLUSION #1:</u> <u>THE PROPERTY/CASUALTY INDUSTRY</u><br><u>IS IN ADEQUATE AND IMPROVING</u><br><u>FINANCIAL CONDITION</u> .....                                                                                                                                                   | 18 |
| <u>QUESTION #2:</u> <u>HAVE THERE BEEN VAST INCREASES</u><br><u>IN THE NUMBER AND SIZE OF</u><br><u>LIABILITY CLAIMS WHICH THE</u><br><u>PROPERTY-CASUALTY INSURANCE INDUSTRY</u><br><u>HAS HAD OR WILL HAVE TO PAY?</u> .....                                                           | 21 |
| <u>CONCLUSION #2:</u> <u>THE EVIDENCE SHOWS NO VAST OR</u><br><u>EXPLOSIVE INCREASES IN CLAIMS</u><br><u>OR PAYMENTS TO VICTIMS</u> .....                                                                                                                                                | 35 |
| <u>QUESTION #3:</u> <u>ARE INCREASED CLAIMS THE CAUSE</u><br><u>OF THE INSURANCE INDUSTRY'S FINANCIAL</u><br><u>PLIGHT, AND THEREFORE OF THE</u><br><u>AVAILABILITY AND AFFORDABILITY</u><br><u>PROBLEMS?</u> .....                                                                      | 37 |
| <u>CONCLUSION #3:</u> <u>THE CYCLICAL NATURE OF THE INDUSTRY</u><br><u>ITSELF, AND NOT ANY CHANGE IN TORT</u><br><u>CLAIMS, IS LARGELY RESPONSIBLE FOR</u><br><u>THE CURRENT "CRISIS"</u> .....                                                                                          | 41 |
| <u>QUESTION #4:</u> <u>IS THE WAY TO AVOID DRASTIC</u><br><u>PREMIUM INCREASES AND SUDDEN</u><br><u>CANCELLATIONS, THEREFORE, TO</u><br><u>CHANGE LEGAL RULES TO LIMIT</u><br><u>THE NUMBERS AND SIZE OF LIABILITY</u><br><u>CLAIMS WHICH INSURERS WILL</u><br><u>HAVE TO PAY?</u> ..... | 42 |
| <u>CONCLUSION #4:</u> <u>CHANGES IN THE CIVIL JUSTICE</u><br><u>SYSTEM ARE NOT LIKELY TO SOLVE</u><br><u>THE CURRENT OR FUTURE PROBLEMS</u><br><u>IN AVAILABILITY AND AFFORDABILITY</u><br><u>OF LIABILITY INSURANCE</u> .....                                                           | 44 |
| III. <u>CONCLUSION</u> .....                                                                                                                                                                                                                                                             | 45 |

## 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.<sup>1/</sup> 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.<sup>2/</sup> 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

---

<sup>1/</sup> 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.

<sup>2/</sup> 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.<sup>3/</sup>

---

<sup>3/</sup> 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.<sup>4/</sup> Even where victims are aware that they have been tortiously injured, many choose not to make any type of claim, and many who do

---

<sup>4/</sup> "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<sup>5/</sup> (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

---

<sup>5/</sup> 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.<sup>6/</sup>

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

---

<sup>6/</sup> 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"]).<sup>7/</sup> In addition,

---

<sup>7/</sup> 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.<sup>8/</sup>

---

<sup>8/</sup> 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.<sup>9/</sup>

---

<sup>9/</sup> 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.<sup>10/</sup>

---

<sup>10/</sup> 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

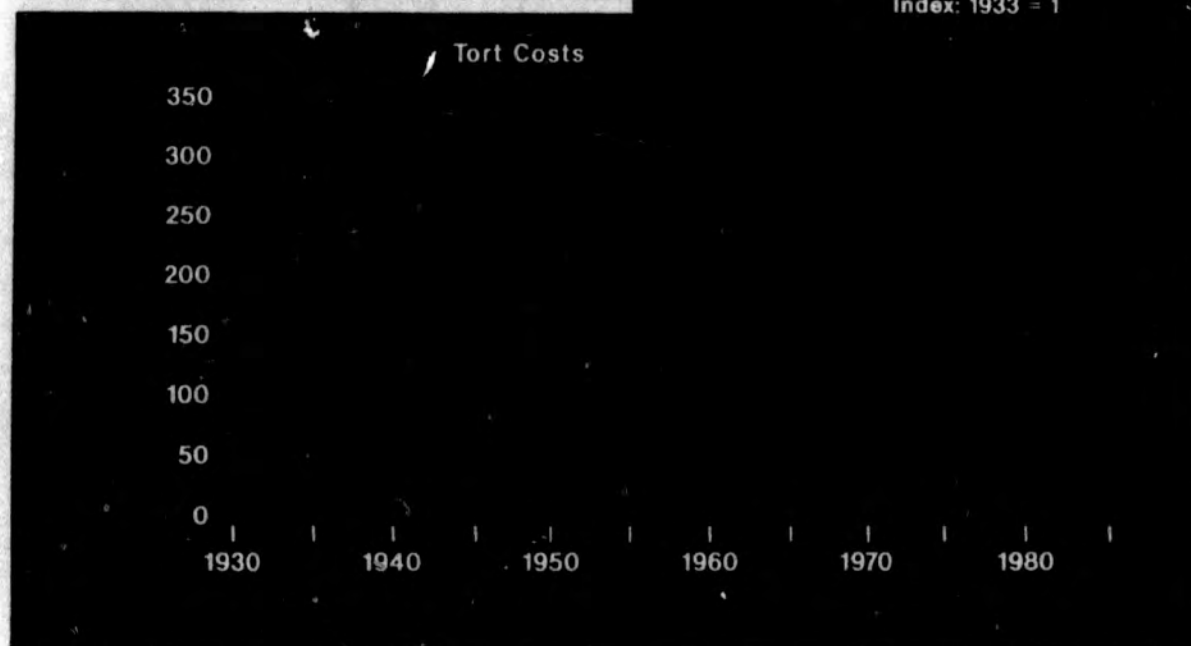
\$93B

\$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

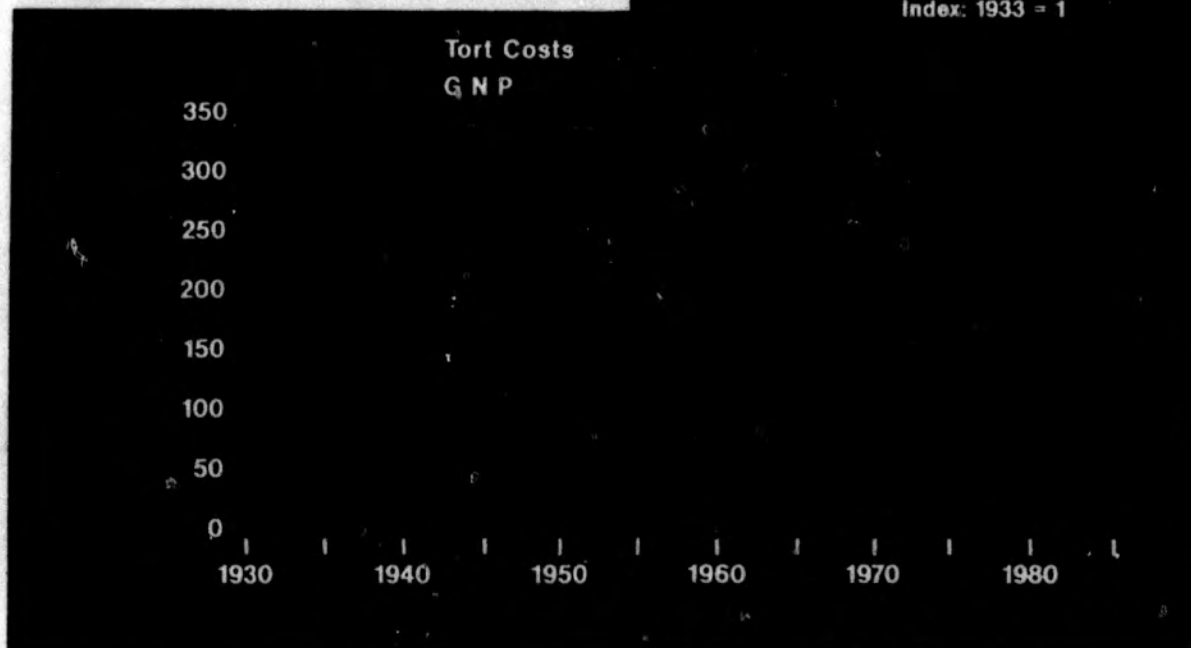


- Over the past 57 years, total tort costs increased approximately 300 times — from slightly less than \$500 million in 1930 to the \$117 billion total noted for 1987.
- Between 1930 and 1950, costs quadrupled, rising from the half-billion-dollar mark to close to \$2 billion in 1950.
- Since 1950, however,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

GROWTH

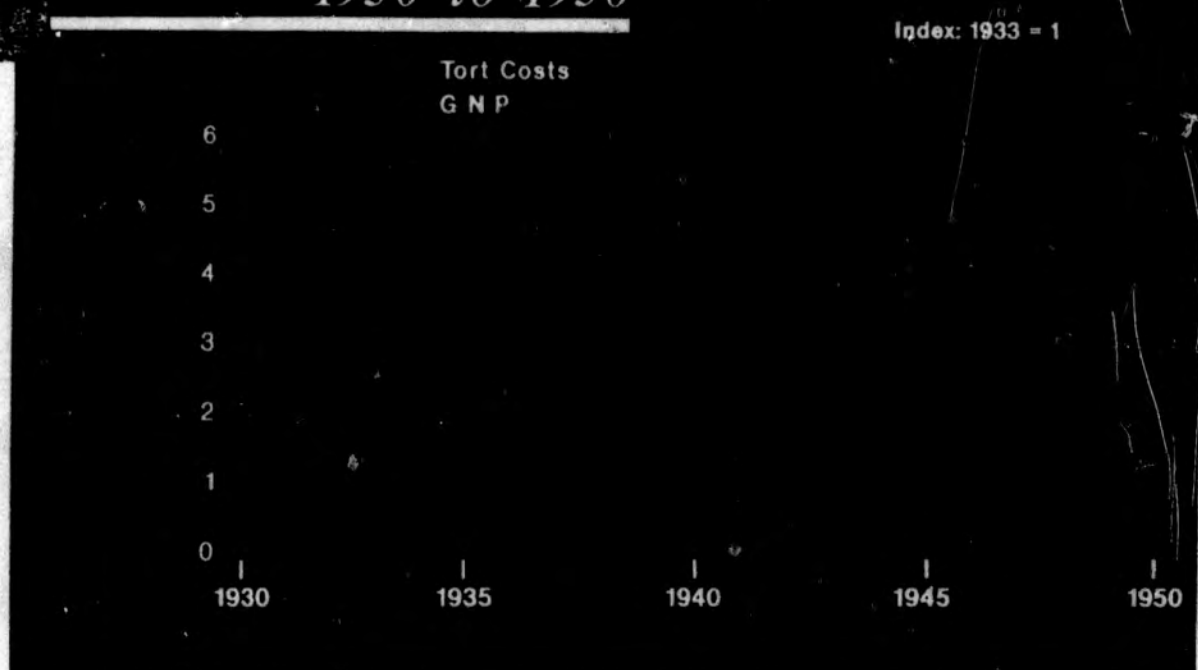
## Torts vs. GNP

Index: 1933 = 1



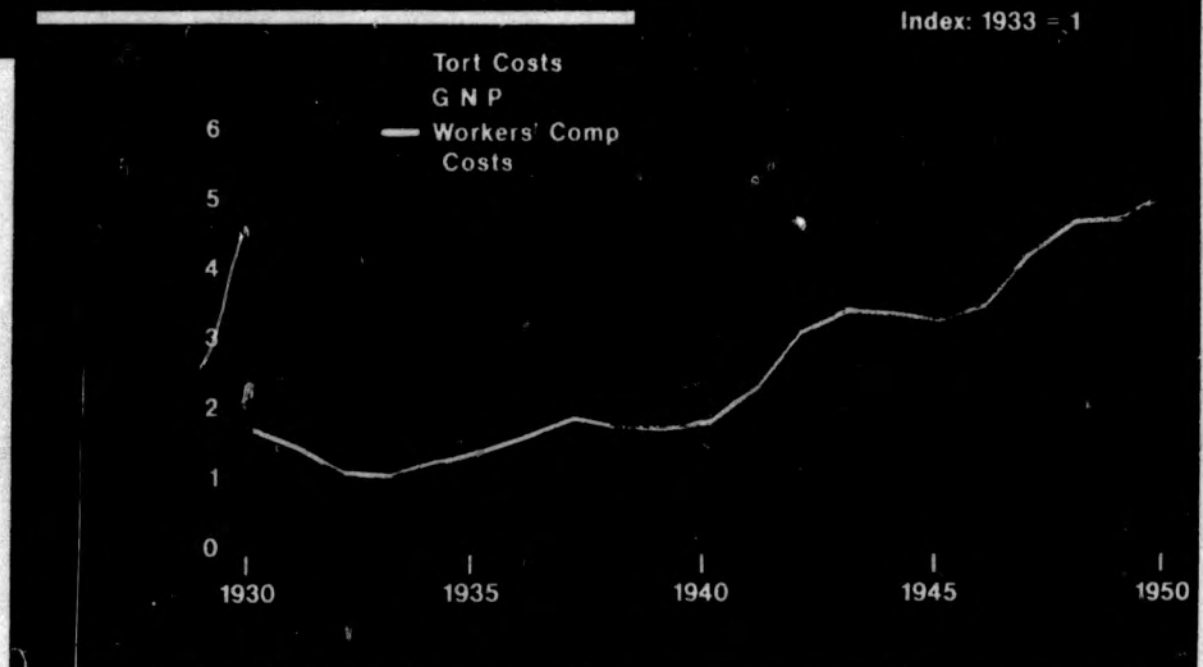
- Tort cost growth far outstripped GNP growth since 1930, increasing 300 times over this 57-year period, compared with a 50-fold increase for GNP.
- Until shortly after World War II, growth in both tort costs and the GNP ran fairly parallel. Only in the late 1940s and early 1950s did the two diverge,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



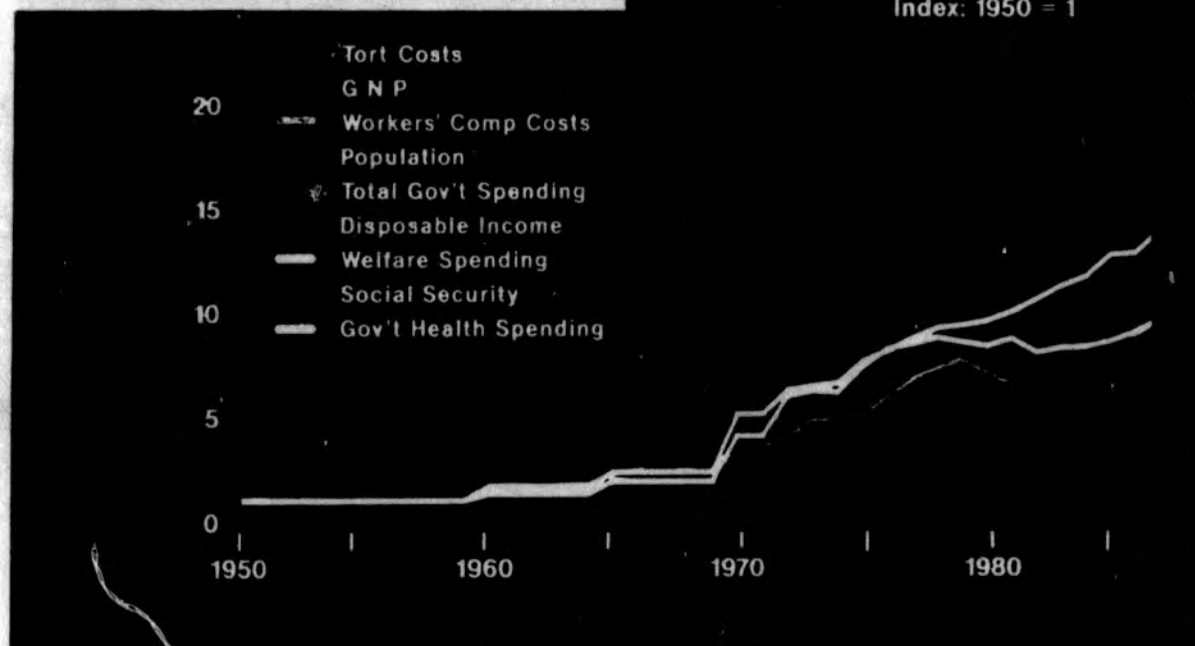
- A comparison of changes in other key economic indicators — disposable income, total government expenditures and public welfare system expenditures — shows that tort system growth continued to outpace virtually everything else in the past 37 years. During the period that tort costs rose almost 14 times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

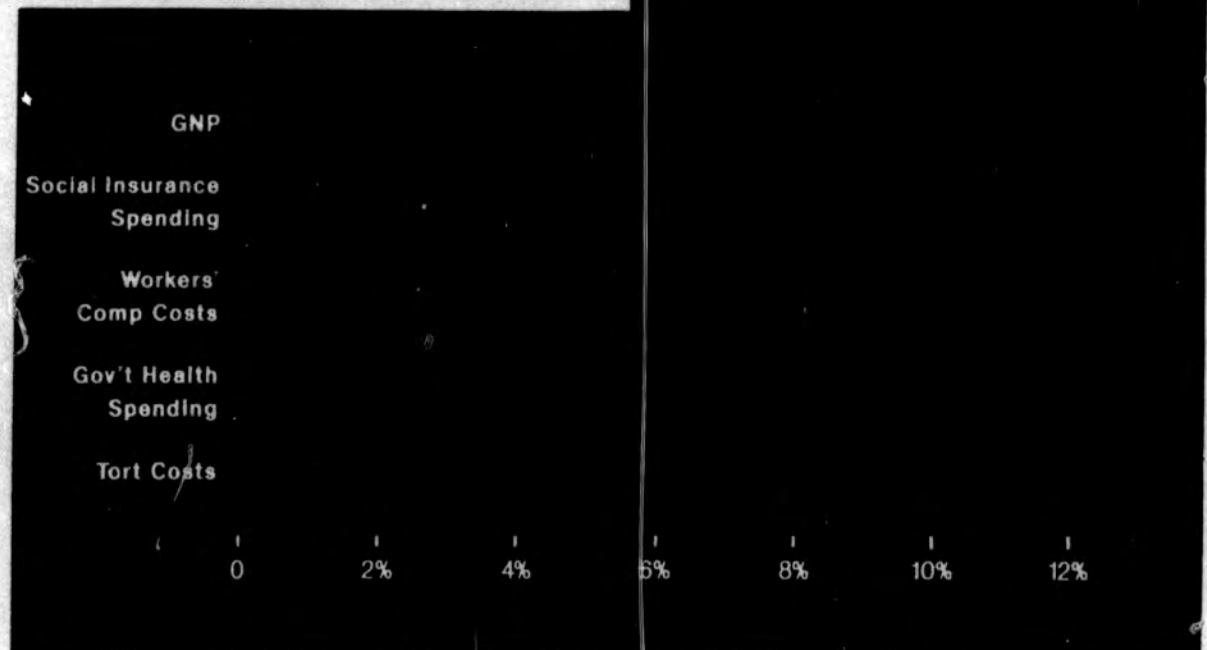
## Real Growth After 1950

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:

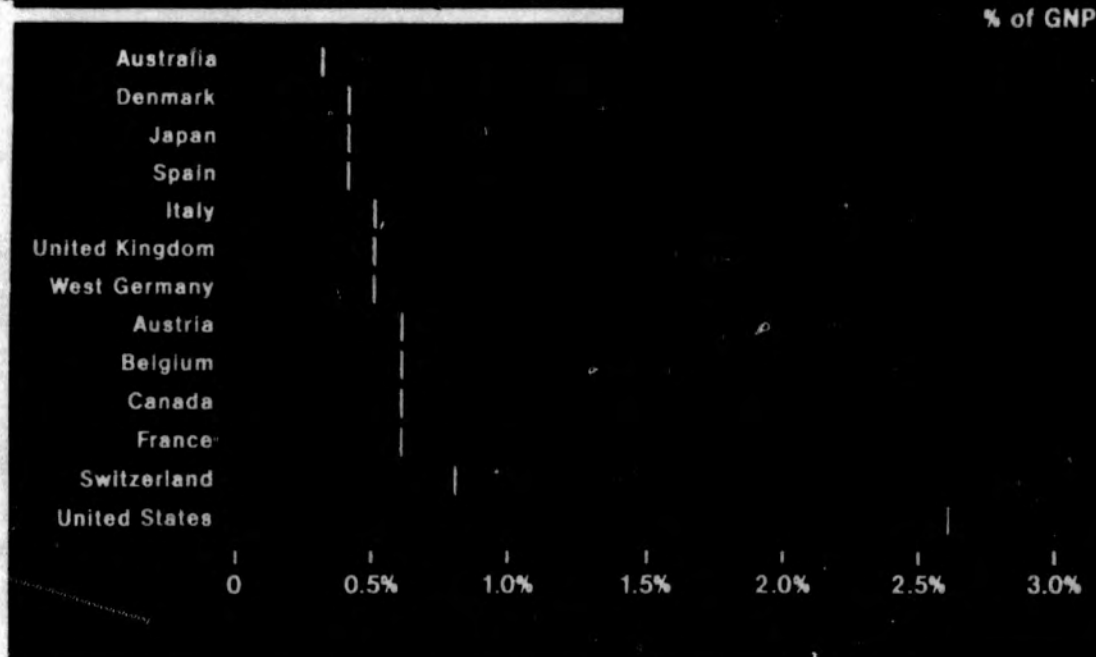
- 5% for government health expenditures
- 4.5% for workers' compensation costs
- 4.2% for Social Security expenditures
- 2.7% for GNP.

## *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.

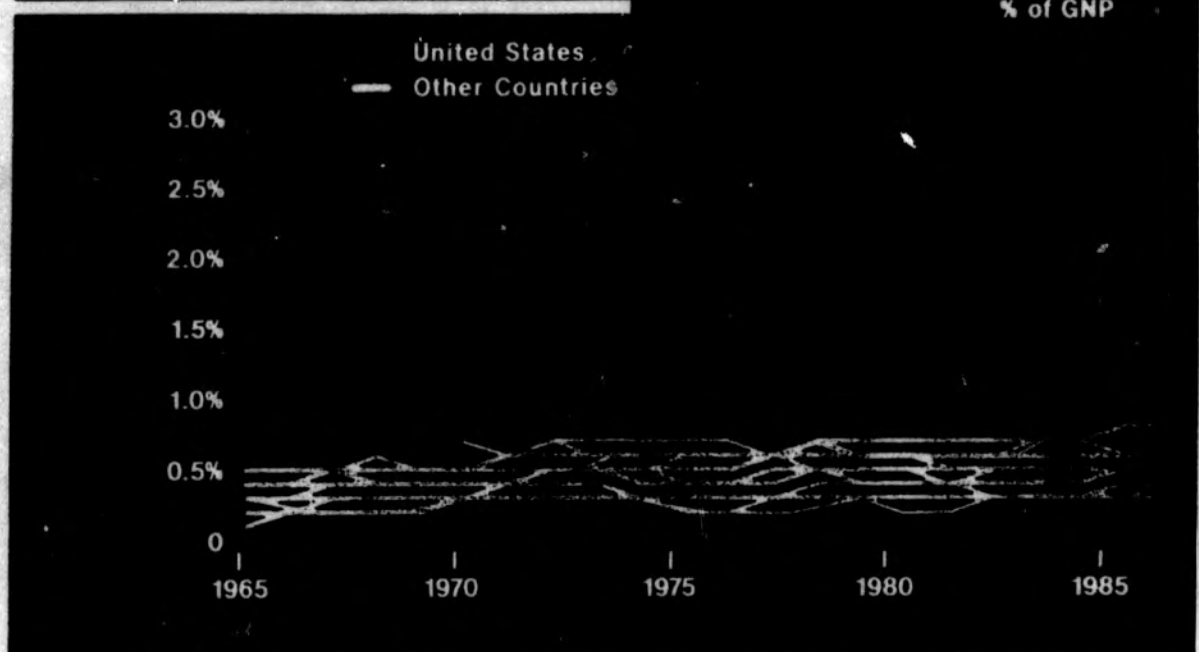
...?  
...?  
...?

## 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.