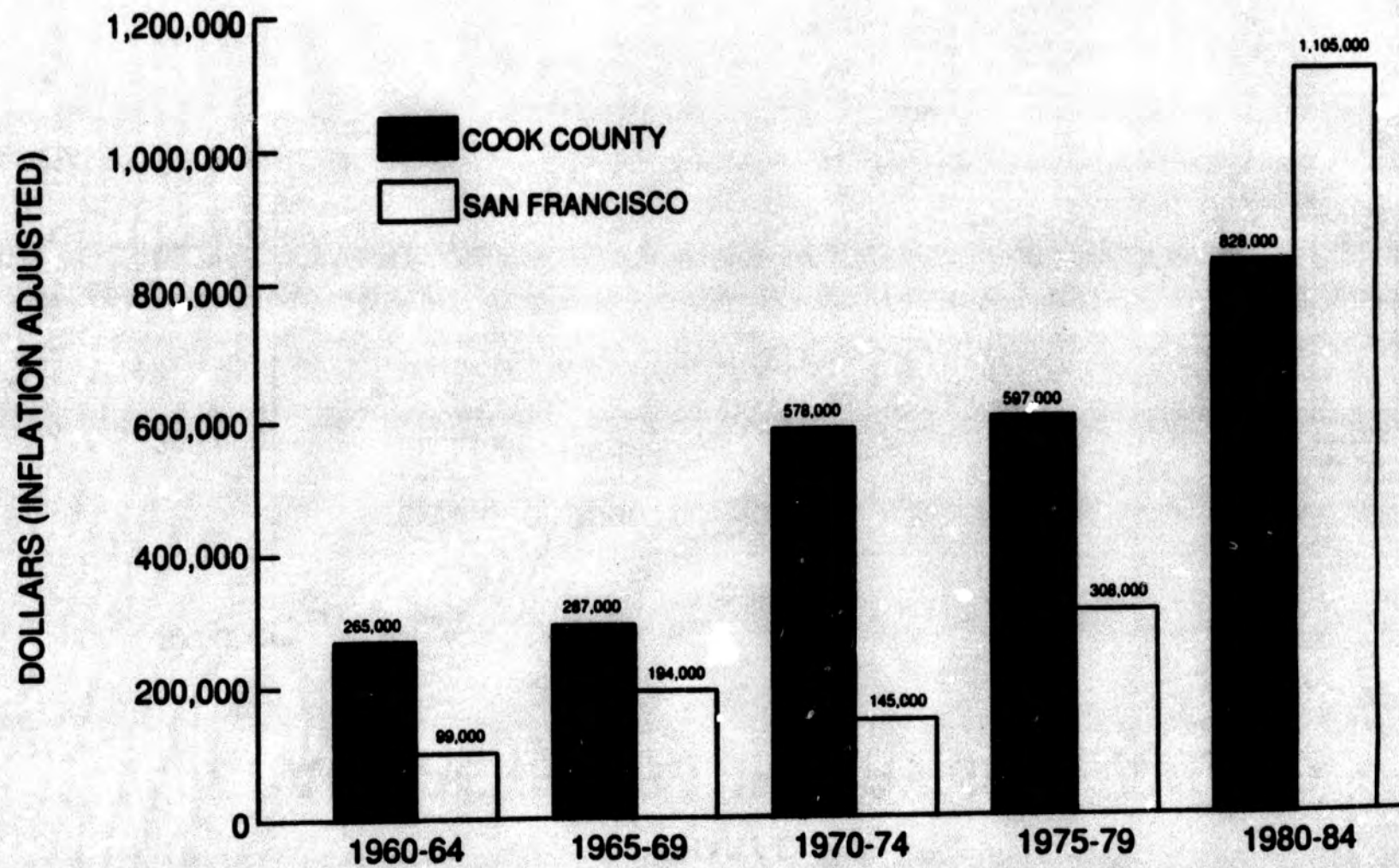


ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672  
1754 SCOMM 69: HOUSE LIABILITY INSURANCE TASK FORCE, 1989-1990<sub>322</sub>

**CHART D**

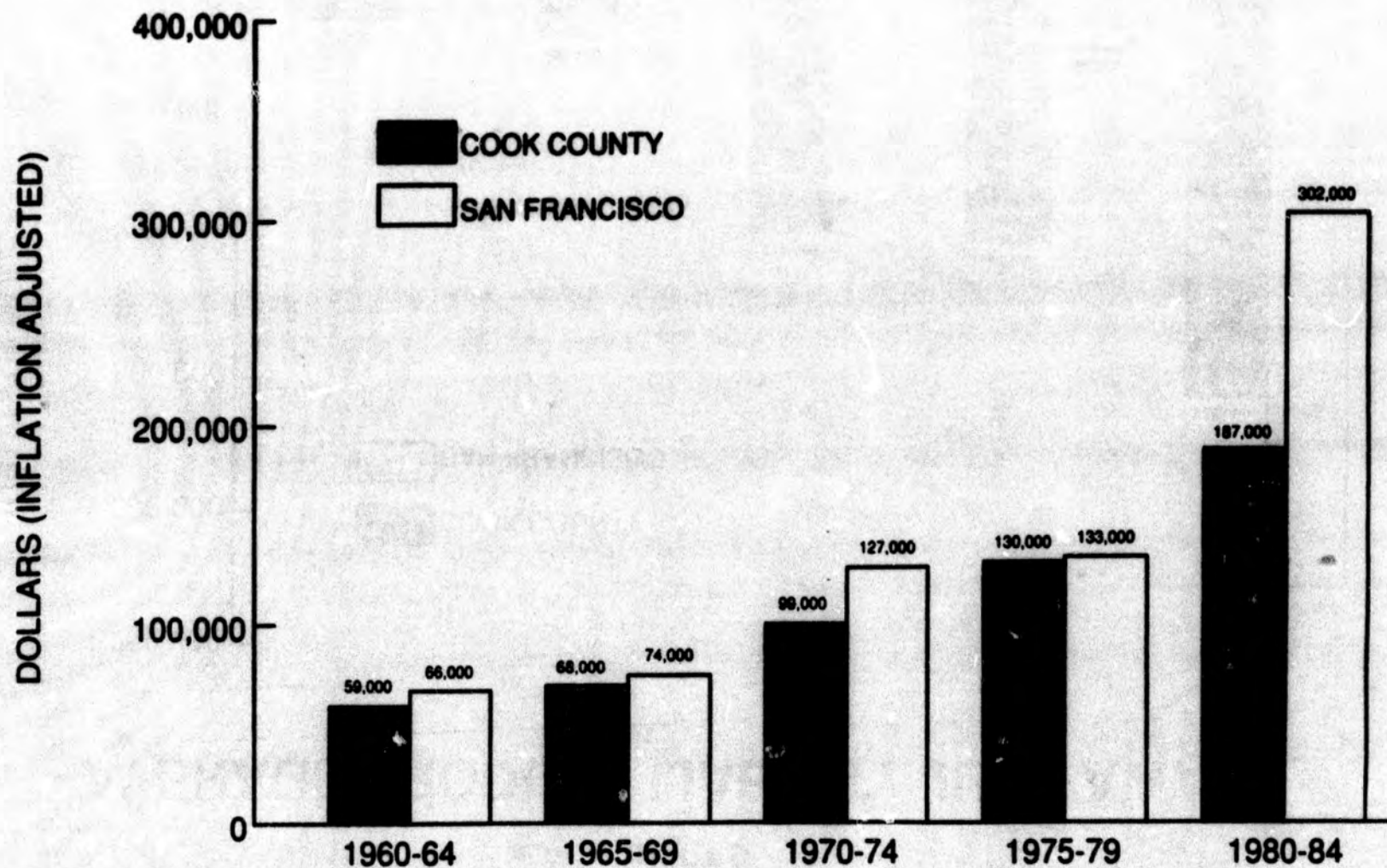
# **AVERAGE PRODUCT LIABILITY JURY AWARD**



**SOURCE: INSTITUTE FOR CIVIL JUSTICE**

**CHART E**

# **AVERAGE PERSONAL INJURY JURY AWARD**



SOURCE: INSTITUTE FOR CIVIL JUSTICE

## B. Expected Jury Awards

This offers another way of illustrating the change in jury verdicts over the past two decades -- the "expected award"; that is, the average jury award multiplied by plaintiff's likelihood of success.<sup>21</sup> The expected award for malpractice jury verdicts increased from the early 1960's to the early 1980's by 4,254% in Cook County (from \$13,000 to \$566,000) and by 1,712% in San Francisco (from \$34,000 to \$616,000) (see Chart F).<sup>22</sup> During the same period, the expected award for product liability jury verdicts increased by 445% in Cook County (from \$76,000 to \$414,000) and by 927% (from \$56,000 to \$575,000) in San Francisco (see Chart G).<sup>23</sup> Similarly, from the early 1960's to the early 1980's, the expected award for personal injury jury verdicts increased by 307% in Cook County (from \$28,000 to \$114,000) and by 448% in San Francisco (from \$33,000 to \$181,000) (see Chart H).<sup>24</sup>

The expected award data illustrate even more clearly that the vast bulk of the increase in jury verdicts occurred during the early 1980's. In many of the above categories of cases the increase during the early 1980's in the expected jury award was double or triple the entire increase in the prior twenty years.

The degree to which average jury awards have increased dramatically in recent years is further illustrated by the data published by Jury Verdict Research, Inc. While the Jury Verdict Research data are not inflation-adjusted and do not meet the same

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<sup>21</sup> Critics of the February, 1986 Report have argued that the average jury awards cited in the Report are "inflated" because they do not reflect cases in which defendants prevail before the jury. The argument misses the point, however, since the Report sought to document the trend of rapidly increasing jury awards. As long as the same categories of data (that is, plaintiffs' verdicts) are compared over time, the Report's conclusion as to the trend remains entirely valid. But since the Report did not reflect that plaintiffs steadily have increased the percentage of jury verdicts in which they prevail, the Report, if anything, understated the magnitude of the trend.

In any event, "expected award" data fully take into account those cases in which defendants prevail before the jury.

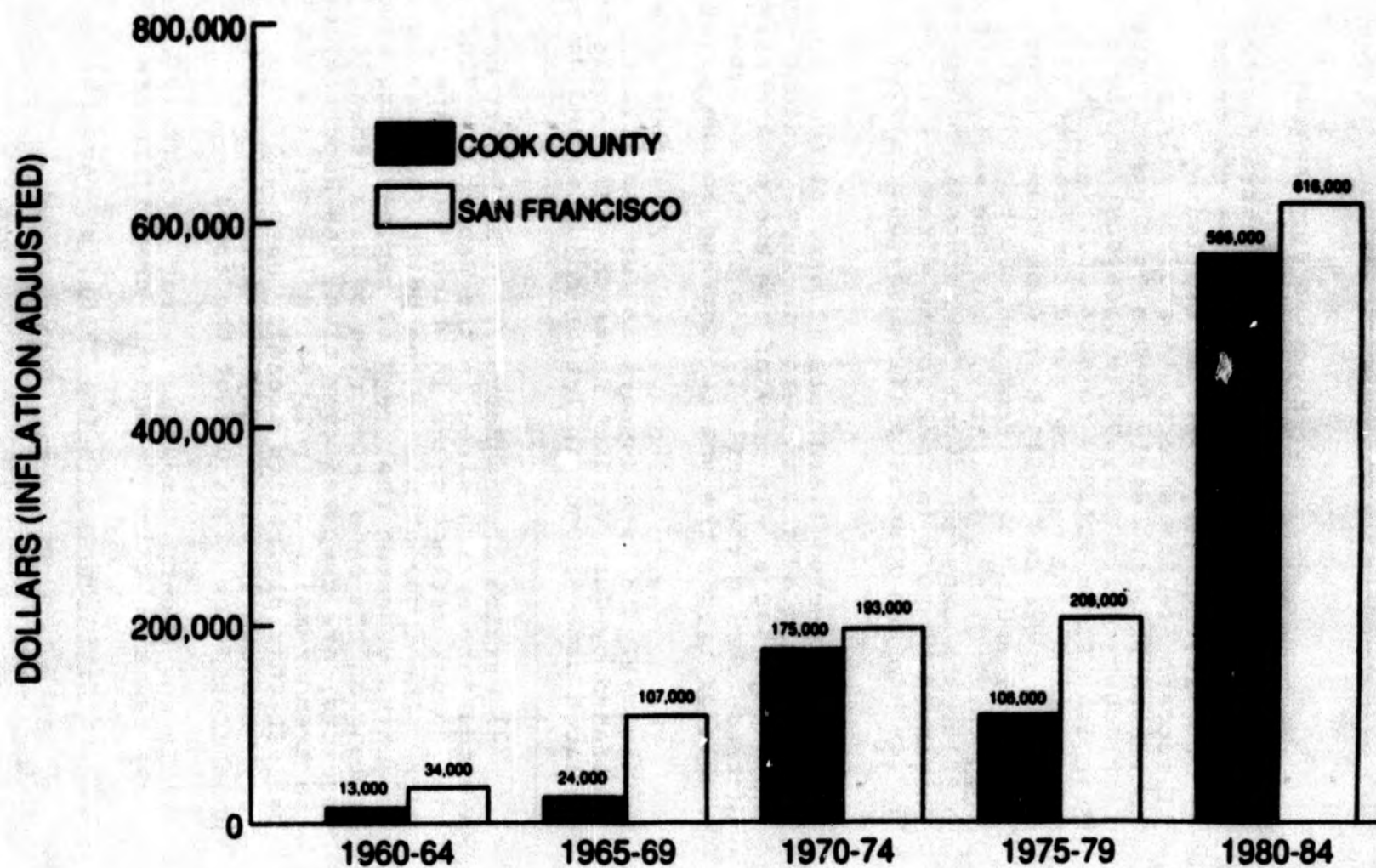
<sup>22</sup> Civil Juries in the 1980s, at page 26.

<sup>23</sup> Id.

<sup>24</sup> Id., at page 35. As with the average jury verdicts, the expected awards are inflation-adjusted and expressed in 1984 dollars.

**CHART F**

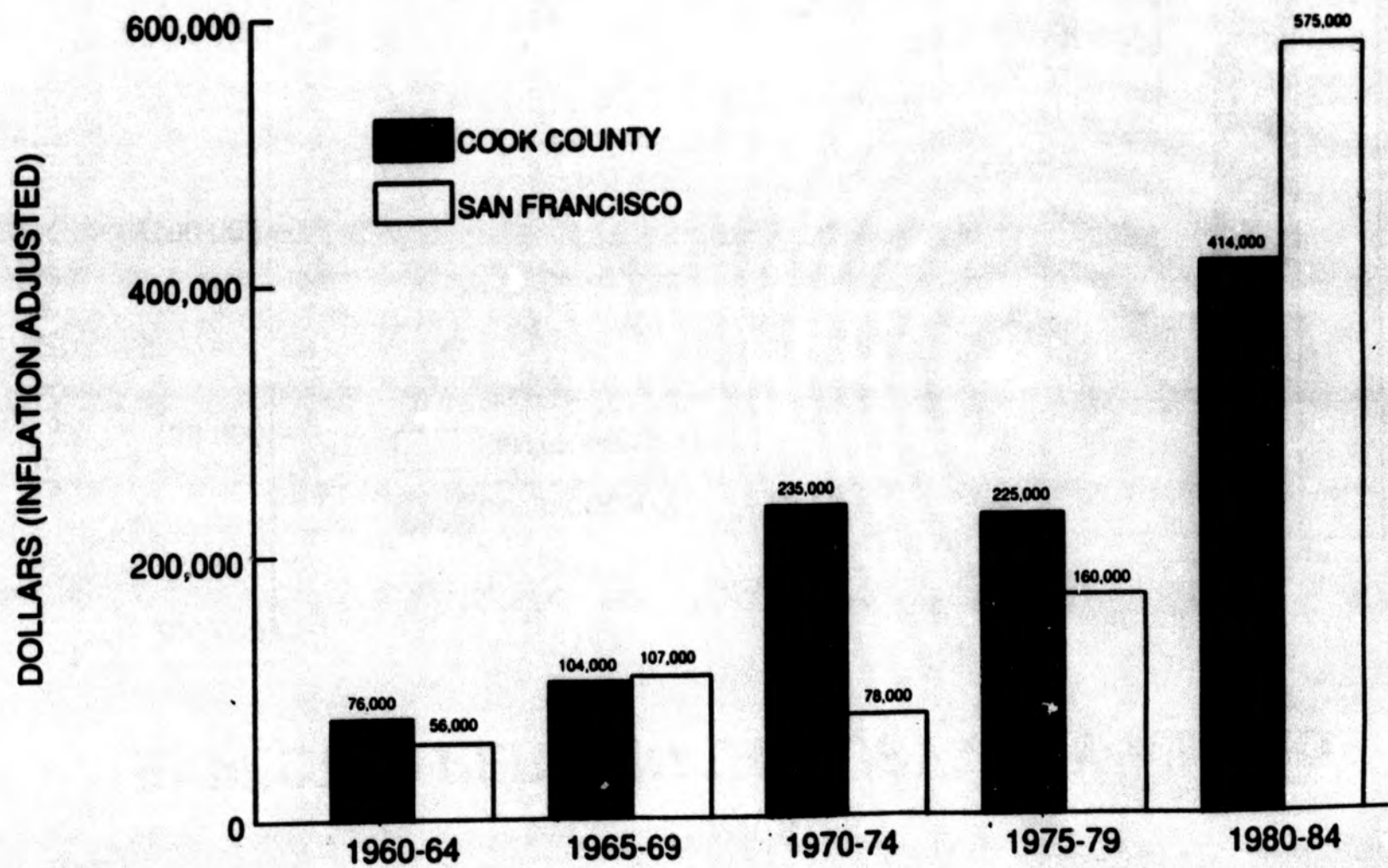
# **EXPECTED MALPRACTICE JURY AWARD**



SOURCE: INSTITUTE FOR CIVIL JUSTICE

**CHART C**

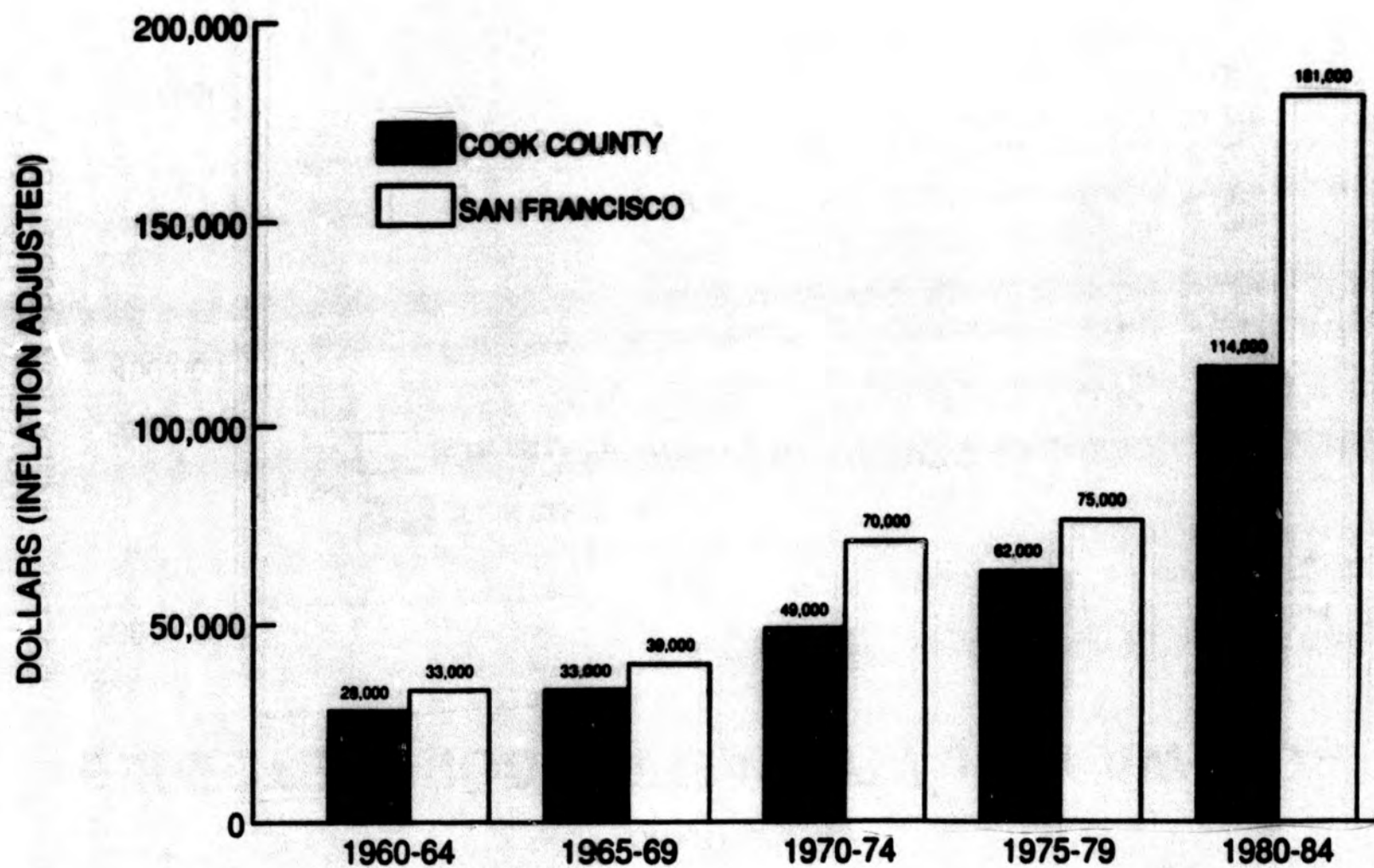
# **EXPECTED PRODUCT LIABILITY JURY AWARD**



SOURCE: INSTITUTE FOR CIVIL JUSTICE

**CHART H**

# **EXPECTED PERSONAL INJURY JURY AWARD**



SOURCE: INSTITUTE FOR CIVIL JUSTICE

rigorous methodological criteria used by the Institute for Civil Justice,<sup>25</sup> they also demonstrate an explosive trend in average verdicts. For example, the average medical malpractice jury award increased from \$220,018 in 1975 to \$2,056,525 in 1986, a 835% increase (see Chart I).<sup>26</sup> The average product liability jury award increased from \$393,580 in 1975 to \$1,971,655 in 1986, a 401% increase (see Chart J). Of particular interest is the fact that the average medical malpractice jury award grew by only \$184,708 from 1975 to 1980 but by \$1,651,799 from 1980 to 1986, while the average product liability jury award grew by only \$169,858 from 1975 to 1980 but by \$1,408,217 from 1980 to 1986. Clearly, the 1980's have been a period of extraordinary and unsurpassed growth in jury awards which has troubling implications for the stability of the entire tort system.

### C. Million-Dollar Jury Awards

The empirical analysis of the Institute for Civil Justice also provides interesting data on the growth in million-dollar jury awards. In its earlier Report, the Working Group noted the substantial growth of million-dollar verdicts, as reported by Jury Verdict Research, Inc. Because the Jury Verdict Research data are not inflation-adjusted, and because it is likely that its methodology understates the absolute number of such verdicts, the data was cited in the February, 1986 Report not as a

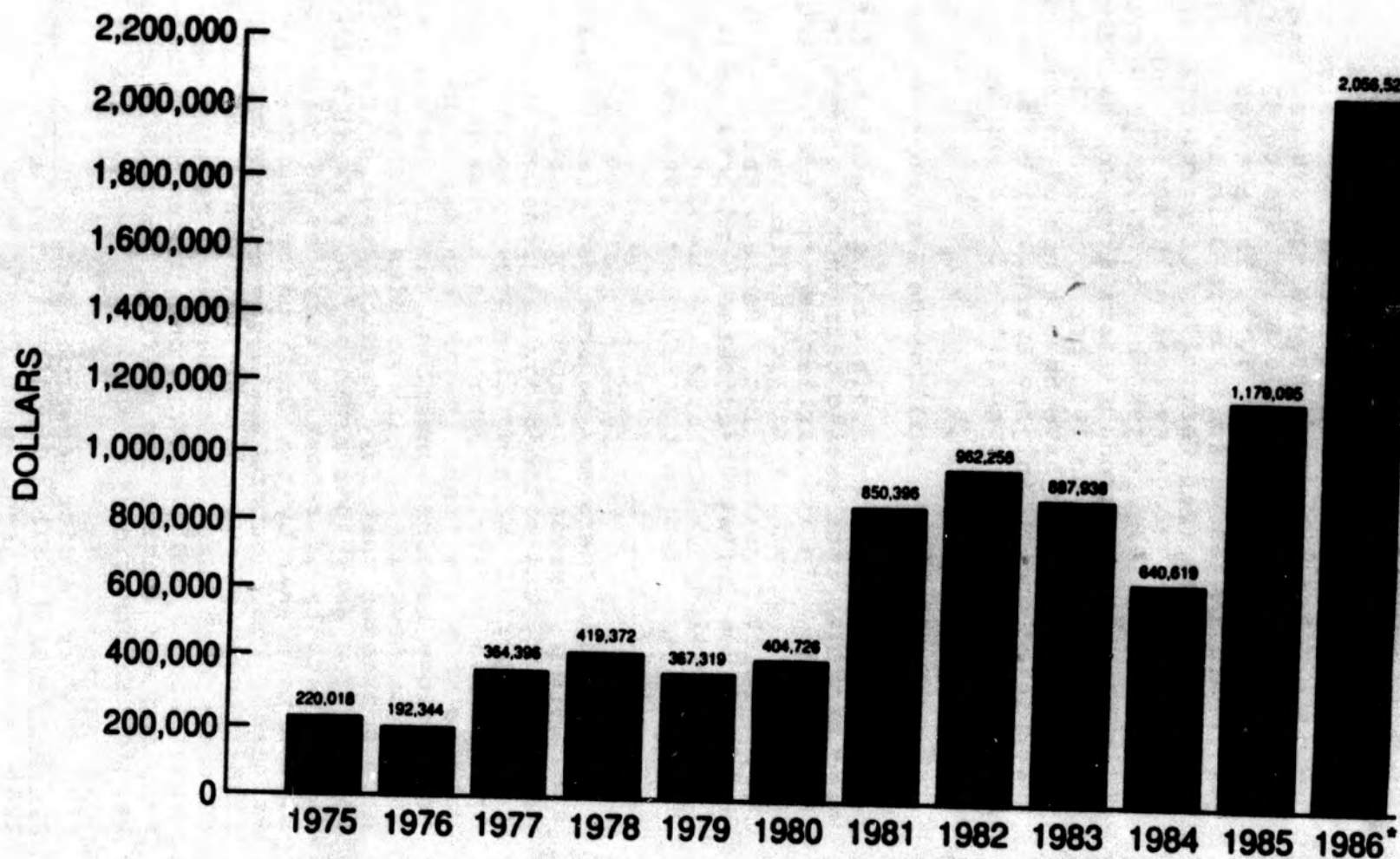
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<sup>25</sup> While there may be some deficiencies with the methodology used by Jury Verdict Research, Inc., as noted in the February, 1986 Report, the methodology has remained consistent over the relevant period. See Working Group Report, at page 35 n.33. Thus, it is entirely appropriate to use Jury Verdict Research data to show the trend in jury awards, since as long as its methodology remains consistent the trends derived from the data should be accurate. While critics of the February, 1986 Report have contended that Jury Verdict Research data are collected purely from newspaper articles, Jury Verdict Research in fact uses a variety of reporting services to obtain jury verdicts. As stated last year by the Chairman of the Board of Jury Verdict Research, Inc., before the House Subcommittee on Economic Stabilization: "We are confident that the data for the hundreds of cases that Jury Verdict Research receives and processes each week (about 2,000 a month) constitutes more than a representative sampling and enables our staff to compile valid statistical verdict information."

<sup>26</sup> Jury Verdict Research, Inc., Injury Valuation: Current Award Trends (1987). The 1975 to 1979 data can be found in the 1986 issue of Current Award Trends, and are summarized in the Working Group's February, 1986 Report, at pages 35-39. The award data for 1986 are incomplete and subject to refinement.

**CHART I**

# **AVERAGE MEDICAL MALPRACTICE JURY VERDICT**

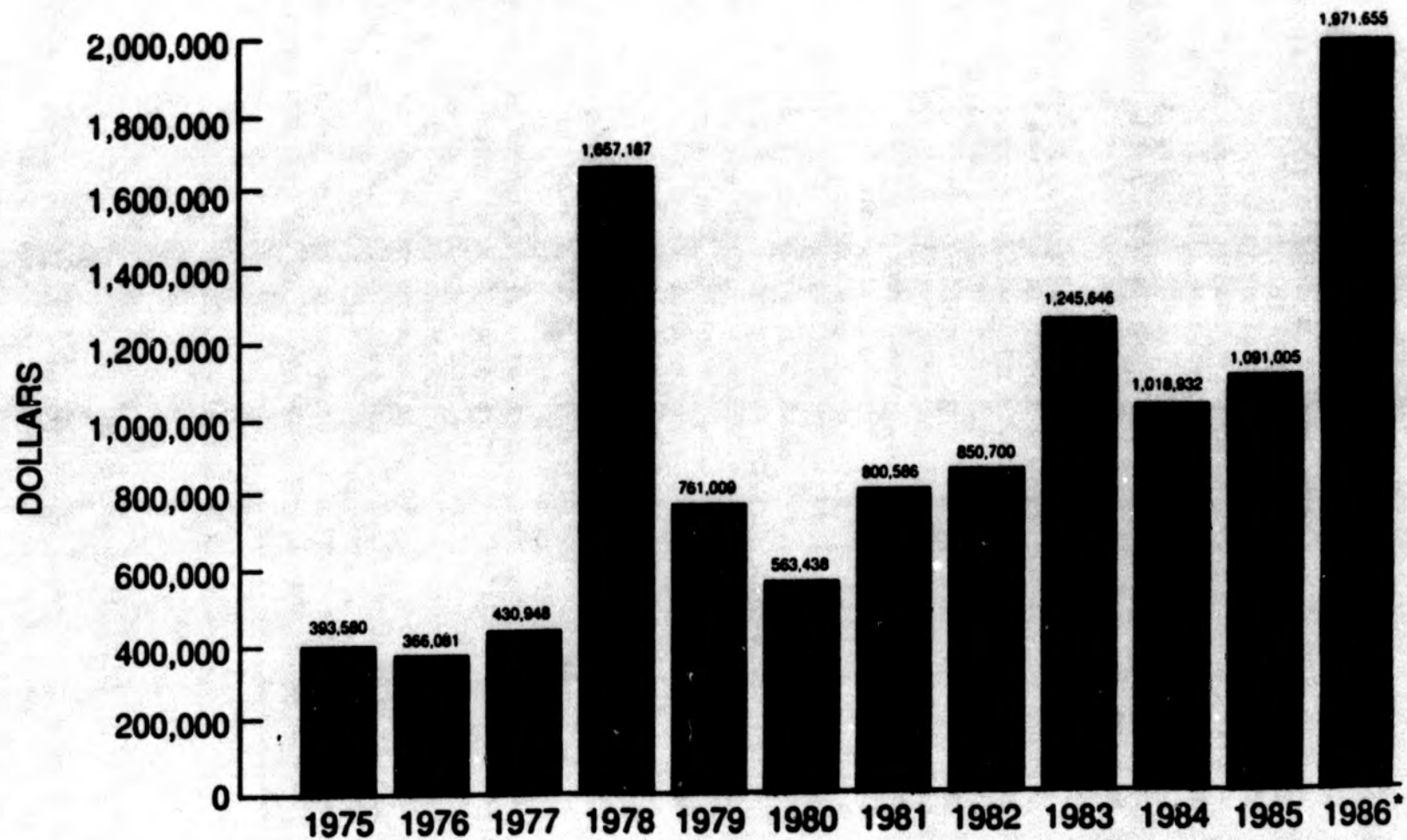


SOURCE: JURY VERDICT RESEARCH, INC.

\* 1986 INFORMATION NOT COMPLETE

**CHART J**

**AVERAGE PRODUCT  
LIABILITY JURY VERDICT**



SOURCE: JURY VERDICT RESEARCH, INC.

\* 1986 INFORMATION NOT COMPLETE

statement of the absolute number of such verdicts, but primarily to demonstrate the rapid growth of "high-end" verdicts. As noted in the Report, these verdicts appear to be largely responsible for the recent extraordinary increases in average jury awards. The Institute's data on million-dollar verdicts are more meaningful in that they are inflation-adjusted (expressed in 1984 dollars), and appear to include all million-dollar jury awards in the analyzed jurisdictions. Not unexpectedly, the data clearly confirm a very substantial increase in million-dollar jury awards.

In Cook County, the analysis shows that million-dollar awards increased from a total of 2 in 1960-64 to 67 in 1980-84, while in San Francisco, such awards increased from a total of 5 in 1960-64 to 21 in 1980-84.<sup>27</sup> What is particularly important is the percentage of the total dollars awarded by juries that were awarded through verdicts of a million dollars or more. In Cook County, this percentage grew from only 4% in 1960-64 to 85% in 1980-84 (see Chart K),<sup>28</sup> while in San Francisco the percentage grew from 14% in 1960-64 to 58% in 1980-84.

The Institute's analysis also provides data on million-dollar personal injury awards as a percentage of all personal injury awards for the 1980-84 period (as noted, this category of cases also includes many lawsuits that typically involve lower monetary stakes). The data show that in Cook County 65% of the total dollars awarded by juries in all personal injury cases were awarded in verdicts of a million dollars or more, while in San Francisco the corresponding percentage was 47%.<sup>29</sup> What is particularly noteworthy is the small percentage of all tried personal injury cases which resulted in million-dollar awards. In Cook County, only 2.8% of all plaintiffs' personal injury jury verdicts resulted in an award of a million dollars or more, yet, as noted, those verdicts accounted for nearly two-thirds of the total of personal injury damages awarded by juries.<sup>30</sup> In San Francisco, only 3.8% of all personal injury verdicts for plaintiffs resulted in an award of a million dollars or more, yet those verdicts accounted for nearly half of the total damages awarded. The obvious conclusion to be drawn from this data is that a very small percentage of all tort cases account for a very

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<sup>27</sup> Civil Juries in the 1980s, at page 33.

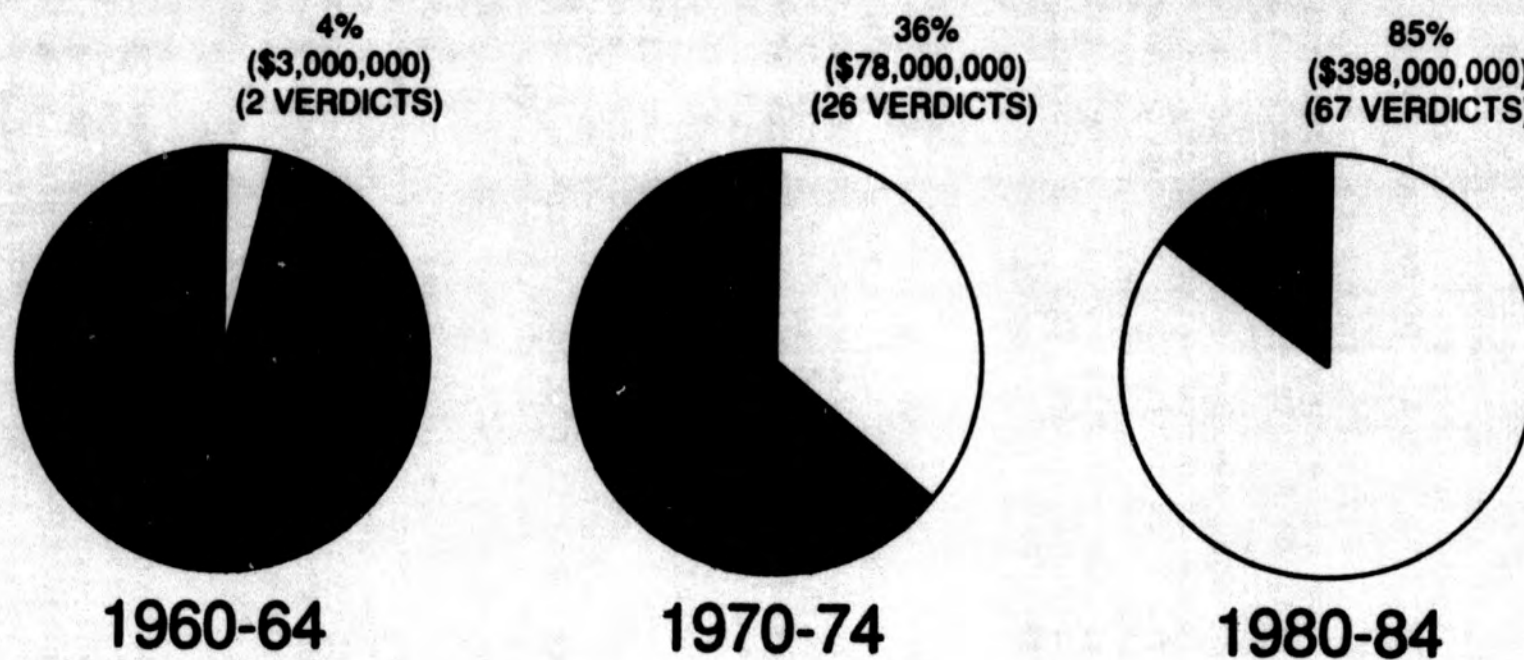
<sup>28</sup> Id.

<sup>29</sup> Id., at page 37.

<sup>30</sup> Id. As a percentage of all personal injury jury trials, including those in which defendants prevailed, million-dollar awards occurred in only 1.7% of all such trials. The corresponding percentage for San Francisco was 2%.

**CHART K**

**PERCENTAGE OF TOTAL DOLLARS\*  
AWARDED BY COOK COUNTY  
JURIES ATTRIBUTABLE TO  
MILLION-DOLLAR VERDICTS**



SOURCE: INSTITUTE FOR CIVIL JUSTICE

\*INFLATION-ADJUSTED DOLLARS

large percentage of all awarded tort damages. Thus, it appears that much of the explosion in jury awards that has manifested itself so dramatically in recent years can be attributed in large part to a small percentage of all cases.

While the Institute's analysis does not distinguish economic from non-economic damages awarded in these "high-end" verdicts, available data suggest that much of the increase in awarded damages is in the form of non-economic damages -- that is, damages awarded for pain and suffering, mental anguish and other forms of nonpecuniary injury.<sup>31</sup> Since non-economic damages are far more subjective and open-ended than economic damages,<sup>32</sup> it should be by no means surprising that a sudden surge in damage awards would be largely attributable to a change in the non-economic rather than the economic components of such damage awards.

#### D. Median Jury Awards

Many of the critics of the Working Group's February, 1986 Report have focused on the Report's use of average (or mean) rather than median jury verdicts to illustrate the extraordinary growth in jury awards and its effect on insurance availability and affordability. Simply put, the average award is derived by dividing the total dollars awarded in a particular category of verdicts by the total number of such awards, while the median award is the dollar level at which half of the awards are at or below and the other half at or above. To illustrate, if there were three jury awards -- one for \$50,000, one for \$150,000, and one for \$1,000,000 -- their average would be \$400,000, while their median would be \$150,000.

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<sup>31</sup> Patricia Danzon, for example, in her analysis of medical malpractice damages, estimates that for jury awards involving more than \$100,000 in non-economic damages, on the average 80% of the entire award is for non-economic damages. See February, 1986 Working Group Report, at pages 67-68. She also estimates that non-economic damage awards in excess of \$100,000 account for between 28% to 50% of all paid out medical malpractice damages. Id.

<sup>32</sup> While the valuation of components such as lost earnings and the cost of necessary medical care is a relatively straightforward process, compensation for pain and suffering, mental anguish and other forms of non-economic damages is wholly subjective and often varies greatly between cases involving similar injuries. Moreover, once economic damages are adjusted for inflation, the objective criteria used to determine these components should preclude large fluctuations over time. Non-economic damages, in contrast, are based on subjective criteria which can change dramatically over time.

Critics of the Working Group's Report have argued that median rather than average jury award data should be used to measure the change in jury verdicts, and that median data do not demonstrate a substantial change in verdicts over the past two decades.<sup>33</sup> They contend that average jury awards, by including a small number of "high-end" verdicts, provide a distorted picture.<sup>34</sup>

The use of median data essentially obscures -- to the point of non-recognition -- the effect of "high-end" verdicts on the trend in jury awards. But, as noted, these "high-end" verdicts, while only a small percentage of all jury awards, represent a very large percentage of the total dollars awarded by juries.<sup>35</sup>

<sup>33</sup> This often repeated assertion appears to be highly questionable. The recently published Institute for Civil Justice analysis shows a very substantial increase in inflation-adjusted median jury verdicts from the early 1960's to the early 1980's. For example, median malpractice jury awards increased in Cook County from \$35,000 in the early 1960's to \$121,000 in the early 1980's, with a corresponding increase in San Francisco from \$64,000 to \$156,000. Civil Juries in the 1980s, at page 22. Median product liability awards in Cook County increased from \$103,000 to \$187,000 during this period, with a corresponding increase in San Francisco from \$27,000 to \$200,000. Id. Jury Verdict Research data, which are not inflation-adjusted, show a very substantial increase during the 1980's in median jury awards for both medical malpractice (from \$200,000 in 1980 to \$515,000 in 1986) and product liability (from \$225,000 in 1980 to \$603,400 in 1986). For purposes of comparison, the Consumer Price Index during this period increased by 33%.

<sup>34</sup> See, e.g., Public Citizen, The Assault on Personal Injury Lawsuits: A Study of Reality Versus Myth; An Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance (1986) (prepared for the National Association of Attorneys General by a task force headed by former Attorney General of Massachusetts Francis X. Bellotti); P. Hermann & Jury Verdict Research, Inc., Report to the Subcommittee on Economic Stabilization of the Committee on Banking, Finance and Urban Affairs, U.S. House of Representatives (1986).

<sup>35</sup> For example, as noted, from 1980 to 1984, 2.8% of all Cook County personal injury jury awards accounted for two-thirds of all awarded personal injury damages, while 3.8% of all San Francisco personal injury awards accounted for nearly half of all such awarded damages. Thus, the use of median jury awards effectively would eliminate from a trend analysis the impact of one-half to two-thirds of all the damages awarded by juries.

Accordingly, median data substantially understate the growth of jury verdicts by eliminating or at least greatly obscuring the effect of the large awards which appear to be the major source of the problem. It is perhaps for that reason that critics of the Working Group's Report have so enthusiastically embraced the use of median rather than average verdicts in analyzing the growth of jury awards.

The simple answer to these critics, however, is that median data cannot, by their very nature, provide any meaningful insight into the relationship between tort damages and insurance premiums. Thus, to the extent one is analyzing jury award trends to assess the effect of those trends on insurance availability and affordability, median data simply are incapable of providing useful information.

An insurer calculating its premiums or a self-insurer setting aside liability reserves is interested in obtaining as accurate a projection as possible of its total liability. If it were to use projected median awards and settlements, it would most likely vastly underestimate its total liability since such data do not reflect the small number of "high-end" settlements and awards that account for a large percentage of its likely total payout. On the other hand, an accurate projection of the average award or settlement would allow the insurer or self-insurer to determine its actual exposure if it could also accurately project the number of settlements and awards it would have to pay.

A simple example illustrates this point. Let us assume that an insurer projects that it will have to pay four claims on a particular policy -- that three of those payments will be in the range of \$100,000, but that at least one payment will be for a million dollars. If it were to use the median payment (\$100,000) to calculate its premiums, the insurer would only collect sufficient premiums to cover a total payout of \$400,000 (4 x \$100,000). If its projections proved correct, it would lose \$900,000 on the policy. On the other hand, if it based its premiums on the average payment (\$325,000), the insurer would collect sufficient premiums to cover the projected payout of \$1,300,000 (4 x \$325,000). Assuming its projections proved correct, the insurer would break even.

Simply put, those who must pay the liability generated by the tort system cannot afford the luxury of using data which effectively ignore the cases which result in the largest payouts. Accordingly, it is virtually impossible to understand the effect (or even to appreciate the existence) of rapidly increasing settlements and awards on the availability and affordability of insurance if one relies on median data.

In sum, the recently published jury award data by the Institute for Civil Justice show an extraordinary growth in jury awards, much of which appears to have occurred in the 1980's.<sup>36</sup> The bulk of this growth seems to come from a small percentage of "high-end" verdicts that account for a very substantial percentage of all awards. Because such "high-end" verdicts tend to consist predominantly of non-economic damages, such damages appear to be the most significant contributing factor to this surge in jury awards.

## II. Case Filings

Some critics of the Working Group's February, 1986 Report have contested the Report's conclusions regarding the increase in the number of product liability and medical malpractice lawsuits. The Report noted that the number of product liability actions filed in federal court from 1974 to 1985 had increased by 758%, and that federal district court medical malpractice actions had increased almost three-fold in the past decade.<sup>37</sup> In addition, the Report cited separate data showing a 123% increase in malpractice claims against physician-owned companies from 1979 to 1983, and a doubling of malpractice lawsuits per 100 physicians from 1976 to 1981<sup>38</sup> (with a tripling per 100 obstetricians/

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<sup>36</sup> It is sometimes suggested that jury awards are irrelevant because only a small percentage of all claims result in a jury verdict, while most claims are settled before trial. But, as previously noted by the Working Group, "settlements by their very nature reflect the range of verdicts available to the plaintiffs. Thus, as jury verdicts skyrocket, so do settlements." Working Group Report, at page 49 n.56. The quoted passage goes on to observe that "[s]ettlements also reflect the plaintiff's likelihood of success." *Id.* As noted, the Institute's data show that plaintiffs have over the years increased their likelihood of success. Accordingly, the most accurate measure of the rate of increase of settlements probably is provided by expected award rather than by average award data.

<sup>37</sup> See Charts J (page 46) and K (page 48) of the February, 1986 Report.

<sup>38</sup> A recently published American Medical Association report indicates that, on average, claims per 100 physicians increased from 3.2 in 1980 to 10.1 in 1985. The Continuing Need For Legislative Reform of the Medical Liability System, at page 7 (1987).

gynecologists during the same period).<sup>39</sup> The Report also cited data showing a substantial increase in recent years in tort claims filed against municipalities (New York City, for example, witnessed a 375% increase between 1979 and 1983).<sup>40</sup>

Nonetheless, these critics have denied that there has been any substantial increase in the number of filings, and have relied almost entirely in this assertion on a study published last year by the National Center for State Courts.<sup>41</sup>

#### A. The National Center for State Courts Study

The Center's study of tort lawsuits used State court data from thirteen States. Based on this data, the Center concluded that there had only been a nine percent increase in tort filings between 1978 and 1984, and that this increase roughly mirrored population growth (eight percent) during the same period. The Center thereupon concluded that there was no "litigation explosion."

At the outset, it must be noted that the Center's study has serious methodological deficiencies, particularly when compared to federal district court caseload data. The Center's study, for example, was limited to only thirteen States, and only two of those States (Kansas and Ohio) provided complete and unqualified data. Eleven of the surveyed States either did not provide tort data for all available courts, or provided data that were otherwise incomplete.<sup>42</sup> In contrast, the federal data are

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<sup>39</sup> These statistics are not, of course, limited to federal court filings. It is worth noting, however, that these numbers are entirely consistent with the federal district court caseload data.

<sup>40</sup> Working Group Report, at page 47.

<sup>41</sup> National Center for State Courts, State Court Caseload Statistics: Annual Report, 1984 (1986).

<sup>42</sup> Idaho, Alaska and Hawaii provided data from all available courts, but the data itself were incomplete. For example, while both superior court and district court data were obtained for Alaska, "low volume" district court data were not included. The Center did not clarify what constitutes a "low volume" district court case, and how many such cases are filed in Alaska. *Id.*, at table 33, p. 184. For Florida, the data do not cover all appropriate courts, and what is provided is incomplete. Specifically, the data for Florida contain circuit court statistics, but no data from the 67 county courts which can also

(continued...)

obtained from all ninety-four judicial districts throughout the United States, and are compiled and maintained in a consistent manner which facilitates comparison over time and among regions or States.

An example illustrates the incomplete nature of the Center's data. The Center's data on filings in California include only superior court filings, not filings from the 85 municipal courts. By using only the superior court data, the Center "found" only a 12% increase in tort filings between 1978 and 1984, identical to the increase in population. But, statistics from the 1976 and 1985 versions of the Annual Report of the Judicial Council of California, which include both superior court and municipal court filings, document an increase in civil tort filings between 1974 and 1984 of 55%, while the population only increased by 21% during this period.<sup>43</sup>

There are other problems with the data used by the National Center for State Courts. The Center used only three snapshots of caseload statistics to substantiate its conclusions. It provided no information on the intervening years (1979, 1980, 1982 and 1983), and, of course, there is no pre-1978 or post-1984 data. Unlike the federal data, which span twelve years, with statistics for each year, the Center's data are, at best, barely adequate to identify trends. Simply put, the Center's use of a very limited number of discrete data points makes it difficult to determine whether those points actually represent trends or, instead, unknowingly focus on aberrations in the data attributable to other factors.<sup>44</sup>

Even more importantly, however, the data used by the Center fail to account for the significant decrease in automobile accident lawsuits which has taken place in recent years. With

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<sup>42</sup>(...continued)

hear some tort cases. And even the Florida circuit court statistics do not include any "professional tort cases."

<sup>43</sup> The superior court filings may show a smaller increase than the combined filings because of an increase in the jurisdictional limits of the municipal courts from \$5,000 to \$15,000 in 1978.

<sup>44</sup> Thomas Marvell, in the May 19, 1986 issue of the National Law Journal, in an article entitled "There is a Litigation Explosion," highlighted the danger of trying to draw conclusions about trends from the limited data used by the National Center for State Courts. Marvell concluded that because of prevailing economic conditions, data from 1981 to 1984 could substantially understate long term litigation trends. He also concluded that "we can expect a very large increase [in civil filings] in 1986."

the advent of no-fault automobile liability insurance, and a nationwide decrease in the number of automobile-related injuries,<sup>45</sup> there has been a corresponding large reduction in automobile accident tort lawsuits.<sup>46</sup> Since automobile accident cases reflect the vast bulk of all tort filings<sup>47</sup>, when these reductions are unaccounted for, they readily can mask substantial growth in other types of tort lawsuits, including product liability and medical malpractice actions. Because the Center's study provides no separate data as to areas of liability such as product liability, medical malpractice and municipal liability, but instead aggregates these claims along with all other tort claims (including automobile accident cases), the Center's report provides no information on the trend of filings in these particular areas of liability.

Thus, because the Center's study aggregates all tort filings, it is impossible to derive any credible conclusions from its study as to the growth in tort claims alleging product liability, medical malpractice, other forms of professional liability or municipal liability -- that is, the very areas of liability that have experienced serious insurance availability/affordability problems and which have been at the core of the debate over tort reform. Indeed, as noted, even a small reduction in filed automobile accident claims could more than mask a massive increase in lawsuits in these other areas of tort liability.

#### B. Federal District Court Caseload Data

Critics of the February, 1986 Report also have raised a number of other arguments regarding the federal district court data cited by the Working Group. They have suggested that the federal data are not meaningful because they represent only a small percentage of all filed tort claims, that the federal data

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<sup>45</sup> Automobile-related injuries dropped from 2,000,000 in 1980 to 1,600,000 in 1984. Automobile-related deaths dropped from 51,100 in 1980 to 43,900 in 1984. Statistical Abstract of the United States, 1986, page 592.

<sup>46</sup> A Department of Transportation study indicates that implementation of some form of no-fault automobile insurance scheme, alone, resulted in reductions in automobile accident lawsuits of from 31% to 80%, depending upon the type of scheme and the jurisdiction. "Compensating Auto Accident Victims" (1985), pages 113-117.

<sup>47</sup> It is generally thought that, at least in the absence of no-fault automobile liability insurance, automobile accidents account for one-half to two-thirds of all tort lawsuits.

are somehow different or atypical, and that the statistics compiled by the Administrative Office of the United States Courts are skewed by a recent surge in removals and the fact that some cases may be counted more than once.<sup>48</sup> All of these assertions simply miss the mark.

While most tort cases in fact are filed in State court, federal court tort filings provide a valuable source of reliable data on the trend in the public's propensity to sue. For example, whether originally filed in federal court, or later removed there, federal district courts handle a significant number of product liability cases each year. In the twelve-month period ending June 30, 1985, over 9,000 non-asbestos related product liability suits were filed in federal court.<sup>49</sup> This, alone, represents almost a 500% increase over 1974. During the same period, total civil filings in federal court rose only 164%.<sup>50</sup> Obviously, whatever its share of total tort filings, district court product liability filings have risen at a rate which greatly exceeds the general rise in civil filings. To dismiss these figures, as some would suggest, simply because they represent a small percentage of all tort cases is specious.

As noted, critics also have claimed that the federal court statistics are inaccurate because they allegedly reflect a continued growth in removed cases and double or triple count transferred cases. These assertions are either completely wrong or insignificant. The percentage of civil filings in district court which are removals from State courts has remained virtually constant over the last ten years. Between 1976 and 1985 that percentage was never lower than 5.8% and never higher than 6.5%.<sup>51</sup> Moreover, the number of civil filings which are original filings also has been remarkably steady. Original filings (that is, not transfers, removals, remands, etc.), have constituted between 88.1% and 89.6% of all federal civil filings for each of

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<sup>48</sup> See Public Citizen, The Assault on Personal Injury Lawsuits: A Study of Reality Versus Myth (1986).

<sup>49</sup> Non-asbestos related claims are cited since it has been asserted that the asbestos litigations make federal product liability data unrepresentative. Id. While many asbestos injury claims in fact are filed in State courts, it should be noted that the deletion of asbestos related lawsuits does not appreciably alter the import of the federal data.

<sup>50</sup> Total civil filings in federal district court rose from 103,530 in 1974 to 273,670 in the twelve-month period ending June 30, 1985.

<sup>51</sup> Annual Report of the Director of the Administrative Office of the United States Courts 1985, Table 17, page 136.

the last ten years. This consistency clearly repudiates the assertion that the growth in federal filings is attributable to any increased inclination to remove cases to federal court.

Nor is the assertion of multiple counting significant. While it is true that a case which is both originally filed and transferred to another district in the same year is included twice in the raw number of civil filings reported by the Administrative Office, the absolute number of such cases is, at best, minimal.<sup>52</sup> More importantly, however, the percentage of civil filings which are transfers has been highly consistent over the years, and has never been high.<sup>53</sup> Equally consistent has been the combined percentage of civil filings which are either original filings or removals from State courts. These categories, which do not include any cases which are double counted, routinely have constituted 95% of all civil filings.

This consistency strongly corroborates the validity of the federal data when used to evaluate trends. There may be minor discrepancies between the raw numbers of "new" federal cases. But these discrepancies are statistically insignificant, and, in any event, have been present in each year's data. Accordingly, the Working Group's conclusions about the percentage growth in federal court litigation are absolutely valid.

In the absence of meaningful data on case filings in State court in areas such as product liability and medical malpractice, the federal district court data compiled by the Administrative Office of the United States Courts provide the most accurate data available on the growth in filed cases. While federal cases represent only a fraction of all tort cases in either of these categories, there is no reason to believe that they do not accurately reflect what is happening in the State courts. Despite its notoriety, the study of the National Center for State Courts simply does not provide the kind of meaningful data which justifies rejecting the obvious conclusions to be drawn from the very substantial increases in federal district court case filings.

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<sup>52</sup> The percentage of civil filings which were transfers in 1985 was less than 1.4%. Id. And, of these cases, only some were transferred in the same year as originally filed.

<sup>53</sup> That percentage hovered around 2% in the late 1970's, but actually decreased to about 1.5% in the first half of the 1980's. Id.

### III. Punitive Damages

In its prior Report, the Working Group noted the extraordinary increase in recent years in the level of punitive damage awards. For example, the Working Group cited data published by the Institute for Civil Justice showing that the average punitive damage award has increased in Cook County from \$63,000 in 1970-74 to \$489,000 in 1980-84, while the average personal injury punitive damage award in Cook County increased from \$40,000 to \$1,152,174 during the same period.<sup>54</sup>

The Working Group did not, however, recommend that punitive damages be abolished. Rather it recommended two reforms: that punitive damages be included within a cap on all non-economic damages; and, that the standard used for awarding punitive damages be one of actual malice.<sup>55</sup> As discussed in Chapter 4, a number of States in 1986 enacted legislation addressing punitive damages. In addition, punitive damages has been a key issue in the debate over tort reform, and was a particularly important element of the recent Senate consideration of a federal product liability bill.

While there are some who believe that punitive damages do not present a significant problem, there appears to be a growing consensus within the legal community that punitive damages indeed are in need of reform. For example, the Task Force on Litigation Issues of the American College of Trial Lawyers recently made the following statement on punitive damages.<sup>56</sup>

The Task Force unanimously agrees that one of the greatest problems with the current tort system is the way in which punitive damages are handled. Awards often bear no relationship to deterrence and reflect a jury's dissatisfaction with a defendant and a desire to punish, often without regard to the true harm threatened by a defendant's conduct. There is a general feeling that punitive damage awards should be

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<sup>54</sup> Working Group Report, at pages 39-42. The awards are inflation adjusted and expressed in 1984 dollars. The Institute recently has published a more thorough analysis of punitive damage awards, which not only reviews available data for Cook County and San Francisco, but also includes data for all of California for the 1980-1984 period. M. Peterson, S. Sarma & M. Shanley, Punitive Damages: Empirical Findings (1987).

<sup>55</sup> Working Group Report, at pages 68-69.

<sup>56</sup> Report of the Task Force on Litigation Issues, American College of Trial Lawyers, at page 4 (1986).

more difficult to obtain and that the amounts of such awards should be controlled much more than they are at the present time. . . . The most important reform should be to limit, either by a lid or some general formula (for example, three or four times actual damages), the amount of punitive damages that may be recovered.

Most recently, the American Bar Association House of Delegates approved the recommendation of its Action Commission to Improve the Tort Liability System regarding punitive damages. Among other proposals, the ABA recommends tightening both the standard of conduct and standard of proof necessary to obtain punitive damages, as well as giving judges the authority in certain cases to allocate part of such damages to public purposes.<sup>57</sup>

Those who disagree with the proposition that punitive damages are a serious problem in need of reform generally base their argument on two assertions.<sup>58</sup> First, they contend that punitive damages have not really grown excessively if median rather than average award data are used. Second, they argue that because punitive damages are rarely awarded, and because the "typical" (that is, the median) punitive damage is not really that high, the problem has been overstated. Unfortunately, these critics do not appear to appreciate fully the nature of the problem.

At the outset, it should be noted that punitive damage awards, while generally infrequent, are not nearly as rare as often suggested. For example, the recent analysis by the Institute for Civil Justice indicates that the number of punitive damage awards in Cook County grew from 3 in 1960-64 to 75 in 1980-84, and in San Francisco grew from 14 in 1960-64 to 51 in 1980-84.<sup>59</sup> In San Francisco, almost one out of every seven

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<sup>57</sup> The Action Commission originally recommended that all punitive damages be allocated to public purposes after paying "a reasonable portion of the punitive damage award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim." This recommendation was watered down in a compromise before being submitted to the House of Delegates.

<sup>58</sup> See, e.g., Public Citizen, The Assault on Personal Injury Lawsuits: A Study of Reality Versus Myth; An Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance (1986) (prepared for the National Association of Attorneys General by a task force headed by former Attorney General of Massachusetts Francis X. Bellotti.)

<sup>59</sup> Punitive Damages: Empirical Findings, *supra*, at page 9.

The following is the Working Group's draft of a statutory formulation for an effective limitation on non-economic damages.

#### **Limitation on Non-Economic Damages**

- (a) Non-economic damages may not be awarded in excess of \$200,000 in any action subject to this Act.
- (b) For purposes of this section, "any action" includes all actions (including multiple actions) for damages, and includes all plaintiffs and all defendants in such actions, which arise out of or were caused by the same personal injury or death.
- (c) As used in this section, "non-economic damages" means all damages other than damages for economic loss, and includes punitive or exemplary damages. "Economic loss" means past and future (A) expenses of health or other care, (B) expenses of rehabilitation, (C) loss of earnings, (D) loss of homemaker services, and (E) burial expenses.

The limitation includes a definition of economic loss because of the concern expressed by some that courts hostile to a limitation on non-economic damages would create new forms of economic damages to substitute for limited non-economic damages.

#### **III. Punitive Damages**

As is obvious from the language of the above draft limitation on non-economic damages, the Working Group recommended in its prior Report that punitive damages be included within the overall limitation on non-economic damages. This remains the Working Group's preferred approach. While some have recommended a separate, perhaps higher, limitation for punitive damages, the Working Group is concerned that such an approach would lead courts and juries to award punitive damages as a way of circumventing a limitation on non-economic damages. Certainly, it would lead plaintiffs' attorneys to add punitive damage claims almost routinely to every claim (which, unfortunately, increasingly is the case anyway).

There are, however, alternative approaches that have considerable merit. One obvious reform is simply to abolish

punitive damages in all cases where the underlying claim for compensatory damages is based on negligence, malpractice or strict product liability. Historically, punitive damages arose in the context of intentional torts. It is only relatively recently that they have found their way into non-intentional tort actions. Restricting their application to intentional torts would simply return them to their traditional role in the tort system.

Another alternative is to limit punitive damages to a portion or multiple of plaintiff's awarded economic damages.<sup>137</sup> Such an approach would have the benefit of ensuring that the larger punitive damage awards are made to seriously injured plaintiffs.

A third alternative is to have all or virtually all of the award paid to the state to be used for public purposes. Since punitive damages are a windfall for the plaintiff and his attorney, there is much to be said for ensuring that this windfall accrues to the public. However, this approach is unprecedented in our legal system (although several States enacted such provisions last year), and may generate difficult problems of application and administration, particularly for the vast majority of cases settled out of court.

A fourth approach is to restrict attorneys' contingency fees to no more than 5% of any punitive damage award. While it is unlikely that such a restriction would prevent plaintiffs from seeking punitive damages where they are merited, it would reduce the incentive many plaintiffs' attorneys now have to pursue such claims at the cost of a reasonable settlement in their client's best interest.

The Working Group is relatively skeptical about the value of changing the standard of conduct or burden of proof which plaintiff must demonstrate to obtain punitive damages. While commendable, such changes are highly subjective, and thus quite susceptible to abuse. The recent increase in punitive damages has taken place, for the most part, with no articulated change in the doctrinal standard pursuant to which they are awarded. Accordingly, the Working Group believes that the most effective legislative approach to reforming punitive damages is to place some objective restriction on such damages, as discussed above. However, if the only possible reform is to address the required standard of conduct or burden of proof, the Working Group strongly recommends that punitive damage awards be restricted to

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<sup>137</sup> The Working Group recommends that economic damages be used because the highly subjective nature of non-economic could lead to an inflated non-economic damage award to increase the punitive damage award.

cases where the plaintiff can demonstrate by clear and convincing evidence that the defendant acted with actual malice.<sup>138</sup>

#### IV. Periodic Payments

The use of periodic payments for future economic damages can produce savings for the defendant or his insurer without depriving the plaintiff of anything to which he otherwise is entitled. Periodic payment provisions address those cases where the judge or jury have found that at some point in the future the injury suffered as a result of a defendant's conduct will cause the plaintiff to incur certain expenses or to forego certain income. The use of periodic payments simply allows these sums to be paid to the plaintiff as they accrue.

As a result, there should be little reason to oppose the availability of periodic payments when either party believes it to be a better course of action in a particular case. When cases are settled for large amounts, the parties frequently agree to structured terms which result in the payment of the settlement over a long period of time. There is no reasoned distinction for precluding the use of similar arrangements simply because the amount of damages has been determined by a jury instead of through a settlement.

There are several important criteria, however, to the effective use of periodic payments. First, their use should not be left to the court's discretion. Instead, they should be required, but only when at least one of the parties indicates that some form of periodic payments is desirable. It serves no purpose to require periodic payments in a case where neither party desires that they be used.

Second, whatever periodic payments schedule is fashioned, it must not be open-ended -- that is, it must not be subject to subsequent modification, except upon agreement of the parties. To allow either party to seek changes to the agreement from the court will quickly consume in additional litigation and transaction costs any savings that result from the use of periodic payments. In other words, a periodic payments provision should under no circumstances undermine the finality of the court's damage award.

Third, the Working Group continues to believe that periodic payments should not be imposed when future economic damages do

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<sup>138</sup> Under an actual malice standard, the plaintiff must show that the defendant acted with an "evil motive," such as with an actual intention to inflict harm. See Smith v. Wade, 461 U.S. 30, 78 n.12 (1983) (Rehnquist, J., dissenting).

not exceed a certain minimum level. The Working Group recommends a minimum of \$100,000, though some States have set an even higher level.

Finally, such a provision should protect plaintiffs from the possible insolvency of defendants by permitting the court under appropriate circumstances to require the defendant to purchase an annuity providing the periodic payments.

The Working Group drafted the following provision which meets its criteria for periodic payments.

#### **Periodic Payments of Judgments**

- (a) In any action subject to this Act in which the damages awarded for future economic loss exceeds \$100,000, no person may be required to pay damages for future economic loss in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur.
- (b) The court may require such person to purchase an annuity making such periodic payments if the court finds a reasonable basis for concluding that the person may not make the periodic payments.
- (c) The judgment of the court awarding such periodic payments may not be reopened at any time to contest, amend, or modify the schedule or amount of the payments in the absence of fraud.
- (d) This section shall not be construed to preclude a settlement providing for a single, lump-sum payment.

#### **V. Collateral Source Rule**

The collateral source rule provides that a plaintiff's award may not be reduced by other sources of compensation the plaintiff receives as a result of the same injury. The Working Group sees no reason for why plaintiffs should be permitted to receive double compensation, particularly where part of the compensation is paid by the government. It simply makes no sense to require consumers of goods and services to pay higher prices to

compensate plaintiffs through tort settlements or judgments, and then to pay higher taxes to compensate plaintiffs a second time through government benefits for the same injury.<sup>139</sup>

There are two important qualifications to the Working Group's position on the collateral source rule. First, it does not believe that collateral sources purchased purely by the plaintiff or his family should be included in the offset. Only benefits paid for in whole or in part by the government or by some independent source (such as the plaintiff's employer) should be treated as collateral sources to be offset from the tort award.

Second, the Working Group is concerned that existing subrogation rights not be lost. Thus, a collateral source offset ideally should not apply where there is a subrogated claim for restitution of the collateral source. This makes sense since a source of income is not really "collateral" if the plaintiff is required to reimburse the collateral source from the tort award.

Some have suggested that such subrogation proceedings, particularly as they apply to workers' compensation payments, involve such high transaction costs that it may be advantageous to prohibit subrogation in certain situations. Particularly in the context of product liability, there appears to be considerable support for the position that substantial resources would be saved by a prohibition on subrogation proceedings by employers against liable manufacturers as well as indemnification proceedings by liable manufacturers against employers. The reasoning is that such subrogation and indemnification lawsuits generate considerable attorneys' fees without providing much in the way of social benefit. Thus, it is argued that the prohibition of such suits would be a "wash" for employers and liable manufacturers while saving both sides substantial attorneys' fees.

The Working Group has considerable sympathy for this argument, and does not wish its position on subrogation to be understood as opposition to such an arrangement if mutually acceptable to both employers and manufacturers.

The following is the collateral source modification provision drafted by the Working Group.

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<sup>139</sup> For this reason, the Working Group believes that an abolition of the collateral source rule should be in the form of a mandatory offset rather than a provision which merely allows evidence of collateral sources to be submitted to the jury.

### **Collateral Sources of Compensation**

- (a) Any award of damages to a person in an action subject to this Act shall be reduced by the court by the amount of any past or future payment or benefit covered by this section which the person has received or for which the person is eligible on account of the same personal injury or death for which such damages are awarded.
- (b) As used in this section, "payment or benefit covered by this section" means --
  - (1) any payment or benefit by or paid for in whole or in part by any agency or instrumentality of the United States, a State or a local government, or
  - (2) any payment or benefit by a workers' compensation system or a health insurance program funded in whole or in part by an employer;but does not include any such payment or benefit that is (or by law is required to be) the subject of a reasonably founded claim of subrogation, reimbursement or lien.

### **VI. Attorneys' Contingency Fees**

There is growing recognition that attorneys' contingency fees are a source of abuse that needs to be addressed. Even the American Bar Association House of Delegates recently adopted a recommendation that such fees be scrutinized more carefully.<sup>140</sup> But there continues to be substantial disagreement about how these abuses should best be addressed.

The Working Group believes that a sliding scale is the best and most equitable approach to dealing with the problem of excessive contingency fees. On the one hand, it ensures that contingency fees will be high enough to induce attorneys to take

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<sup>140</sup> The tort reform recommendations recently adopted by the House of Delegates would, among other things, require that, upon a complaint by plaintiff, the fee arrangement and the bill be submitted to the court after judgment is entered, which would then have the power to disallow any "plainly excessive" fee in light of prevailing rates and practices.

smaller claims, while, on the other hand, precluding immense and unjustified windfalls to attorneys from very high verdicts and settlements. The Working Group believes that such a sliding scale will provide more than adequate compensation for attorneys, while significantly reducing the transaction costs that make tort litigation such an extraordinarily expensive dispute resolution system.

The Working Group does not believe that provisions that merely give greater discretion to courts to review contingency fees will be very effective. While some contingency fees undoubtedly would be reduced by some courts if given greater discretion to do so, such actions likely would be rare and would have virtually no impact on the overall cost of tort litigation.

The following is the provision drafted by the Working Group on attorneys' contingency fees.

#### **Attorneys' Contingency Fee Arrangements**

- (a) An attorney who represents, on a contingency fee basis, a person bringing an action subject to this Act may not charge, demand, receive or collect for services rendered in connection with such action in excess of 25 per centum of the first \$100,000 (or portion thereof) recovered, plus 20 per centum of the next \$100,000 (or portion thereof) recovered, plus 15 per centum of the next \$100,000 (or portion thereof) recovered, plus 10 per centum of any amount in excess of \$300,000 recovered by judgment or settlement in such action.
- (b) As used in this section, "contingency fee" means any fee for professional legal services which is in whole or in part contingent upon the recovery of any amount of damages, whether through judgment or settlement.
- (c) In the event that such judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the attorney contingency fee shall be based on the cost of the annuity or trust established to make payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

## CHAPTER 6

### **THE RELATIONSHIP OF TORT REFORM TO INSURANCE AVAILABILITY AND AFFORDABILITY**

In its Report of last year, the Working Group recommended eight reforms of tort law. The Working Group felt that these eight reforms "would bring a greater degree of rationality and predictability to tort law, and thereby significantly assist in resolving the availability and affordability crisis."<sup>141</sup> The Working Group recognized that its list of recommended reforms was by no means exhaustive, but concluded that their adoption would result in "a more predictable and affordable liability allocating mechanism."<sup>142</sup>

The eight reforms recommended by the Working Group were:

- o Return to a fault-based standard for liability.
- o Base causation findings on credible scientific and medical evidence and opinions.
- o Eliminate joint and several liability in cases where defendants have not acted in concert.
- o Limit non-economic damages (such as pain and suffering, mental anguish, or punitive damages) to a fair and reasonable maximum dollar amount.
- o Provide for periodic (instead of lump-sum) payments of damages for future medical care or lost income.
- o Reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery.
- o Limit attorneys' contingency fees to reasonable amounts on a "sliding scale." And,
- o Encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

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<sup>141</sup> Working Group Report, at page 60.

<sup>142</sup> Id.

As related in Chapter 4, a number of States enacted tort reform proposals in 1986, many of which addressed the same problems identified by the Working Group. Recently, however, there has been a growing sense of frustration in some quarters that these enacted reforms have not been followed by immediate substantial rollbacks in the price of insurance. In some instances, the insurance market has tightened even further despite the enactment of tort reform legislation. Not surprisingly, opponents of tort reform have seized upon these events to claim that tort reform has no effect on insurance availability or affordability. But even some strong supporters of tort reform have expressed their disappointment at the fact that insurance prices have not responded more rapidly to the enactment of tort reform legislation.

Unfortunately, the reality is that the deterioration of our civil justice system is a long-term problem, and that any legislative reforms simply will not cure that deterioration overnight. While the impatience and frustration of those who expect immediate results is understandable, it also is unrealistic. There are several important, inescapable reasons for why tort reforms take time to affect insurance availability and affordability, and it is crucial to the national debate on tort reform to understand those reasons.

One important reason that enacted tort reforms frequently do not have an immediate impact on insurance is the time consuming process of determining their constitutionality. It can take years, perhaps a decade or more, before the highest court of a State renders its opinion on the constitutionality of a particular tort reform provision. For the plaintiffs' bar, tort reform is a two-front war -- the first front is the State legislature, but any loss there still can (and usually will) be challenged in the courts.<sup>143</sup>

The time consuming nature of such constitutional litigation is amply demonstrated by California's experience. In 1975 California enacted a set of comprehensive medical malpractice reforms, entitled the Medical Injury Compensation Reform Act of 1975 (MICRA). These reforms were immediately challenged in the

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<sup>143</sup> The September 5, 1986 issue of Business Insurance reported that the American Trial Lawyers Association has established a Constitutional Challenge Committee to coordinate efforts to overturn legislative tort reforms. The article indicates that, among other things, the Committee will provide legal research assistance as well as model briefs. Id., at page 1. For a discussion of various theories and cases challenging tort reforms on State and federal constitutional grounds, see Smith, "Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws," 38 Okla. L. Rev. 195 (1985).

courts, and not until nearly a decade later did the California Supreme Court (by a four to three vote) and the United States Court of Appeals for the Ninth Circuit uphold the constitutionality of the statute. Fein v. Permanente Medical Group, 38 Cal.3d 137, 695 P.2d 665 (1985);<sup>144</sup> Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985).

Insurers, of course, are well aware of such constitutional challenges, and of the fact that many such challenges against the medical malpractice statutes enacted in the mid-1970's were relatively successful. They also are aware that if a particular tort reform provision is declared unconstitutional, their liability will be determined on the basis of pre-existing law, even if the insurance premium was calculated on the basis of the reformed law. Accordingly, many insurers are reluctant to write policies which take tort reforms completely into account until those reforms have been found to be constitutionally valid.

A second factor which often delays the impact of tort reform is the process of judicial construction and application. Frequently, even where the reform is thought to be constitutional, there is sufficient ambiguity in the statutory language to allow courts great leeway in construing and applying the statute. Unfortunately, judges opposed to tort reform often are quite creative in interpreting reform provisions so as to reduce or even virtually eliminate their effect. Other times, however, the problem can be traced to poor legislative draftsmanship and unclear or contradictory legislative history. Thus, many tort reforms provisions are sufficiently confusing or ambiguous (or have minor ambiguities which are exploited by opponents of the provision) that their meaning often can only be determined after years of litigation.

Obviously, the process of judicial construction and application can delay the impact of tort reform legislation for years. Just as insurers are reluctant to write policies on the basis of statutes that may be declared unconstitutional, they also are reluctant to write policies on the basis of statutes whose meaning is ambiguous and whose effect may be eviscerated through hostile judicial interpretation.

A third reason tort reform provisions often take time to have their desired effect on insurance rates is that the impact of some reforms can only be determined through experience. The effect of certain reforms, such as a cap on liability or an offset of collateral sources of compensation, should be

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<sup>144</sup> The United States Supreme Court, in declining to review Fein, held that the decision did not raise a substantial federal question. Fein v. Permanente Medical Group, \_\_\_ U.S. \_\_\_, 106 S.Ct. 214 (1985).

relatively easy to "cost out." The likely savings from other reforms, however, particularly those directed at changing standards of liability or proof, use of alternative dispute resolution, tightening of sanctions for frivolous or abusive litigation, and regulation of attorneys' fees, are far more difficult to assess. In essence, the insurer must make behavioral judgments about plaintiffs, juries and attorneys that are inherently speculative. For example, to what extent does a more rigorous burden of proof (such as the use of "clear and convincing" rather than "preponderance of the evidence") affect the willingness of a plaintiff to bring a claim, or the willingness of his or her attorney to settle the claim, or, most importantly, the final determination of a jury? These are critical questions which are extraordinarily difficult to answer in the abstract.

Insurers often are reluctant to make such abstract behavioral judgments. Where possible they try to base their underwriting decisions on actual claims experience, and such claims experience can accumulate for several years before it provides meaningful insights. That is not to say that insurers cannot and do not attempt to assess the impact of tort reforms without the benefit of detailed claims experience. It is to say, however, that many insurers are unwilling to assume large (and sometimes optimistic) savings on the basis of behavioral assumptions for which there is no corroborating claims experience.

It also is important to note that tort liability is only one factor -- albeit the most important factor -- which determines the price of insurance. There are other considerations which also change over time, such as the prevailing interest rates, the return available from investment securities, State regulatory practices (including reserve requirements), and taxes, which affect the price of insurance. If some or all of these considerations exert upward pressure on the price of insurance, tort reform provisions may do no more in the short-term than to reduce the rate of premium increases.

Finally, the effect of many tort reforms may be obscured by the continuing deterioration of other aspects of the tort system which have not been reformed. Thus, for example, a mandatory offset of collateral benefits may achieve substantial savings, but those savings may be overwhelmed by continuing increases in non-economic damage awards. The collateral benefit reform may have reduced the price of insurance over what it otherwise would have been, but due to other aspects of tort law, the price of insurance nonetheless may have increased, perhaps even substantially.

None of the above should be interpreted to mean that tort reform does not affect the availability and affordability of

insurance. To the contrary, as discussed below, there is persuasive evidence of such an effect. But the above considerations indicate that the impact of tort reform often can be very difficult to ascertain in the short-term, even if its long-term impact can be quite substantial.<sup>145</sup>

While there is some anecdotal evidence showing that the tort reforms enacted in 1986 already are having an impact on insurance availability and affordability,<sup>146</sup> it is far too early to have any solid statistical evidence demonstrating the existence and extent of the impact of these reforms on the insurance market. There is, however, a body of data which is quite useful in documenting the link between tort reform and insurance. This body of data can be derived from the medical malpractice reforms of the mid-1970's, which have been in place (at least in those States where their constitutionality has been upheld) long enough to provide some useful information.

Recently, the General Accounting Office (GAO) studied six State medical malpractice statutes and their affect on claims and

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<sup>145</sup> The Report of the Governor of New York's Advisory Commission on Liability Insurance provides a synopsis of the practical and methodological difficulties inherent in trying to quantitatively document a direct link between specific tort reform measures and insurance pricing. Insuring Our Future, Vol. II, at pages 58-70. Despite these limitations, the Commission was sufficiently persuaded of the link between tort reform and liability insurance to recommend significant tort reforms as part of its overall solution to the liability insurance crisis. Id., at pages 70-180.

<sup>146</sup> For example, it has been reported that, as a result of the tort reforms enacted in Connecticut in 1986, the Hartford Insurance Group has reduced its liability insurance premiums for Connecticut municipalities by as much as 10%; Aetna Life and Casualty has agreed to freeze its liability rates for Connecticut policyholders; and, Fireman's Fund has started to underwrite certain risks for the first time. The elimination of joint and several liability in Wyoming has caused at least one company to lower its municipal liability insurance premiums in that State by 10%. And in New Hampshire, recent tort reforms are reported to have resulted in a 16% decrease in liability rates for both municipalities and day care centers.

In other States, such as Alaska, Colorado and Washington, insurance companies are expressing a willingness to expand their underwriting in certain areas, and even to return to markets that previously had been abandoned as uninsurable. In each case, the reason for this increased availability has been attributed to the tort reforms enacted in those States.

the cost of medical malpractice insurance.<sup>147</sup> Of particular interest is the comparison between California, which enacted a very rigorous medical malpractice statute in 1975,<sup>148</sup> and Florida and New York, which enacted substantially weaker reforms in the mid-1970's.<sup>149</sup>

The three States are useful for purposes of comparison since all three are highly urbanized,<sup>150</sup> and have large populations and substantial insurance markets. It is worth noting that of the three, California has the tort system most generally advantageous to plaintiffs. Indeed, the California Supreme Court has for many years been one of the most activist courts in the Nation in developing new tort liability theories, and has issued many of the seminal opinions which have undermined the role of fault and causation in determining liability. MICRA, on the other hand, is one of the most rigorous medical malpractice statutes in the United States. See footnote 148, *supra*.

The GAO study provides the following data as to the increase in malpractice insurance rates during the 1980's.

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<sup>147</sup> GAO, Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (1986). The six analyzed States were Arkansas, California, North Carolina, Florida, Indiana and New York. The GAO also issued a separate report covering each State. The title of the summary report is somewhat unfortunate, since it suggests tort reform may not affect insurance costs. In fact, the data contained in the report lead to precisely the contrary conclusion. And as already discussed, there are a number of factors that determine the cost of insurance, including aspects of tort liability which were not reformed in some or all of the six selected States.

<sup>148</sup> The California statute, MICRA, has been described by many in the medical community as a model malpractice reform statute. Its key provisions are a \$250,000 cap on non-economic damages, a sliding scale on attorneys' contingency fees which limits the attorney to 10% of any amount over \$200,000, and a periodic payment requirement. The New York and Florida statutes enacted in the mid-1970's are significantly weaker in comparison.

<sup>149</sup> Both Florida and New York enacted more rigorous tort reforms in 1985 and 1986. As noted, however, it is still too early to draw any conclusion from those statutes.

<sup>150</sup> Patricia Danzon has found that urbanization is "the single most important factor contributing to interstate differences in malpractice claims." P. Danzon, New Evidence on the Frequency and Severity of Medical Malpractice Claims, 17 (Institute for Civil Justice, 1986).

**Percent Increase in Malpractice Insurance  
Rates for Selected Specialties Between  
January 1, 1980 and January 1, 1986**

|                              | <u>California</u> | <u>Florida</u> | <u>New York</u> <sup>151</sup> |
|------------------------------|-------------------|----------------|--------------------------------|
| General Practice             | 173%              | 199%           | 335%                           |
| Internal Medicine            | 61%               | 199%           | 326%                           |
| General Surgery              | 88%               | 256%           | 175%                           |
| Anesthesiology               | 35%               | 217%           | 96%                            |
| Obstetrics/<br>Gynecologists | 140%              | 395%           | 345%                           |
| Orthopedic Surgery           | 88%               | 198%           | 216%                           |
| Neurosurgery                 | 113%              | 370%           | 273%                           |

While all three States witnessed an increase in the cost of medical malpractice insurance from 1980 to 1986, both New York and Florida far outstripped California. Particularly in the two high litigation risk specialties (obstetrics/gynecologists and neurosurgery), the difference between California, on the one hand, and New York and Florida, on the other, is stark. For both of these specialties, the percentage rate of increase in insurance premiums was two to three times greater in Florida and New York than in California.

These findings are consistent with a 1985 report to the New York Medical Society.<sup>152</sup> Among other things, the report contains data on the 1985 premiums for a \$1,000,000/\$3,000,000 malpractice insurance policy,<sup>153</sup> as well as the size of the premiums as a percentage of physician net income and gross revenue.

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<sup>151</sup> The New York data did not include Nassau, Suffolk, Bronx, Kings, Queens, Richmond, Rockland, Sullivan, New York, Orange, Ulster or Westchester Counties. Interestingly, some of these counties reportedly have had among the most substantial insurance problems in New York State.

<sup>152</sup> Report to the Medical Society of the State of New York, An Analysis of Medical Malpractice Insurance Expenses and Physician Income in New York and Selected States, prepared by Healthscope Management Services Corporation in association with the Center for Health Policy Studies (1985).

<sup>153</sup> The premium data in the report to the New York Medical Society show substantially higher premiums for New York physicians than the data collected by the GAO. The most likely explanation for the difference is that the GAO data do not include a number of New York counties that reportedly have experienced serious insurance problems. See footnote 151, *supra*.

# 1985 Premiums

|                                   | <u>Malpractice<br/>Insurance<br/>Premiums</u> | <u>Premiums as<br/>a Percentage<br/>of Net Income</u> | <u>Premiums as<br/>a Percentage<br/>of Gross Revenue</u> |
|-----------------------------------|-----------------------------------------------|-------------------------------------------------------|----------------------------------------------------------|
| <b>All Physicians</b>             |                                               |                                                       |                                                          |
| California                        | \$10,547                                      | 9.5%                                                  | 5.0%                                                     |
| Florida                           | \$16,018                                      | 11.9%                                                 | 6.6%                                                     |
| New York                          | \$17,109                                      | 18.0%                                                 | 10.2%                                                    |
| <b>Obstetrics/<br/>Gynecology</b> |                                               |                                                       |                                                          |
| California                        | \$36,685                                      | 27.7%                                                 | 13.6%                                                    |
| Florida                           | \$57,781                                      | 38.5%                                                 | 20.9%                                                    |
| New York                          | \$51,420                                      | 51.6%                                                 | 23.5%                                                    |

Both the GAO study and the report to the New York Medical Society show quite clearly that California physicians have fared substantially better than their Florida or New York colleagues as far as the cost of their malpractice insurance. Not only is the absolute cost of medical malpractice insurance significantly lower in California, but perhaps even more importantly from the standpoint of showing the link between tort reform and malpractice, the rate of premium increases has been far more moderate in California. The inescapable conclusion is that MICRA has had a very substantial impact on the cost of medical malpractice insurance for California physicians.

Two useful conclusions can be drawn from the above data applicable to more general tort reform efforts. First, strong tort reform measures that rigorously address the problems of tort law -- such as California's MICRA -- can have a very real and substantial effect on insurance costs. Second, weak tort reform measures -- such as the medical malpractice statutes enacted in Florida and New York in the mid-1970's -- probably will have only a very limited impact on insurance availability and affordability.

There also are some important additional observations on the link between tort reform and insurance availability and affordability. One observation is that patience is important; tort reform works, but only if given time. And, obviously, the sooner reforms are enacted, the sooner they will begin to have their effect on the insurance market. A second critical observation is that tort reform statutes will be far more effective, and achieve their purposes more quickly, when they are

drafted clearly with all ambiguities resolved prior to enactment. Finally, and perhaps the most important consideration, the ultimate success of tort reform measures depends greatly on the sensitivity of the courts to the legitimate need for and very real benefits of such legislation. The natural inclination of many judges is to oppose tort reform. And judicial hostility to tort reform can defeat, or, at a minimum, substantially delay the implementation of even the most necessary and popular reforms of the civil justice system. In this regard, the recent success of MICRA before the California Supreme Court, the United States Court of Appeals for the Ninth Circuit, and the United States Supreme Court, suggests that the courts may be much more receptive to such legislation than in the recent past.

## CONCLUSION

While there are a number of conclusions and recommendations contained within this Report, the following are the Working Group's primary conclusions regarding the insurance and liability crisis and the appropriate response of the federal government to that crisis.

First, the crisis in insurance availability and affordability, while substantially ameliorated, continues to impose significant costs on much of the American economy. The effects of the crisis likely will be felt throughout the economy -- particularly in certain sectors -- for some time to come.

Second, tort liability is a key underlying reason for the crisis in insurance availability and affordability. Its contribution to the crisis is two-fold: rapidly expanding liability, including dramatically higher damage awards, have substantially increased the cost of the tort liability system; and, changing doctrinal standards have significantly heightened the uncertainty and unpredictability of the tort system, and thereby have exacerbated the already serious problems of the system.

Third, legislative tort reforms are a reasonable, legitimate and effective response to many of the deficiencies of tort law. Such legislation, however, is by no means the only answer to the problems of the tort system; much of the responsibility for improvement remains with the courts.

Fourth, rigorous and meaningful tort reforms can have a real impact on insurance availability and affordability if given the opportunity and sufficient time to work.

Fifth, the Working Group continues to believe that there is no justification or need for federal insurance regulation or the creation of federal insurance or indemnification programs.

Sixth, there is an appropriate role for federal tort reform legislation in those areas where there is a compelling federal interest. Such areas include product liability, the liability of federal government contractors, and the tort liability of the federal government and its employees.

Seventh, the Administration should continue to support and work actively with Governors and State legislators to achieve reasonable and workable tort reforms at the State level. And,

Eighth, the Working Group continues to believe that the eight tort reforms recommended in its prior Report represent the most sensible and effective potential reforms of the American civil justice system.

## APPENDIX

### THE CRISIS IN PROPERTY-CASUALTY INSURANCE

Antitrust Division, United States Department of Justice

Extensive debate continues as to the causes of the crisis in property-casualty insurance. The crisis is manifested by serious problems in affordability, availability, or both, in several lines. In most of those lines, these problems are of relatively recent origin. This report describes and evaluates the most commonly alleged causes of the crisis.

The Antitrust Division's preliminary economic assessment indicates that three of the four most commonly alleged causes of the crisis--collusion among insurers, imprudent business practices and declines in investment income, and state regulation--all are unlikely to have caused the crisis. In contrast, both theoretical economic analysis and empirical evidence support the conclusion that unanticipated changes in the manner in which tort liability has been established and damages assessed, along with the uncertainty engendered by these changes, are directly responsible for the current affordability and availability problems in property-casualty insurance.

#### I. Collusion

It has been asserted that a principal cause of the crisis has been concerted, anticompetitive actions by insurers to raise prices in certain lines of property-casualty insurance or even to refuse to write such insurance. Economic analysis of the relevant insurance markets, however, leads to the conclusion that such a scenario is implausible.

##### A. The Legal Environment for Collusion

A major purpose of the antitrust laws is to deter concerted pricing and marketing decisions among competitors. Certain types of collusive conduct, particularly agreements to raise price and restrict output, are illegal per se and expose the participants to both severe criminal sanctions and civil

actions for treble damages by injured parties. In the insurance area, however, the McCarran-Ferguson Act <sup>1/</sup> provides a limited antitrust exemption for the business of insurance.

The McCarran-Ferguson Act of 1945 was a response to a Supreme Court decision that held that the business of insurance was within the regulatory power of Congress under the Commerce Clause and, thus, was subject to the antitrust laws. <sup>2/</sup> The Act secured the primacy of the states in the regulation and taxation of the business of insurance: it delimited the influence of the federal government, relegating only a residual role to the federal antitrust laws. Under the Act, the Sherman, Clayton, and Federal Trade Commission Acts apply to the business of insurance only to the extent that such business is not regulated by state law, <sup>3/</sup> or if the challenged conduct involves boycott, coercion, or intimidation. <sup>4/</sup>

Because the McCarran-Ferguson exemption is premised on state regulation, however, its net immunizing effect is more limited than otherwise might be supposed. There appears to be a substantial overlap between the McCarran-Ferguson exemption and another antitrust exemption, the "state action doctrine," which holds that the federal antitrust laws do not prohibit anticompetitive conduct properly attributable to the states rather than to private parties. <sup>5/</sup>

Recent state action cases have established a two-pronged test for determining whether private anticompetitive conduct that restrains competition is entitled to state action immunity. The restraint must be the product of a "clearly articulated and affirmatively expressed" state policy to displace competition, and the state must actively supervise any private anticompetitive conduct. <sup>6/</sup>

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<sup>1/</sup> 15 U.S.C. §§ 1011-1015.

<sup>2/</sup> United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944).

<sup>3/</sup> 15 U.S.C. § 1012(b).

<sup>4/</sup> 15 U.S.C. § 1013(b).

<sup>5/</sup> See Parker v. Brown, 317 U.S. 341 (1943).

<sup>6/</sup> California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

In its 1985 Southern Motor Carriers decision, 7/ the Supreme Court held that a state need not "compel" private anticompetitive conduct in order to satisfy this test. In that case, state regulation of collective ratemaking by intrastate motor carriers was considered sufficient. Thus, Southern Motor Carriers suggests that at least some forms of state insurance regulation could protect concerted decisions among insurers from antitrust liability, even if the McCarran-Ferguson exemption did not exist.

While Southern Motor Carriers may have narrowed the difference between McCarran-Ferguson immunity and state action immunity, significant distinctions remain. The McCarran-Ferguson Act applies only to conduct that constitutes the "business of insurance" within the meaning of the Act, 8/ whereas the state action doctrine is potentially applicable to any conduct regulated by the states. Also, states may regulate some insurer conduct in a manner that is sufficient to trigger the McCarran-Ferguson exemption, but not sufficient to provide state action immunity. For example, it has been held that states do not have to regulate the specific practices challenged under the antitrust laws for the McCarran-Ferguson immunity to attach:

Unless the practice amounts to a boycott, the states are free to regulate it or choose not to regulate. They do not have to expressly authorize a specific activity, or proscribe it, for the exemption to apply. . . . It is enough that a detailed overall scheme of regulation exists. 9/

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7/ Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48 (1985).

8/ Not all insurer conduct necessarily constitutes the "business of insurance." See, e.g., Group Life & Health Insurance Co. v. Royal Drug, 440 U.S. 205 (1979).

9/ Klamath-Lake Pharm. v. Klamath Med. Serv. Bureau, 701 F.2d 1276, 1287 n.10 (9th Cir.), cert. denied, 464 U.S. 822 (1983) (citations omitted). See also Addrisi v. Equitable Life Assur. Soc., 503 F.2d 725 (9th Cir. 1974), cert. denied, 420 U.S. 929 (1975); Mackey v. Nationwide Ins. Companies, 724 F.2d 419 (4th Cir. 1984); Commander Leasing Co. v. Transamerica Title Ins. Co., 477 F.2d 77 (10th Cir. 1973); Feinstein v. Nettleship Co., 714 F.2d 928 (9th Cir. 1983), cert. denied, 466 U.S. 972 (1984).

Without a detailed, state-by-state analysis of regulation in the crisis lines, however, it is difficult to assess the extent to which concerted insurer decisions would enjoy state action immunity from the antitrust laws. Antitrust immunity by itself, however, does not necessarily imply that insurance providers are currently colluding: Even in the absence of legal prohibitions, the structure of the market for property-casualty insurance may render successful collusion difficult or even impossible.

## B. Economic Indicators of the Likelihood of Collusion

### 1. Theory

Collusion can be difficult to detect: the conduct itself is usually covert, and the effects on prices can be difficult to discern, especially when competitive benchmarks for prices or output levels are not available. Economic theory, however, can help assess the likelihood of collusion from observable evidence on market structure.

In using evidence on market structure to evaluate the probability of collusion, correct market definition is crucial. Market definition involves identifying groups of products the sellers of which collectively would have market power in the sense that if they could coordinate their pricing decisions they would price significantly above competitive levels. <sup>10/</sup> Not all of these firms may currently be selling the same product in the same geographic area. However, any firm that is selling--or could readily sell--the same product, or other products that are good substitutes for the product in question, may undermine collusion, at least to some extent.

There are four aspects of market structure that are highly relevant to the probability that collusion will be attempted or will be successful if attempted. First, the fewer firms there are in a market, the easier it is for them to agree to raise price or restrict output and the greater the probability of collusion. Second, holding constant the number of firms, the greater the dispersion of market shares, the more likely it is that agreement among only a subgroup of the full number of firms would be necessary for collusion to be successful. Thus, a market with ten firms where two firms each hold forty-five percent of the market is more conducive to collusion than a market with ten equal-sized firms.

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<sup>10/</sup> See U.S. Department of Justice, Merger Guidelines (1984).

Third, the easier it is for colluding firms to detect and police any cheating on the collusive agreement by other cartel members, the greater the probability of collusion. In the insurance industry, for example, where the McCarran-Ferguson Act and state regulation often permit collective (i.e., bureau) rate making, colluding firms might find it easy to monitor each other's activities. This could facilitate successful collusion among insurers. On the other hand, in industries such as insurance, where the product is heterogeneous and multi-dimensional, individual firms can often increase quality in a continuous and subtle fashion, making cheating on a collusive agreement relatively difficult to detect and collusion less likely.

Finally, the entry of new firms into the market may limit or even completely deter collusion. 11/ Collusion would be deterred either if entry were so rapid as to make a price increase impossible, 12/ or if entry would eventually restore prices to their original or lower levels but leave the colluding firms with lower market shares so that long-term losses from collusion would outweigh any short-term gains. Furthermore, even if collusion would be profitable, rapid entry would shorten any collusive episode and reduce the probability of its recurrence.

## 2. Market Definition and Market Structure in the Property-Casualty Insurance Industry

In assessing collusion as a possible cause of affordability-availability problems in the crisis lines, it is first necessary to delineate the relevant markets. Under

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11/ As noted above, it is appropriate to designate specific firms that readily could, but do not currently, sell the product in question as being "in the market" rather than "potential entrants." The difference between firms who do not currently sell a product being "in the market" and being "potential entrants" is mostly a question of time. According to the Department of Justice Merger Guidelines, if a firm could begin selling the product within one year, it is considered to be already in the market. If the firm would need more than one year, but less than two, it is considered a potential entrant.

12/ Under some circumstances, entry may make price increases not only unprofitable but impossible. For a discussion of such "contestable" markets, see Baumol, Panzer, and Willig (1982). But see Schwartz (1986).

principles outlined in the Department's Merger Guidelines, markets for purposes of competitive analysis are delineated by considering very narrow groups of products and expanding until a hypothetical monopolist of that group of products would have significant market power, i.e., the ability profitably to raise price. The analysis basically consists of assessing the extent to which a price increase for the product under consideration would cause a reduction in quantity that would be large enough to make the price increase unprofitable. In the case of insurance, a price increase could cause a quantity reduction either because of substitution to other types of insurance or because of substitution of self-insurance. The former type of substitution is not very likely: a doctor seeking malpractice insurance, for example, is unlikely to find fire insurance to be an acceptable substitute.

Self-insurance is likely to be the best substitute for any particular line of insurance. Self-insurance, however, is likely to be an unattractive alternative for the vast majority of individuals for most perils. The loss of one's home from fire or one's life savings from a malpractice suit, for example, both likely would be too devastating an event for one to be willing to risk. For such individuals, the only alternative to accepting a collusive price increase may be to form a mutual, where the policyholders share responsibility for the residual risk of the group by setting premiums ex post rather than ex ante. <sup>13/</sup>

Self-insurance is much more attractive for large corporations and governments. For governments, the residual risk can be spread across the taxpayers in that governmental unit. The larger the unit, the lower the cost of self-insurance, since, as long as all the risks assumed are not perfectly correlated, the larger the unit the less the residual risk assumed by each individual taxpayer and the easier it is for the individual taxpayer to pool that risk with other imperfectly correlated risks. For corporations whose equity holders can diversify widely and inexpensively in stock and

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<sup>13/</sup> The Risk Retention Act Amendments of 1986, Pub.L. No. 99-563, were designed to allow related or similarly situated businesses and groups to purchase their liability insurance on a group basis or to provide security in lieu of insurance through interstate cooperatives called risk retention groups.

other capital markets, the attraction of self-insurance is even greater. 14/

Notwithstanding any potential ability of large corporations and governments to self-insure in response to even a small collusive price increase, it is clear that a hypothetical monopoly supplier of any particular line of insurance would price well above competitive levels because of the unattractiveness of self-insurance to individuals and smaller corporations or governments. A hypothetical insurance monopoly likely would be able to raise price just to individuals if necessary, so large corporations and governments would not prevent the exercise of market power. 15/

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14/ Indeed, one might ask why corporations would ever buy insurance. To the extent that the risks assumed by a corporation are ultimately assumed by shareholders who are capable of diversifying their portfolios directly, managers would appear to maximize share values by maximizing the expected value of earnings. Since the purchase of market insurance will always require payment of a premium over the expected cost, self-insurance would appear to always dominate. Paying such a premium may be in the interest of shareholders, however, if insurance reduces managerial control problems by allowing more concentrated equity ownership, or if insurance provides an outside check on opportunistic behavior by managers toward shareholders or by shareholders toward bondholders. In addition, especially if bankruptcy is possible, some insurable risks may ultimately be borne by non-shareholders such as workers or managers, who cannot inexpensively diversify away such risks. If the price such input suppliers would charge to assume those risks is greater than the premium over the expected cost that must be paid to an insurance company, the purchase of market insurance can be consistent with maximizing share values. Finally, if costs would be involuntarily borne by third-parties, federal or state laws are likely to require firms or individuals to buy insurance.

15/ If a sufficient number of large corporations and governments would self-insure in response to even a small collusive price increase, however, we would expect that an exercise of market power by insurers would not lead to a significant increase in all premiums, but rather to an increase in the premiums paid by individuals and small corporations and governments relative to those paid by large corporations and governments.

The next step in the analysis of market structure is to identify the competitors in the relevant markets. All property-casualty insurers in the United States should be considered as competitors in any relevant market if all easily could offer any particular line of insurance. To determine whether such is the case, the Division conducted telephone interviews with executives from a size-stratified sample of ten national and regional insurance companies, as well as with the insurance regulators of the ten most populous states plus West Virginia. The Division found strong indications that insurers normally can, quickly and easily, acquire the necessary licenses and expertise to either begin selling their existing lines of insurance in new states or to provide new lines in the states in which they are already licensed. This appears true even with respect to those lines considered in crisis. These facts suggest that, even though at any one time only a small number of firms may be observed writing a specific line in a particular state, all firms in the property-casualty industry in the United States should be included in the relevant market for any particular type of property-casualty insurance. 16/

The third step in the analysis of market structure is the assignment of market shares. Market shares should be assigned to competitors according to their abilities to compete and, in particular, to undermine any anticompetitive activities of rivals. The ability of an insurance company to expand output is potentially limited, at least in the short run, by state solvency regulation, which is keyed to certain financial ratios. Thus, these financial ratios could be combined with data on net assets to provide a capacity-based measure of market share. Data on premiums is more readily available, however, and, to the extent that premium-to-surplus ratios are uniform across firms, provide a good proxy for relative ability to write insurance. Thus, premiums were used to measure market shares. To the extent that insurers can shift capacity across types of insurance total premiums for all insurance would be the best measure. To be conservative, however, the premiums used were limited to the property-casualty lines.

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16/ Companies that currently provide only life insurance but that could be expected to establish a property-casualty subsidiary in response to a collusive price increase could also be included in the property-casualty market.

### C. Could Collusion Be the Cause of the Crisis?

Table I provides measures of market concentration for property-casualty insurance. The first line shows the Herfindahl-Hirschman Index, or HHI, <sup>17/</sup> for All Property-Casualty insurance in the United States from 1979 to 1985. Table I also shows the HHIs for Medical Malpractice and Other Liability insurance, lines that are generally considered to be in crisis. Even if these lines were appropriate markets and competitors limited to current sellers of these lines, the low HHIs would imply that collusion would be an unlikely explanation for significant increases in prices.

The highest HHI for All Property-Casualty was 229 in 1985. Even if Medical Malpractice and Other Liability were valid antitrust markets and competitors limited to just current sellers of those lines, their highest HHIs would be 663 and 278. These are low HHI values. The 1984 Department of Justice Merger Guidelines, for example, indicate that mergers raising the HHI to a level under 1000 are not a cause of competitive concern. These low levels of market concentration imply that successful collusion among property-casualty insurers is highly unlikely, even in the absence of any legal prohibitions.

Finally, even if collusion were likely in this unconcentrated market because of McCarran-Ferguson or state action immunity, there are several reasons why the current availability-affordability problems cannot be blamed on collusion. First, the antitrust immunities have applied to all lines of insurance since at least 1945, with de facto immunity since the 1869 decision of the Supreme Court in Paul v. Virginia, <sup>18/</sup> while the crisis is of relatively recent origin and is occurring in only a few lines. Second, collusion cannot explain unavailability: Firms do not collusively raise prices above costs and then refuse to sell the product. Third, collusion as an explanation for the large price increases .

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<sup>17/</sup> The HHI is an index of market concentration calculated by summing the squares of the market shares of all of the firms in the market. It varies from near 0 (extremely unconcentrated) to 10,000 (total monopoly). The HHI is higher, the smaller the number of firms and the more unequal their market shares. The HHI thus provides a single summary measure for the first two of the four aspects of market structure discussed above.

<sup>18/</sup> 75 U.S. (8 Wall.) 168 (1869).

observed in recent years is directly contradicted empirically by both the fall observed over that period in the ratio of premiums to underwriting costs (discussed below in Section IV) and by indications of significant underperformance by property-casualty firms in recent years in the stock market (see Lacey (1976)).

All things considered, it is highly unlikely that increased collusion could have been a significant contributor to the recent affordability or availability problems in property-casualty insurance.

## **II. Imprudent Insurance Company Business Practices and Declining Investment Income**

Some commentators cite short-sighted or otherwise imprudent business practices as possible causes of the crisis. In particular, they perceive the recent dramatic increases in premiums as a reaction by insurance companies to "inappropriate" (i.e., too low) pricing in previous periods. They further argue that declining investment income is a major cause of current affordability-availability problems.

It is maintained that during the late 1970s and early 1980s unusually high interest rates encouraged property-casualty insurers to lower their premium rates substantially. Because high returns on investments could be expected to offset anticipated casualty losses, insurers charged "artificially" low prices to attract business. As long as interest rates remained high, insurance companies could cover casualty losses while maintaining relatively low premiums.

The lower initial premiums could be made up by the higher investment income that could be earned on those premiums between the time they were collected and when they would be required to pay policyholders for their covered losses. Insurers were able--and, in a competitive market, would be forced--to lower their rates. In this scenario, falling interest rates in 1985 and 1986 resulted in an unanticipated decline in investment income. Insurers facing large anticipated casualty losses found themselves with investment income insufficient to cover those losses, and were forced to turn to their only remaining source of funds--current policyholders--whose premiums escalated rapidly. In sum, it is theorized that the additional income from recent, very substantial premium increases has been sought by insurers to compensate for unexpected declines in investment income.

Theoretical analysis suggests that if property-casualty insurance markets are competitive--and the concentration data presented above support that assumption--it would not be possible for insurers to recover sunk losses due to past pricing mistakes by charging higher, supra-competitive premiums to current policyholders, especially if new insurers, not suffering from previous errors, could profitably undercut the inflated premiums of the old insurers. 19/ Moreover, even if dramatic declines in investment returns could in theory have resulted in the observed availability and affordability problems, it is not clear that any such losses or declines have actually occurred. In particular, column 2 of Table 2 shows that net investment income as a percentage of premiums earned in the property-casualty industry increased significantly after 1980, from 7.88 percent of earned premiums over the 1967-80 period to 14.62 percent of earned premiums over the 1981-85 period. 20/ Thus, we must look to the property-casualty industry's underwriting gain/loss experience, shown in column 1 of Table 2, rather than to the industry's past investment experience, in order to explain either any financial problems in the industry or their actions on pricing and availability.

Regardless of past experiences, any decline in anticipated future investment returns would place upward pressure on overall premiums. But cyclical movements in anticipated investment income would not cause severe affordability-availability problems to appear suddenly in only certain lines. While some small part of the higher cost of property-casualty insurance today may be due to anticipations

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19/ As noted in Section IV, below, however, unanticipated changes in the manner in which tort liability has been established and damages assessed can lead to large ex post losses on policies, especially (see Table 6) in lines where there are long delays between the time that premiums are set and received and the time that claims are settled. Unless new capital can flow easily into the industry, such accumulated losses may deplete reserves and, in the presence of solvency regulation or other constraints on the ratio of premiums to reserves, contribute to a supply problem, at least in the short run.

20/ As shown in Table 2, this increase of 6.74 percent is statistically highly significant. With an F-statistic of 66.10, the probability of such an increase being due to random movements is less than .01.

of lower investment income, the primary causes of the "crisis" must be found elsewhere. 21/

### III. State Insurance Regulation

We turn now to the third potential cause of the insurance crisis, changes in state regulation. Any full discussion of state regulation of the insurance industry would be far beyond the scope of this report, but we can at least briefly examine three types of state regulation--regulation of prices, regulation of quality (i.e., solvency), and regulations that attempt to redistribute wealth by widening risk pools--and their potential roles in the crisis in property-casualty insurance.

Turning first to the potential role of price regulation, any regulatory change could result in both higher prices and unavailability if the regulators imposed regulations that raised costs or restricted output considerably and then allowed prices to rise by less than would have been required to clear the market. Alternatively, suppose that costs were rising--perhaps but not necessarily because of increased regulation--and the regulators responded by imposing price ceilings to limit the price increase. The result would be both higher prices and an availability problem, i.e., even at the higher prices, insurers would not be willing to supply as much insurance as consumers would like to buy.

There has been considerable research on the effects of regulation on the price of property-casualty insurance. Unfortunately, no consensus has emerged: some researchers have found that regulation has raised prices; others have found no effect. For example, Joskow (1973) found that prices for property-casualty insurance were higher in New York, where

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21/ Even if anticipated net investment income were to fall to zero, however, the compensating proportional increase in premiums would not be greater than the previous ratio of anticipated net investment income to premiums. As shown in Table 4, the ratio of net investment to income has been highest in the crisis lines of Medical Malpractice and Other Liability, where, as shown in Table 6, the time between when premiums are collected and when losses are paid out is the greatest. The premium increases observed in these lines, however, have been far greater than these net investment ratios.

their attempts to set maximum prices are likely to be frustrated by reductions in quality. Under such conditions, the effect of maximum price ceilings is more likely to be unavailability of quality than unavailability of quantity.

Some industry observers have argued that such binding price ceilings did exist, at least through 1985, in those states where availability problems were particularly severe. The Antitrust Division's ongoing interviews with state regulators and insurance company executives, however, have not found any supporting evidence to date for this claim in the lines and states of the crisis. Moreover, in some lines, such as environmental exposure, unavailability appears to be a national problem and thus cannot be explained by state-specific events. Thus, some if not all of the explanations for unavailability must be found elsewhere than in state regulation.

The next major type of state regulation that needs to be considered is regulation of quality. Although the competitive nature of the insurance industry precludes the need for any form of price regulation, solvency regulation may be defended as one way to protect the interests of policyholders and third-party liability claimants, as well as other insurance firms that contribute to guaranty funds. Every state has a guaranty fund for its property-casualty insurers. If an insurer licensed to do business in a particular state goes bankrupt, the other licensed insurance companies in the state assume at least partial responsibility for the failed firm's policies through the guaranty fund. The inability to ex ante "experience rate" individual insurance companies' contributions to the guaranty fund creates an incentive for insurers to underwrite too many policies relative to their net assets. 22/

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22/ The problem is analytically very similar to that created by the existence of federal deposit insurance that is available to all depository institutions. Financing such insurance with a flat-rate premium encourages depository institutions to assume more risk than if premiums were adjusted to reflect the risk of each bank's activities and investments. It can be argued that the appropriate response to potential moral hazard problems, whether in banking, insurance, or elsewhere, is to impose risk-based premiums. To the extent that risk-based premiums cannot be used, however, perhaps because of difficulties in accurately predicting the probability of bankruptcy, direct control measures such as minimum capital and surplus requirements or constraints on portfolio choice may be appropriate second-best solutions.

This type of market failure, however, cannot be used to

Footnote Continued

While solvency regulation can thus be defended in principle as a way to prevent insurers from free riding on each other, the efficiency or effectiveness of such regulation in practice is an empirical question (see Munch and Smallwood (1980)). Moreover, as noted in the next section, state solvency regulations may have played a significant role in the crisis due to their interaction with the increased uncertainty induced by changes in tort liability.

Finally, we turn to a third type of state regulation, restrictions on the size of risk pools. In several states, regulators have frustrated efforts by insurance companies to keep risk pools as narrow as possible in order to minimize the self-selection problem that is endemic to all insurance. Mandating broader, more heterogeneous risk pools can transfer wealth from low-risk to high-risk individuals, but only at a real cost. Broader risk pools reduce the efficiency of the insurance contract by increasing the real cost of insurance to low-risk consumers and thus reducing their demand. As enough low-risk consumers reduce the amount of insurance they purchase or even drop out of the pool entirely, insurance, like solid-gold Cadillacs, can become economically unavailable. <sup>23/</sup>

Without seeking to minimize the real costs of this type of regulation, however, it is difficult to identify regulatory broadening of risk pools as a major contributor to the current crisis. These regulations may well have contributed significantly to a long-term upward trend in insurance costs in a number of lines in particular states, but such increases do not appear to match the lines and states in crisis.

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**22/ Footnote Continued**

justify regulations that maintain prices above competitive levels. There is a clear analogy here to the airline industry, where the recognition that price regulation was unnecessary and harmful to consumers led eventually to the dismantling of the CAB. In contrast, safety regulation by the FAA can still be justified since, because of limited liability, an airline with assets that were less than the maximum potential liability from a crash, including punitive damages, (literally a "fly-by-night" airline) would have an economic incentive to provide less than the optimal amount of safety.

**23/ See Joskow (1973) and Priest (1986).**

Finally, for all three types of state regulation, while significant research on their effects in the specific crisis lines is lacking, timing alone suggests the lack of a significant, or at least exclusive, connection. In the mid 1970s there was a crisis in medical malpractice insurance (see Freedman (1986)). The 1980s brought another crisis in Medical Malpractice, as well as in several other lines of property-casualty insurance. If regulation were to blame for these crises, one would expect to find that regulation increased during or slightly before each crisis and slackened at other times. This, however, does not appear to have been the case. The lack of any apparent correlation between changes in regulation and the development or resolution of availability-affordability problems in particular states indicates that state regulation is not directly to blame for the current crisis.

#### IV. Change and Uncertainty in Tort Liability

Perhaps the most frequently offered explanation for the current crisis in property-casualty insurance involves the legal system. Significant changes in the manner in which tort liability is established and damages are assessed are cited as causes of dramatic rate increases and reductions in insurance availability. Examples of these changes include the perceived movement from a fault-based standard to a no-fault standard, eased requirements for establishing joint and several liability, the award of very large damages for such noneconomic losses as pain and suffering, punitive or exemplary damages against insuring companies for bad-faith failure to acknowledge liability, and the shift from first-party to third-party tort insurance. 24/

In the rest of this section, we attempt to evaluate this explanation by examining the consistency of its implications with the available accounting data on changes over time in the

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24/ See U.S. Department of Justice (1986). For an extensive and insightful analysis of the effects of shifting from first-party insurance to third-party corporate-provided insurance administered through the tort system, see Priest (1986). For a comparative analysis of the Canadian liability insurance crisis, which in many ways parallels the U.S. experience, see Trebilcock (1987) who concludes that the Canadian crisis was caused by increased uncertainty in the judicial determination of liability and quantification of damages.

costs and revenues of the property-casualty industry. 25/ We begin with broad overall data categories and progress to specific lines and narrower categories of costs and revenues, looking first for changes in average levels and then for signs of increased uncertainty.

#### A. Changes in Average Levels

The first implication of an explanation based on changes in the tort liability system is that we should observe a deterioration in the overall financial performance of the property-casualty industry, with the greatest deterioration occurring in the crisis lines. As can be seen from column 3 of Table 2, for all property-casualty lines combined there has been a significant decline in combined net income (the sum of underwriting gains and net investment income) as a percentage of premiums earned, from 6.18 percent over the 1967-80 period to 1.33 percent over the 1981-85 period. 26/

This deterioration in overall financial performance can also be seen in the last column of Table 4, which compares the 1976-80 period with the 1981-85 period for all property-casualty lines combined as well as for two crisis lines, Other Liability and Medical Malpractice, and two non-crisis lines, Private Passenger Auto Liability and Homeowners' Multiple Peril. For all lines of property-casualty, the overall operating ratio 27/ suffered a statistically highly significant deterioration of 8.64 percentage points, from 94.18 to 102.82. This deterioration is particularly marked in the crisis lines. In the two non-crisis lines, Auto Liability and Homeowners, overall operating ratios rose respectively by 9.42 points to

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25/ We should stress that empirical testing can only disprove hypotheses: If the implications of a particular hypothesis are inconsistent with the data, the hypothesis can be rejected, but since any given set of data may be consistent with the implications of a number of hypothesis, a particular hypothesis can never be empirically proven.

26/ The F-statistic for a test of equality of means is 5.55, implying that the probability of this decline being due to random variations is less than .01.

27/ The overall operating ratio is the ratio of total expenses (i.e., losses incurred plus loss adjustment expenses plus commissions and brokerage expenses plus other underwriting expenses plus dividends) minus net investment gain and other income, to premiums earned.

101.24 and by 6.88 points to 103.96. Both the increases and the final levels are considerably greater, however, in the two crisis lines, Other Liability and Medical Malpractice, where overall operating ratios rose respectively by 22.86 points to 113.52 and by 21.96 points to 113.58.

A second implication of an explanation based on changes in the tort liability system is that this deterioration in overall financial performance should be due to declines in underwriting gains (or increases in underwriting losses) rather than declines in net investment income. As discussed in Section II, this implication is strongly supported by the data in Table 2, which shows a statistically highly significant increase in net investment income as a percent of earned premiums, from 7.88 percent over the 1967-80 period to 14.62 percent over the 1981-85 period, combined with a statistically highly significant increase in underwriting losses as a percentage of earned premiums, from 1.70 percent for 1967-80 to 13.28 percent for 1981-85.

Continuing this disaggregation process, Table 3 shows that, for all lines of property-casualty insurance, this deterioration in the ratio of underwriting costs to premiums earned, by 11.64 percentage points, from 100.74 over the 1961-80 period to 112.38 for the 1981-85 period (as shown in the last column of Table 3) cannot be explained by increased administrative expenses, which actually fell somewhat as a percentage of premiums written. The source instead lies entirely with the increase in the ratio of underwriting losses and adjustment expenses to earned premiums by 12.56 percentage points, from 70.44 percent to 83.00 percent. This result is confirmed in Table 4. For all lines of property-casualty, the underwriting losses incurred (the first column of Table 4) increased significantly by 8.60 points and by 1.56 points, respectively in both the non-crisis lines, Homeowners and Auto Liability. In the crisis lines of Other Liability and Medical Malpractice, however, the increases in the underwriting loss ratio and the loss adjustment ratio have been much more dramatic: 21.74 percentage points and 9.70 percentage points for Other Liability, and 35.50 percentage points and 6.46 percentage points for Medical Malpractice.

The determination that the source of the deterioration in the overall financial ratios for the property-casualty industry lies entirely in increases in underwriting losses and adjustment expenses, with particularly dramatic increases observed in the crisis lines, is consistent with the implications of a hypothesis that the crisis is due to changes in the tort liability system. By contrast, the data appear to

directly contradict the implications of two other hypothesized potential causes of contributions to the crisis, collusion and declines in investment income. The collusion scenario would imply an increase in the ratio of premiums to underwriting costs rather than the statistically highly significant decrease actually observed, while the investment scenario would imply a decrease in the ratio of net investment income to premiums, rather than the statistically highly significant increase actually observed.

#### B. Increased Uncertainty

If insurers were risk-neutral, the competitive premium for a policy would be the expected value of its cost. Bankruptcy costs and insurance regulations, however, require insurers to maintain minimum solvency levels in order to limit the probability of default. This requires insurers to load (raise) premiums by a factor over actuarially fair premiums in order to ensure a sufficiently low probability of failure. This load factor is higher, the greater the uncertainty with respect to the insurer's future net income. Thus, a costly change in the legal environment that also increased the variability in the financial results would induce a premium increase greater than the increase in the expected value of costs. 28/

An increase in variability of casualty losses and investment income thus could trigger a crisis because insurers would have to set higher premiums in order to maintain an acceptable fixed probability of financial solvency. If the increase in financial variability becomes sufficiently large, the premiums required to maintain solvency requirements might be so high that coverage would be unattractive to or even out of the reach of potential insureds. There would then appear to be an affordability crisis in the affected line. Should variability be so great as to exceed the ability or willingness of insurers to cope with it, coverage might be unavailable at any price. Questions would remain as to the underlying causes of large, perhaps greatly increased, variability, but an adverse effect on the affordability of insurance is predictable whatever those causes actually are.

To track down the source of any potential increase in uncertainty, we carry out the same disaggregation process as in

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28/ For a more rigorous mathematical modeling of the effects of uncertainty on load premiums, see Clarke, Simon, Smith, and Warren-Boulton (1986) and Winter (1986).

the examination of changes in the average level of financial ratios. We measure the variability of each ratio by its standard deviation. Normalized comparisons of variability across ratios of different mean values can be made by computing each ratio's coefficient of variation, i.e., the standard deviation of the ratio divided by its mean. 29/

Table 2 shows that while the standard deviation (variability) of the underwriting gain/loss ratio has risen significantly during the 1980s relative to the 1967-80 period, the standard deviation of the net investment income ratio has actually declined significantly. This greater variability of the underwriting gain/loss ratio becomes clear when we note that the coefficient of variation for the underwriting gain/loss during 1981-85 was .41--ten times the coefficient of variation for net investment income, which measured only .04 over the same period. This suggests that any increase in overall uncertainty must have resulted from increased unpredictability of loss payouts and expenses rather than from any increase in the instability of investment income. Combined with the observation from Tables 2 and 4 that investment income increased significantly after 1980, this would appear to make it very difficult to blame imprudent investments for causing today's premium hikes and coverage withdrawals.

Table 3 shows that the variability of both the administrative expense ratio and the dividend ratio has actually decreased, though insignificantly. This result narrows the source of any increase in uncertainty even further, to the underwriting loss and adjustment ratio.

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29/ The relevant definition of uncertainty is uncertainty in the prediction of ratios over the life of policies currently being issued. To the extent that these ratios are serially correlated, however, i.e., to the extent that they follow a predictable cycle or trend, the standard deviation will overestimate the absolute level of uncertainty. Under such conditions, a more accurate measure would be the standard error of a predictive equation for the ratios over time. Even if the assumption of serial independence is unwarranted, however, if the degree of serial correlation is held constant, changes in the standard deviation provides an unbiased measure of changes over time in the degree of uncertainty.

More accurate measures of uncertainty may be developed in the near future. In addition to improving indexes for uncertainty that are based on accounting data, efforts are being made to develop ex ante measures of uncertainty using data from financial and capital markets.

The pattern of increased uncertainty emerges most clearly in Table 4. While the increase in the variance of the overall operating ratio was not statistically significant for All Lines of property-casualty combined, variability in the loss incurred and loss adjustment ratios increased significantly. The two non-crisis lines showed no significant increases in variability in either their overall operating ratios or any of the component ratios. Furthermore, of the crisis lines, only Other Liability exhibited a substantial increase in overall variability as well as substantial increases in the variability of underwriting losses.

This suggests an anomaly. Why does the other crisis line, Medical Malpractice, fail to exhibit such increases in variability of its ratios? There is an explanation. Medical Malpractice is a line of insurance that has popularly been thought to have been in a state of crisis since the mid-1970s. Thus, it is not anomalous that its variability has not increased greatly over the 1980s--it was highly variable to begin with. To see this, one need only look at the coefficient of variation exhibited by Medical Malpractice's overall operating ratio in 1976-80 and in 1981-85 as shown in Table 5. In both the earlier and later periods it was .09. Compare this with the coefficients of variation in the overall operating ratio for Other Liability. In the earlier period its coefficient of variation was only .05, but it soared to .11 in the later period.

In fact, if one examines the levels of all lines' coefficients of variation in the period 1981-85, one sees that these coefficients of variation are almost universally higher for each ratio in the crisis lines than for the corresponding ratio in the non-crisis lines.

Table 5 thus shows a sharp distinction between the crisis and non-crisis lines in terms of the variability of their financial ratios. As noted above, increasing variability reflects the increasing difficulty for insurers in accurately predicting their future liability, and therefore in their ability to underwrite the risks. To maintain an acceptable probability of solvency, insurers may choose either to raise premiums to "safe" levels, or to withdraw coverage from these lines.

One source of the greater financial uncertainty observed in the crisis lines may be the greater severity of delays before final settlement in the crisis lines. As shown in Table 6, for All Lines of property-casualty insurance, 18.30 percent of

claims incurred in 1982, for example, were unpaid at the end of 1985. For Other Liability, however, 44.79 percent of expenses incurred in 1982 were unpaid at the end of 1985 while for Medical Malpractice 64.42 percent of expenses incurred in 1982 were unpaid at the end of 1985. Such delays suggest a more uncertain and thus more costly tort liability process.

The overall pattern in the data is thus one of high and increasing cost ratios for underwriting losses and adjustment expenses, especially in the crisis lines, and high and increased variability in these ratios for the crisis lines. These changes can cause dramatic increases in premium rates. Because of the increased load factors required by increased uncertainty, premium increase can be expected to be significantly greater than even the already large increase in costs in those lines. Increased cost ratios and uncertainty in crisis lines also can give rise to unavailability problems in those lines. Thus, given the findings from several studies that changes in the tort liability system have caused both higher expected awards and greater variability in such awards, the overall pattern of the data is consistent with explanations for the property-casualty crisis grounded in these changes in the tort liability system.

Table 1

National Herfindahl-Hirschman Indices for  
Select Insurance Lines, 1980-1985

|                              | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 |
|------------------------------|------|------|------|------|------|------|
| All<br>Property-<br>Casualty | 213  | 213  | 215  | 225  | 226  | 229  |
| Medical<br>Malpractice       | 513  | 523  | 500  | 567  | 663  | 622  |
| Other<br>Liability           | 224  | 219  | 220  | 220  | 236  | 278  |

SOURCE: A.M. Best's Aggregates and Averages (1980-1986).

Table 2

## Time Series Variation in Property-Casualty Industry Operating Results

| Years                                                              | Underwriting Gain/Loss<br>(Percent to Earned<br>Premiums) |             | Net Investment Income<br>(Percent to Earned<br>Premiums) |                      | Combined Net Income<br>(Percent to Earned<br>Premiums) |             |
|--------------------------------------------------------------------|-----------------------------------------------------------|-------------|----------------------------------------------------------|----------------------|--------------------------------------------------------|-------------|
|                                                                    | yearly avg.                                               | std. dev.   | yearly avg.                                              | std. dev.            | yearly avg.                                            | std. dev.   |
| 1967 - 1980                                                        | -1.70                                                     | 3.35        | 7.88                                                     | 1.78                 | 6.18                                                   | 3.99        |
| 1981 - 1985                                                        | <u>-13.28</u>                                             | <u>5.41</u> | <u>14.62</u>                                             | <u>.65</u>           | <u>1.33</u>                                            | <u>4.93</u> |
| Change                                                             | -11.58                                                    | 2.06        | 6.74                                                     | -1.13                | -4.85                                                  | .34         |
| F statistic for<br>equality of means<br>or increase in<br>variance | 31.98***                                                  | 2.61*       | 66.10***                                                 | 7.70*** <sup>1</sup> | 5.55**                                                 | 1.89        |

\*\*\*Significant at .01 level

\*\*Significant at .05 level

\*Significant at .10 level

<sup>1</sup>F statistic of decrease in variance.

SOURCE: Best's Aggregates and Averages: Property and Casualty 1986, p. 72

Table 3

## Time Series Variation in Property-Casualty Industry Loss and Expense Ratios

| Years                                                              | Loss and Adjustment<br>Ratio to<br><u>Premiums Earned</u> |             | Administrative<br>Expenses Ratio to<br><u>Premiums Written</u> |            | Premium Dividend<br>Ratio to<br><u>Premiums Earned</u> |            | Combined Ratio to<br><u>Premiums Earned</u> |             |
|--------------------------------------------------------------------|-----------------------------------------------------------|-------------|----------------------------------------------------------------|------------|--------------------------------------------------------|------------|---------------------------------------------|-------------|
|                                                                    | yearly avg.                                               | std. dev.   | yearly avg.                                                    | std. dev.  | yearly avg.                                            | std. dev.  | yearly avg.                                 | std. dev.   |
| 1961 - 1980                                                        | 70.44                                                     | 3.78        | 28.54                                                          | 2.26       | 1.76                                                   | .29        | 100.74                                      | 3.01        |
| 1981 - 1985                                                        | <u>83.00</u>                                              | <u>5.25</u> | <u>27.50</u>                                                   | <u>.26</u> | <u>1.86</u>                                            | <u>.18</u> | <u>112.38</u>                               | <u>4.82</u> |
| Change                                                             | 12.56                                                     | 1.47        | -1.04                                                          | -1.30      | .10                                                    | -.11       | 11.64                                       | 1.88        |
| F statistic for<br>equality of means<br>or increase in<br>variance | 39.10***                                                  | 1.93        | 1.03                                                           | .18        | .61                                                    | .39        | 47.79***                                    | 2.64*       |

\*\*\*Significant at .01 level

\*\*Significant at .05 level

\*Significant at .10 level

SOURCE: Best's Aggregates and Averages: Property-Casualty, 1986, p. 75

Table 4

## Time Series Variation in Underwriting Experience - By Line

| Line            | Years   | Losses Incurred <sup>1</sup> |              | Loss Adjustment Exp. <sup>1</sup> |             | Commission & Broker Exp. <sup>2</sup> |            | Other Underwriting <sup>2</sup> |             | Dividends to Policy <sup>1</sup> |            | Net Investment Gain/Loss & Other Income <sup>1</sup> |             | Overall Operating Ratio <sup>1</sup> |              |
|-----------------|---------|------------------------------|--------------|-----------------------------------|-------------|---------------------------------------|------------|---------------------------------|-------------|----------------------------------|------------|------------------------------------------------------|-------------|--------------------------------------|--------------|
|                 |         | avg.                         | std. dev.    | avg.                              | std. dev.   | avg.                                  | std. dev.  | avg.                            | std. dev.   | avg.                             | std. dev.  | avg.                                                 | std. dev.   | avg.                                 | std. dev.    |
| Total All Lines | '76-'80 | 63.60                        | 2.20         | 9.24                              | .21         | 12.94                                 | .21        | 12.96                           | .55         | 1.42                             | .26        | 5.96                                                 | .92         | 94.18                                | 2.45         |
|                 | '81-'85 | <u>72.20</u>                 | <u>4.64</u>  | <u>10.80</u>                      | <u>.65</u>  | <u>12.52</u>                          | <u>.29</u> | <u>14.98</u>                    | <u>.70</u>  | <u>1.86</u>                      | <u>.18</u> | <u>9.56</u>                                          | <u>.84</u>  | <u>102.82</u>                        | <u>4.06</u>  |
| Change          |         | 8.60                         | 2.44         | 1.56                              | .44         | -.42                                  | .08        | 2.02                            | .15         | .44                              | -.08       | 3.60                                                 | -.08        | 8.64                                 | 1.61         |
|                 | F       | 14.00***                     | 4.46*        | 26.00***                          | 9.88**      | 6.78**                                | 2.02       | 25.66***                        | 1.62        | 9.68**                           | .49        | 41.51***                                             | .84         | 16.57***                             | 2.75         |
| Homeowners'     | '76-'80 | 58.48                        | 5.37         | 7.00                              | .37         | 18.56                                 | .36        | 12.86                           | .15         | .64                              | .13        | 3.16                                                 | .29         | 94.36                                | 5.21         |
|                 | '81-'85 | <u>65.66</u>                 | <u>3.02</u>  | <u>8.18</u>                       | <u>.46</u>  | <u>17.42</u>                          | <u>.12</u> | <u>13.86</u>                    | <u>.34</u>  | <u>.06</u>                       | <u>.01</u> | <u>4.46</u>                                          | <u>.42</u>  | <u>101.24</u>                        | <u>3.26</u>  |
| Change          |         | 7.18                         | -2.28        | 1.18                              | .29         | -1.14                                 | -.21       | 1.00                            | .19         | -.58                             | -.12       | 1.30                                                 | .20         | 6.88                                 | -1.95        |
|                 | F       | 6.72**                       | .33          | 12.17***                          | 3.09        | 41.92***                              | .17        | 35.46***                        | 5.13*       | .29                              | .56        | 25.92***                                             | 2.92        | 6.25**                               | .39          |
| Auto Liability  | '76-'80 | 65.90                        | 2.23         | 11.38                             | .34         | 10.42                                 | .26        | 13.34                           | .28         | .88                              | .37        | 6.32                                                 | .64         | 94.54                                | 2.31         |
|                 | '81-'85 | <u>76.12</u>                 | <u>4.05</u>  | <u>12.08</u>                      | <u>.43</u>  | <u>9.92</u>                           | <u>.18</u> | <u>14.24</u>                    | <u>.26</u>  | <u>.84</u>                       | <u>.15</u> | <u>9.20</u>                                          | <u>.74</u>  | <u>103.96</u>                        | <u>3.23</u>  |
| Change          |         | 10.22                        | 1.82         | .70                               | .09         | -.50                                  | -.08       | .90                             | -.02        | -.04                             | -.22       | 2.88                                                 | .10         | 9.42                                 | .92          |
|                 | F       | 24.42***                     | 3.30         | 8.06**                            | 1.60        | 12.62***                              | .48        | 27.74**                         | .87         | .05                              | .17        | 42.89***                                             | 1.35        | 22.42***                             | 1.95         |
| Other Liability | '76-'80 | 55.14                        | 3.26         | 19.28                             | 1.03        | 14.14                                 | .29        | 12.86                           | 1.38        | .54                              | .09        | 11.32                                                | 2.04        | 90.66                                | 4.25         |
|                 | '81-'85 | <u>76.88</u>                 | <u>12.52</u> | <u>28.98</u>                      | <u>3.87</u> | <u>12.38</u>                          | <u>.92</u> | <u>17.30</u>                    | <u>2.63</u> | <u>.64</u>                       | <u>.11</u> | <u>22.70</u>                                         | <u>3.02</u> | <u>113.52</u>                        | <u>12.50</u> |
| Change          |         | 21.74                        | 9.26         | 9.70                              | 2.84        | -1.76                                 | .63        | 4.44                            | 1.25        | .10                              | .02        | 11.38                                                | .98         | 22.86                                | 8.25         |
|                 | F       | 14.13***                     | 14.77**      | 29.27***                          | 14.06**     | 16.65***                              | 10.20**    | 11.20**                         | 3.64        | 2.38                             | 1.63       | 48.86***                                             | 2.20        | 14.98***                             | 8.64**       |
| Medical         |         |                              |              |                                   |             |                                       |            |                                 |             |                                  |            |                                                      |             |                                      |              |
| Malpractice     | '76-'80 | 68.70                        | 10.42        | 26.56                             | 2.74        | 6.22                                  | 1.06       | 7.72                            | .97         | 1.08                             | .80        | 18.66                                                | 7.34        | 91.62                                | 8.53         |
|                 | '81-'85 | <u>104.20</u>                | <u>9.36</u>  | <u>33.02</u>                      | <u>3.70</u> | <u>4.98</u>                           | <u>.33</u> | <u>10.24</u>                    | <u>1.32</u> | <u>1.34</u>                      | <u>.29</u> | <u>40.18</u>                                         | <u>3.27</u> | <u>113.58</u>                        | <u>10.73</u> |
| Change          |         | 35.50                        | -1.06        | 6.46                              | .96         | -1.24                                 | -.73       | 2.52                            | .35         | .26                              | -.41       | 21.52                                                | -4.07       | 21.96                                | 2.20         |
|                 | F       | 32.14***                     | .81          | 9.82**                            | 1.82        | 6.54**                                | .05        | 11.78***                        | 1.86        | .43                              | .24        | 35.89***                                             | .20         | 12.84***                             | 1.58         |

\*\*\* Significant at .01 level

\*\* Significant at .05 level

\* Significant at .10 level

<sup>1</sup> Percent of premiums earned<sup>2</sup> Percent of premiums written

F statistics against null hypotheses of

- equal means

- increasing variance

Table 5

## Coefficients of Variation in Underwriting Experience By Line

|                     | <u>Losses Incurred</u> |         | <u>Loss Adj. Exp.</u> |         | <u>Comm. &amp; Brok.</u> |         | <u>Other Underwriting</u> |         | <u>Dividends</u> |         | <u>Net Investments</u> |         | <u>Overall Operating</u> |         |
|---------------------|------------------------|---------|-----------------------|---------|--------------------------|---------|---------------------------|---------|------------------|---------|------------------------|---------|--------------------------|---------|
|                     | 1976-80                | 1981-85 | 1976-80               | 1981-85 | 1976-80                  | 1981-85 | 1976-80                   | 1981-85 | 1976-80          | 1981-85 | 1976-80                | 1981-85 | 1976-80                  | 1981-85 |
| Total All Lines     | .03                    | .06     | .02                   | .06     | .02                      | .02     | .04                       | .05     | .18              | .10     | .15                    | .09     | .03                      | .04     |
| Homeowners'         | .09                    | .05     | .05                   | .08     | .02                      | .01     | .01                       | .02     | .20              | .17     | .09                    | .11     | .06                      | .03     |
| Auto Liability      | .03                    | .05     | .03                   | .04     | .02                      | .02     | .02                       | .02     | .42              | .18     | .10                    | .08     | .02                      | .03     |
| Other Liability     | .06                    | .16     | .05                   | .13     | .02                      | .07     | .12                       | .15     | .17              | .17     | .18                    | .13     | .05                      | .11     |
| Medical Malpractice | .15                    | .09     | .10                   | .11     | .17                      | .05     | .13                       | .13     | .74              | .29     | .39                    | .08     | .09                      | .09     |

SOURCE: Computed from Table 3. The coefficient of variation is: (standard deviation)/(average).

Table 6

Fraction of Total Losses and Loss Expenses that Remain Currently Unpaid

| <u>Year When Loss<br/>Was Incurred</u> | <u>Total<br/>All Lines</u> | <u>Various<br/>Multiple Peril</u> | <u>Auto<br/>Liability</u> | <u>Other<br/>Liability</u> | <u>Medical<br/>Malpractice</u> |
|----------------------------------------|----------------------------|-----------------------------------|---------------------------|----------------------------|--------------------------------|
| Prior to 1976                          | 2.42                       | .55                               | .26                       | 6.46                       | 15.66                          |
| 1976                                   | 5.05                       | .88                               | 1.02                      | 12.32                      | 24.88                          |
| 1977                                   | 5.45                       | 1.20                              | 1.34                      | 13.34                      | 27.62                          |
| 1978                                   | 6.43                       | 1.87                              | 1.57                      | 15.50                      | 32.74                          |
| 1979                                   | 7.75                       | 2.26                              | 2.21                      | 19.78                      | 39.21                          |
| 1980                                   | 9.70                       | 3.31                              | 3.45                      | 24.89                      | 46.24                          |
| 1981                                   | 13.40                      | 5.74                              | 6.19                      | 33.80                      | 54.52                          |
| 1982                                   | 18.30                      | 8.79                              | 10.95                     | 44.79                      | 64.42                          |
| 1983                                   | 26.42                      | 13.54                             | 19.77                     | 59.92                      | 76.57                          |
| 1984                                   | 38.96                      | 20.87                             | 34.80                     | 74.60                      | 87.02                          |
| 1985                                   | 65.69                      | 44.26                             | 65.68                     | 90.80                      | 96.98                          |

SOURCE: Best's Aggregates and Averages: Property-Casualty, 1986, pp. 59-60

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January 26, 1989

James P. Lynn, Chairman  
Aetna Life and Casualty Company  
151 Farmington Avenue  
Hartford, CT 06156

Dear Mr. Lynn:

I am writing to you about how Aetna can reduce costs -- especially through loss prevention -- instead of continuing its three decade drive to take away injured peoples' legal rights in courts of law.

Insurance companies say that Californians should be denied their right to receive Proposition 103's rate relief and insurance industry reform because, they say, Prop. 103 will cost them money. They say that the one-year 20 percent rate reduction ordered by Prop. 103 is unfair and unreasonable since auto insurance rates are already too low, and because "costs," i.e. legal fees, medical bills and car-repair expenses, are rising. "The cost increases have outpaced our ability to manage efficiently, so we have to charge more," Safeco's president told the Wall Street Journal.

Rather than looking at their own waste, inefficiency, mismanagement and inattention to loss prevention for the solution to controlling costs, insurers have spent many millions of dollars campaigning not only to defeat proposed reforms of the insurance industry, but to restrict the rights of victims to sue the perpetrators of their harm and obtain fair compensation for injuries.

Proposition 103's enactment, notwithstanding the industry's multi-million dollar campaign to defeat it, has mobilized citizens nationwide to fight for strengthened regulation and increased competition for the insurance industry. Therefore, companies will have to look for ways to reduce their costs, specifically through more efficient operation, and more effective advocacy for health and safety to prevent injuries and property damage from occurring.

#### 1. Efficiency

The insurance industry represents one of the greatest bundles of capital ever brought together in world history. Property/casualty companies in the United States have assets totalling over \$300 billion; and over 2,000 life insurance companies have assets totalling over \$900 billion. This huge industry, however, is an inefficient and wasteful bureaucracy. If insurance companies operated more efficiently, they could easily reduce rates.

For example, in the private passenger automobile liability line, the industry overall pays 35.3 percent of what it writes in

44.5  
Letter to James P. Lynn, Page 2.

loss adjustment and underwriting expenses, including claims processing, defense fees, commissions and brokers. Yet USAA, one of the best service companies in the market, operates at only a 20 percent expense level. According to the National Insurance Consumer Organization, auto liability insurance rates would drop by an average of 19 percent nationally if the industry on average were as efficient as USAA.

Insurance companies have operated so inefficiently in California and elsewhere because the insurance market is, in important ways, not competitive. Insurers engage in price-fixing because such practices are not subject to antitrust laws. In addition, states have anti-rebate laws which prohibit insurance agents from offering discounts to policyholders. As a result, the most efficient agent can not compete for market share by offering a discount. Also, many state laws prohibit group auto and homeowner insurance sales which could enhance buyer bargaining power. And consumers do not have access to good, comparative information about prices and services.

Proposition 103 repeals the antitrust exemption, the rebate and the group sales prohibition in California and allows banks to sell liability insurance. Prop. 103 also provides for a computerized consumer information system to facilitate comparison shopping. These measures should provide much needed incentive to insurers to reduce costs caused by waste and inefficiency.

In addition, insurers could be doing much more than simply complaining about legal, medical and auto repair expenses which they say are driving up their costs. For example, insurance companies often insist that information they provide plaintiffs during the discovery process in product liability cases be kept completely confidential. This not only keeps important safety information that can lead to hazard alerts and policies, from consumers and public agencies, but also it forces plaintiffs to start from scratch the discovery process in each similar case, driving up both plaintiff and defense legal fees.

As for medical costs, health insurers like Aetna could be aggressively pushing for strict guidelines to reduce physician's misuse of unnecessary medical tests, like chest X-rays and electrocardiograms, as well as unnecessary surgery, which add billions to health care costs in this country. Former HEW Secretary Joe Califano recently observed in the New York Times Magazine that Americans are four times more likely to have coronary bypass surgery than Western Europeans with the same symptoms, and that at least half of the 900,000 Caesarean sections performed in 1986 were unnecessary.

Insurance rates have risen out of all proportion to auto repair costs, according to the National Insurance Consumer Organization. Even so, however, insurers could be doing much more to encourage automobile design changes which would reduce repair costs without sacrificing safety, and reduce auto theft, which is responsible for the largest component of comprehensive insurance costs. I recently received a letter from a Houston inventor who has developed a patentable computer key system which

would make cars virtually impossible to "hot-wire" and steal. He contacted a number of insurance companies, as well as his local chapter of the industry-backed National Auto Theft Bureau, with his idea. Not a single insurer responded, and the NATB chapter provided him no encouragement or support.

## 2. Loss Prevention

Former Pennsylvania insurance commissioner Herbert Denenberg wrote in 1970,

It would be an act of gross social irresponsibility to permit insurance companies to acquire this expertise in saving life and limb and then permit them to utilize this information only for the purpose of estimating the cost of deaths and injury and not for the purpose of eliminating death and injury.

The insurance industry should be the safety sentinel for the nation's economy. The industry should put into practice its theoretical vested interest in increasing profits by reducing claims and should be making great strides in areas of hazard control and loss prevention. Unfortunately, and contrary to their historic mission, however, insurers are barely lifting a finger to eliminate or reduce hazards that cost insurers billions yearly.

Three centuries ago, Lloyd's of London wrote insurance for ships travelling to the Orient on the condition that the insurer adopt certain safety precautions, such as equipping ships with lifeboats. That was an early display of the insurance industry's early commitment to loss prevention, and it had some notable successes in succeeding centuries, such as in the areas of industrial boiler and elevator safety.

But today, insurance companies are usually indifferent to loss prevention because they have become predominantly cash-flow financial institutions. More and more attention is paid to increasing investment income through premium volume. They pay very inadequate attention to safety and engineering contributions that could reduce premiums but retain prudent underwriting profits. Insurance companies would much rather charge a premium of \$1,000 and pay out \$500 in claims, then charge \$500 and pay \$250 in claims, because they would prefer having more money to put in investments that pursue their financial objectives.

As a result, even repeated litigation arising from well-known and identical hazardous products or services has not prompted the insurance industry to insist that hazards be eliminated. In the area of auto safety, the Insurance Institute for Highway Safety (IIHS), once an important voice in efforts to ensure crashworthiness and permanent design safety improvements to motor vehicles, has shifted focus in recent years from the automobile product to the automobile victim. While supporting seat-belt and drunk driving laws -- as do many other consumer and victim groups -- the IIHS recently has shown less public interest in crashworthiness issues. For example, although side impact

crashes result annually in nearly 3,000 deaths and 25,000 serious injuries, IIHS offered no position during NHTSA's 1986 hearings on side crashworthiness protection.

Unfortunately, IIHS has aligned itself with the automobile industry in other areas detrimental to the public health and safety. For example, IIHS supported Ford's petition to extend to 1994 full implementation of DOT's passive restraint rule, giving companies four more years to satisfy the requirement with driverside only air bags, instead of full front air bags or automatic belts. The Center for Auto Safety called Ford's petition an attempt to hold "the safety of the American driving public for ransom."

Insurance companies point to the IIHS and other safety and anti-crime organizations such as the Insurance Crime Prevention Institute and the National Auto Theft Bureau, as evidence of their financial commitment to safety organizations and loss prevention. Notice, however, the insurance industry's inattention in pressing automobile companies to design more theft-resistant locks, especially GM whose locks car thieves have long known are easier to defeat. And compare, for example, the \$7.6 million annual budget of the IIHS with the far greater resources needed to advocate, test and lobby for loss prevention in auto safety.

In addition, our 1987 survey of 11 major U.S. property/casualty company foundations showed that casualty prevention is not accorded much of a priority in making foundation grants and other contributions. Only Travelers contributed as much as \$10,000 to safety (meaning loss prevention) programs. Aetna, American Financial Corporation, Chubb, Continental and Farmers Insurance Group contributed \$5,000 or less. See "Loss Prevention and the Insurance Function," published in the Fall, 1987 Suffolk University Law Review.

Moreover, if insurance companies were sufficiently determined to minimize hazards causing injury and death, they could easily use their rate and coverage control to accomplish their goal. For example, companies could use their own rating function to penalize through increased rates insureds who do not improve safety, or require implementation of hazard prevention measures as part of the insurance contract. They could establish structured programs to disclose information about product hazards, which their investigators have documented for their insurance company files, to those authorities responsible for ensuring safety. (The media has learned to look infrequently to insurance companies for such information or comment.) And they could set more quickly and amply loss prevention examples in their own shop, such as by requiring their entire fleet of cars to be air bag equipped. Only a very few casualty companies have done the latter. The major life companies have not.

Moreover, insurers have innumerable opportunities to exercise their full muscle before government bodies, whether lobbying Congress, formally petitioning regulatory safety agencies, or seeking enforcement of health and safety standards

in judicial proceedings. Instead, the contact insurance companies have with the court system is in fighting claims and essentially defending hazards. A few luminous exceptions have occurred, such as when State Farm successfully petitioned the U.S. Court of Appeals to reverse NHTSA's 1981 rescission of the automatic restraint standards, or when State Farm and Allstate challenged the 2 1/2 mph bumper protection standard. But even the IIHS has only occasionally petitioned for auto recalls and even more rarely for new or stronger motor vehicle safety standards.

To demonstrate how little attention insurance companies pay to safety and loss prevention, consider the nationwide trend in motorcycle helmet use laws. Between 1966 and 1973, almost every state had passed a motorcycle helmet use law. But by 1980, 29 states had repealed or weakened their law and insurance companies did virtually nothing to stop them. More than 500 excess deaths and many more serious injuries occur yearly in those states with no, or weak helmet laws, compared to states with strong laws. A few other examples serve to demonstrate what opportunities insurance companies have to reduce claims and therefore costs by insisting on the reduction or elimination of hazards.

a. Vehicle Safety:

**55 mph speed limit:** In 1987, a closely divided U.S. Congress revoked the federal 55 mph speed limit on federal interstate highways, leaving to the states authority to raise the limit to 65 mph. According to NHTSA, in the 38 states that have upped the limit on rural roads in the past year, deaths on these highways have increased 19 percent -- an increase nearly three times as high as in states that kept the 55 mph limit.

The insurance industry must share the blame for the increasing costs resulting from this predictable increase in deaths and injuries. Although the IIHS and some companies devoted some support efforts to try to preserve the 55 mph speed limit, had the industry devoted its full political muscle to this issue, there is little doubt the industry could have prevailed on Congress to preserve this proven highway safety measure. And now that the grim facts about increased deaths and injuries are in, why are insurance companies not fighting to lower highway speeds at the state level, or to ensure the 55 mph speed limit is maintained in states which have not raised it?

**Air bags:** The air bag can save at least 12,000 lives and hundreds of thousands of serious injuries a year in this country. Some major auto insurers are providing some financial incentives to encourage purchases of cars equipped with air bags (although the IIHS says the major AAA and other motor club insurers provide no incentive unless required to do so by law as in New York state). The IIHS says USAA's incentive program is exceptional for providing unusually large discounts for medical and personal injury protection for cars equipped with air bags (60 percent,

where as most companies' discounts range from 20-30 percent for medical and personal injury protection). During 1988, USAA also provided \$300 to any policyholder who bought or leased a car equipped with an optional air bag (although for the bonus to apply, the air bag must have been optional, and even this bonus was discontinued in 1989).

But if all insurers put their muscle behind air bags by encouraging air bag retro-fitting, equipping their own entire company fleets with air bags as has Travelers Insurance Co., pushing for mandatory regulations for air bags or their equivalents, many more lives could be saved and billions of dollars more could be saved annually in health costs, wage loss and disability payments.

**Seatbelts:** The National Highway Transportation Safety Administration (NHTSA) conservatively estimated that in 1987, "the 25 percentage point rise in national belt use over 1984 levels saved about 1,300 lives and prevented about 16,000 moderate-to-serious injuries. The resultant reduction in automobile insurance claims was roughly \$1 billion to \$2.5 billion. Other public and private insurers probably saved another \$0.5 billion to \$1.25 billion."

But while seatbelt use in automobiles has reduced deaths, serious injuries and insurance costs, it is not used to reduce premiums. Also, these benefits have not been extended to workers who must drive dangerous vehicles on the job. For example, according to a 1987 Trial magazine article, at least 100 forklift operators are killed or seriously injured each year as they are thrown out, or jump out of forklifts that accidentally tip over. Many tests have demonstrated the effectiveness of seat belt use in preventing these injuries, and although a few companies like Clark Equipment Co. and U.S. Steel require that seat belts be installed on forklifts, most insurance companies have not insisted on this condition.

James W. Smirles, national broker liaison with the Long Grove, Ill.-based Kemper Group, told a risk managers' conference this year that in the worker compensation area, the difference between a very good and a very bad safety record can cause them to raise premiums as much as 400 percent. Wouldn't workers be better off if insurers simply insisted that for continued coverage, employers provide safety protections so that their workers are protected from such accidents so that injuries and insurance claims can be reduced?

**5 mph bumper standard:** Between 1978 and 1982, the government required a 5 mph bumper protection standard, which the Carter administration's Department of Transportation estimated would save consumers over \$400 million a year. Despite overwhelming consumer support for this standard, the Reagan administration, after heavy lobbying by General Motors, rolled the bumper protection standard back to 2 1/2 mph.

While fender-bender accidents represent a large segment of insurance company costs, insurance companies, with a few exceptions like Allstate and State Farm, paid very little attention to this development. In addition to applying its lobbying muscle in Congress, if not before the DOT to have prevented the rollback of bumper protection standards, insurers could have petitioned the government to reinstate the standard once data on the 2 1/2 mph standard's impact came in. They did not. Moreover, insurers have not insisted on bumper standards for light trucks and vans, which now comprise about 1/3 of all new vehicles sales.

b. Fire and Electrical Safety.

Deaths and injuries due to fire are largely preventable. In Japan, for example, the rate of fire deaths is half that of the United States -- 25.7 per million in the United States; 12.5 per million in Japan.

The insurance industry frequently points to its past help in originating the national electrical code and establishing Underwriters' Laboratories and the National Fire Protection Association as examples of its past commitment to loss prevention and fire safety. Yet these efforts are small compared to what the industry should be doing now to make these institutions real change-agents rather than indentured servants.

First, the industry-backed Underwriters' Laboratories' seal of approval on electrical devices does not always ensure the product's design safety. For example, after an alarming increase in residential fires due to kerosene heater use, UL recently upgraded its kerosene heater standard, UL 647, to help reduce some of the fire deaths and injuries. However, the compromise standard failed to address some problems, such as flare-ups and afterburn. See, for example, the analysis in the 1988 report by the Federal Emergency Management Agency/U.S. Fire Administration, "Alternative Heater Fires: A Critical Review of Safety Issues." Moreover, after UL 647 was upgraded, retailers were still permitted to sell out existing stocks of substandard heaters.

Similarly, in a November, 1987, New York Times column, the president of a mailorder home appliance company expressed outrage that UL's new standard to prevent electrocution from accidental immersion of hair dryers in water, applied only to hair dryers manufactured after October 1, 1987. Retailers were permitted to sell out their stock of substandard hair dryers. As a result, during the 1987 Christmas buying season, new and old dryers were on the shelves, both with UL labels, and consumers could not tell which were substandard.

Moreover, insurance companies have not actively promoted the fire-safe cigarette, nor advocated strongly for residential sprinklers. They recently have pushed for tougher criminal laws for arsonists, and have assisted efforts to help catch arsonists with the Insurance Committee for Arson Control and the Insurance Crime Prevention Institute. But David Hemenway, an economist at

the Harvard School of Public Health and a Pew Fellow in Injury Control who has studied insurance industry efforts to promote residential fire safety, has written that the size of these efforts is minuscule compared to the size of the insurance industry and the magnitude of the fire problem. This is an important observation. The insurance industry, when it goes beyond mere rhetoric, rarely puts more than a tiny fraction of its resources and power beyond public and private safety, health and property damage prevention efforts. But Aetna and other companies are known to lobby very vigorously against victims' rights or repeal of the McCarran-Ferguson Act.

Insurers have released very little useful statistical fire data to those responsible for ensuring safety, or to policyholders. Nor do insurers operationally cooperate with ongoing community efforts at fire prevention. For example, one well-known anti-arson group undertook a program to prevent many of the most notorious properties in New York City from getting fire insurance. According to a 1985 article in Citizen Participation magazine, the group wrote to every insurance company known to provide fire insurance in its area, offering to share with those companies some of its own credible "early-warning" data as an aid in evaluating insurance risks. With the notable exception of the Liberty Mutual insurance company, the group's letters and phone calls drew what it termed an "unenthusiastic response." According to the article, other groups which also offered to work with insurers reported similarly disappointing results, "raising suspicions that some insurance companies don't much care about inner-city arson, so long as the premiums keep rolling in to cover it."

In addition to exchanging information and more strongly advocating fire safety measures, Hemenway suggests that insurers should offer policyholder discounts to encourage fire prevention. For example, only in the past few years have residential insurers included discounts for smoke detectors and for not smoking, and these discounts have neither been large nor well-publicized. Such discounts should be expanded to include use of less dangerous wiring and heating systems and for non-flammable furnishings.

#### c. Products:

It is estimated that nearly 100,000 deaths and millions of injuries each year are product-related, and are occurring at increasing rates. There are many ways insurance companies can function to control and minimize these hazards which cause death and injury.

For example, by implementing a structured disclosure program, insurance companies can do a great deal to assist those responsible for making products or services safer. According to safety research consultant David V. MacCollum, former president of the American Society of Safety Engineers, insurance companies should be collecting data on equipment, identifying injuries by

particular hazards, and maintaining a central data bank on hazard information, narratives of occurrences and available safeguards. For each claim or disputed injury, insurance companies should be routinely identifying the product hazard or unsafe condition which resulted in the claim, including the make and model of any product that served as the host for the hazard, or any chemical that could cause toxic injury. Companies should publish annual summaries of all death or injury-related occurrences, assuring public access to this information. These data are crucial for regulatory agencies, for those injured by such products, and for the populace so they may be alerted to unsafe products and conditions.

Internally, insurance companies with multiple lines, like workers' compensation and product liability, should forward information regarding hazards and equipment from one line to another. In addition, information about hazardous conditions and products and those which repeatedly cause serious harm should be communicated to law enforcement officials, as well as advertised to the public.

Insurance companies should also require implementation of hazard prevention measures as part of the insurance contract, particularly after a claim is submitted and specific hazard prevention measures identified. After a legitimate claim is paid, the insurer should routinely conduct a hazard analysis of the product or unsafe circumstance.

The insurance industry's lack of concern in controlling even the most serious hazards that the industry insures, was clearly evident during the House Subcommittee on Surface Transportation of the Committee on Public Works and Transportation hearings, May 19, 1988, on the transportation of hazardous materials. There are 500,000 shipments of hazardous and toxic materials moved each day through, what Rep. Douglas Applegate called "an archaic hazardous materials transportation system." DOT reported incidents of hazardous spills in 1986 were 5,700, and the Office of Technology Assessment says that as many as 50 percent of incidents are not reported.

Twenty-five witnesses testified at this hearing, including generators of hazardous wastes (e.g., the chemical manufacturers and corporations like DuPont); transporters of hazardous wastes (e.g., truckers, shippers); emergency management specialists (e.g., the Federal Emergency Management Agency,); and state and local government associations (e.g., National Governors Association). Not one insurance company nor insurance industry representative testified or even filed materials for the record.

#### d. Smoking

According to findings reported by PrideMark Young & Simon, smokers cost insurance companies 54% more for health care than do non-smokers. It is a mass tragedy that the life and health insurance industries did not crusade against cigarette smoking promotions and establish anti-smoking clinics years ago. Over

Letter to James P. Lynn, Page 10.

the years, Reader's Digest did far more in this area than did insurers such as Metropolitan, Prudential, the Equitable and John Hancock.

According to safety research consultant MacCollum, "If the existence of an effective hazard prevention program within an institution were used as the foremost criteria for providing underwriting coverage for workers' compensation, product liability, public liability, and other such insurance, we would not, today, need to be addressing the problem of exorbitant insurance rates." With their tremendous assets and soaring profits, insurance companies have a great opportunity to contribute to the advancement of health and safety by working to eliminate or reduce hazardous products, services and conditions. And they will reduce their claims costs in the process.

Instead of a major commitment by Aetna in these directions, your company is spending large sums to prejudice public opinion against the rights of injured persons to plead before juries for justice. Presently, in at least four states -- Colorado, Louisiana, St. Louis and upstate New York -- you are spending many policyholders' dollars in full page newspaper ads and electronic media spots. The content of these ads are replete with wild misrepresentations that do not reflect the regular disposition of cases in the courts. These ads are far, far less fair than would be an ad depicting Aetna's lengthy coverup of its knowledge about the Dalkon Shield mutilations as being explicitly representative of the entire insurance industry's practices.

Is this the way Aetna wants to spend money -- caricaturing the American legal system better than any Kremlin propagandist could do? Does Aetna want to provoke an aroused public against its outrageous distortions or would it rather enlist an aroused public into loss prevention project after project -- ranging from motor cycle helmet use to safer motor vehicles, medical devices and pharmaceuticals? Let's hear from you, Mr. Lynn. Which specific projects do you wish to have your company work on, that are mentioned in this letter, for results, not rhetoric?

Sincerely,

/s/

Ralph Nader



Law and Public Affairs Division  
51 Farmington Avenue  
Hartford, CT 06155

RECEIVED  
FEB 10 1989  
FBI - BOSTON

February 8, 1989

Mr. Ralph Nader  
Center for Responsive Law  
P.O. Box 19367  
Washington, DC 20036

Dear Mr. Nader:

Jim Lynn asked me to respond to your recent letter.

We couldn't agree more that the insurance industry can help to improve health and safety in America. But you are either unaware or you choose to ignore the major contributions the industry, generally, and Aetna, specifically, are making to public health and safety.

You charge that we "could be doing much more than simply complaining about legal, medical and auto repair costs." Ralph, we're doing a lot more than complaining.

As you and the plaintiffs' bar are well aware, we have done much more than "simply complain" about the skyrocketing costs of litigation. Unfortunately, when we work with coalitions across the country to reduce delay and waste in the civil justice system, you and the trial bar yell "foul." When we try to enter into a serious dialogue about the need for more fairness in the system, you say we're trying to take away victims' rights.

Why, when so many people from so many different perspectives are decrying our badly flawed tort system, do you uncharacteristically show no concern?

We cannot -- nor should we -- assume responsibility for every facet of safety, as you would have us do. As you must be aware, many of the nation's manufacturers now largely self-insure their products. Without the leverage that the underwriting process provides, we lack the influence to affect product design and marketing. In short, we cannot be held responsible for the safety of products that we do not insure. Nevertheless, I assure you we are aggressive in our efforts to prevent injuries and to promote health and safety.

Ralph Nader  
February 8, 1989  
Page 2

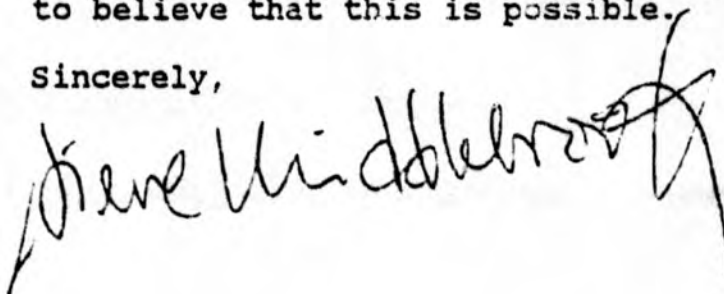
As an industry, we sponsor safety and loss prevention programs for millions of businesses, schools, towns and cities across America. Aetna alone has spent more than \$175 million in the past six years to make offices and factories safer for workers. Since 1979, Aetna alone has trained more than 300,000 police and fire officials in safety and investigation techniques. Our book, Fire and Arson Investigation, has been distributed all over the world and is used by the Federal Bureau of Investigation and the Bureau of Alcohol and Firearms for training recruits.

We work closely with employers on wellness programs, anti-fraud initiatives and cost-containment programs. The list of our activities is long -- very long. By any objective standards, it demonstrates our commitment to public health and safety. But your misperceptions about the insurance industry and your own very well-publicized campaigns against the industry and tort reform suggest either an inability or unwillingness to view us objectively.

There are, of course, problems facing our industry. The costs which drive what we must charge for our products are too high. The regulatory system is imperfect. But what's needed is for those with meaningful ideas to work together on solutions. That doesn't mean attributing every cost problem to insurer profitability or inefficiency. And it doesn't mean using insurers as scapegoats for what are complex societal problems.

We are ready and sincerely interested in working with others to reduce costs. If you share this interest, there may be reason to work together at some time in the future. But based on your statements to date, I'm not encouraged to believe that this is possible.

Sincerely,

A handwritten signature in dark ink, appearing to read "Gene Lindblom", with a stylized flourish at the end.

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RMR JOANNE, RALPH NADER ASST, DLR

CENTER FOR THE STUDY FOR RESPONSIVE LAW RPT DLY MCM, DLR

2000 P ST NORTHWEST

WASHINGTON DC

PLEASE INFORM MR NADER THAT MR LYNN IS AWARE OF HIS MESSAGE HE ALSO  
IS AWARE OF ANY FULLY ENDORSES BE WILLING TO ADDRESS INSURANCE ISSUES  
CONSTRUCTIVELY AND FAIRLY WE WILL BE WILLING TO WORK WITH HIM UNTIL  
THEN WE SEE NO POINT IN FURTHER DISCUSSION

W.U. 1201-SF (RS-69) KATHLEEN A MURRAY ASST VICE PRESIDENT CORPORATE MANAGEMENT

  
western union

Telegram

142 TRUMBULL ST  
HARTFORD CT 06125

1214 EST

NNNN

C.15



ALASKA STATE LEGISLATURE  
HOUSE OF REPRESENTATIVES  
RESEARCH AGENCY

P.O. Box Y, State Capitol  
Juneau, Alaska 99811-3100  
Mail Stop 3100  
(907) 465-3991

March 15, 1989

MEMORANDUM

TO: Representative Sam Cotten

ATTN: David Rogers

FROM: Patricia Young *py*  
Legislative Analyst

RE: Hawaii Court Annexed Arbitration Program  
Research Request 89.306

You asked this agency to provide a copy of the Hawaii statute which allows for arbitration of personal injury claims. You requested a brief description of the process, as well as contacts in Hawaii for more detailed information.

The Hawaii Court Annexed Arbitration Program (CAP) is an alternative dispute resolution program designed to encourage settlements, to reduce litigants' costs, to expedite processing and resolution, and to reduce civil caseloads in the courts. Originally intended to handle comparatively small and simple personal injury cases, the CAP has expanded to include all tort cases with a probable jury award value of \$150,000 or less. The CAP is a mandatory, non-binding program.<sup>1</sup> Litigants may select a private arbitrator, or the arbitration commission administrator will assign one to hear the case and deliver a judgment. A litigant who wishes to appeal a judgment must do so within 20 days of the arbitrator's award. If the court does not alter the award by at least 15 percent in favor of the appealing party, the appealing party is required to pay reasonable costs and fees, costs of jurors, and attorney's fees up to \$5,000.

I have attached a copy of the enabling statute and rules, background information on the program, and caseload and result data. Contacts in Hawaii for more information are Ed Aoki, CAP arbitration administrator, at (808) 548-4380; Peter Adler, director of the Program on Alternative Dispute Resolution (ADR), at (808) 548-3080; and Dee Dee Letts, assistant director, at the same number.

I hope this is information useful. Please call if you have any questions or need further information.

Attachment

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<sup>1</sup>Exemptions from arbitration are considered by the arbitration judge upon request.