ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

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> others against the prevailing party or its insurer; and
> (K) other equitable factors deemed relevant.
>
> If the court varies an award, the court shall explain the reasons for its variation.
>
> . . . .
>
> (e) Effect of Rule. The allowance of attorney's fees by the court in conformance with this rule shall not be construed as fixing the fees between attorney and client.
>
> 2. By adopting these amendments to Civil Rule 82, the court intends no change in existing Alaska law regarding the award of attorney's fees for or against a public interest litigant, . . . or in the law that an award of full attorney's fees is manifestly unreasonable in the absence of bad faith or vexatious conduct by the non-prevailing party.[120]

IV. Amended Rule 82 and its Probable Effects

Amended Rule 82, which became effective on July 15, 1993, changed the Alaska fee taxation scheme significantly. First, and perhaps foremost, the new rule dispenses with the wide flexibility that trial judges had to determine the appropriate percentage of fees to tax when the prevailing party did not recover a monetary judgment. Instead, amended Rule 82 fixes non-schedule based recovery at "30 percent of the prevailing party's actual attorney's fees which were necessarily incurred" for cases going to trial, and 20 percent for cases not going to trial.[121] Procedurally, Rule 82 still requires trial courts to scrutinize fee petitions to verify that the attorney's fee represents actual expenses necessarily incurred.[122] Although the language of the new rule is slightly modified, it appears that judges will engage in the same basic reasonableness determination that occurred under the pre-amendment rule. The real difference is that absent variation under subsection three, judges no longer estimate the appropriate fraction of the fee to shift.

The effect of this new standard clearly benefits plaintiffs vis-a-vis defendants. Prevailing plaintiffs, who receive monetary judgments, still receive their awards based on the schedule, which

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120. Alaska Civ. R. 82.
121. Alaska Civ. R. 82(b)(2).
122. See *supra* text accompanying notes 50-54.

remains the same as under the pre-amendment rule. With this provision, plaintiffs will also be able to predict more accurately the size of the fee award that they will be responsible for should they lose. Prevailing defendants, on the other hand, no longer should receive awards in the range of forty to eighty percent of their actual fees, which was common under the former regime.[123] One Alaska attorney observed that "a review of [s]upreme [c]ourt opinions reveals that the typical award of attorney's fees is usually closer to fifty percent than to thirty or thirty-five percent."[124] Another defense practitioner argued that "creating a cap at anything less than 60% of actual attorneys' fees encourages non-meritorious litigation, reduces the chance of early settlement, and maximizes the chances of a full trial, at considerable expense to the parties and the court system."[125] Although it seems improbable that the new standard tilts the balance of power far enough to have such drastic effects on the litigation process, the provision obviously is designed to address the *Bozarth* access issue by limiting the size of defense awards.

Plaintiffs have a bona fide complaint, however, that the structure of the amended rule continues to institutionalize inequitable fee awards favoring defendants. By confining prevailing plaintiffs to the schedule while allowing prevailing defendants to recover a fixed, albeit lower than pre-amendment, percentage of their actual fees, gross disparity can result between the two parties' potential fee recoveries. Consider the following hypothetical posed by a practitioner:

> For instance in a personal injury case where there was a $50,000.00 judgment, a prevailing plaintiff would receive . . . a total award of about $7,500.00. In the same hypothetical, if a plaintiff's verdict did not exceed defense offers of judgment, the trial court [would] award defendant prevailing party attorney fees based on [thirty percent] of actual [post-offer] fees. In my experience, actual defense costs in a moderate-size personal injury case start at $30,000.00 and escalate rapidly. In this example, I cannot foresee an instance where a prevailing

123. See *supra* text accompanying note 57.

124. Memorandum from Jon T. Givens, Esq., to Christine Johnson, Esq., Court Rules Attorney, Alaska Court System 1 (Oct. 9, 1992) (on file with *Alaska Law Review*).

125. Memorandum from Mark E. Wilkerson, *supra* note 57, at 2.

> defendant would not obtain a substantially larger award than a prevailing plaintiff.[126]

The imbalance appears especially acute in the preceding hypothetical since there is both a monetary award, from which a schedule-based calculation can be made, and a prevailing defendant, requiring application of the new fixed-rate standard. This imbalance also exists independently of Rule 68. One attorney estimated that in the vast majority of small cases, thirty percent of the actual defense fees will far exceed the amount of attorney fees the prevailing plaintiff can recoup under the schedule.[127] While the ideology behind the new fixed rate for non-monetary judgments is a valid consideration, the amendment may fail to redress adequately the inherent asymmetry between the schedule and fixed-rate methods of fee taxation for plaintiffs and defendants respectively.

Another major change to Rule 82 is the addition of a list of factors under which trial courts may vary awards calculated under either the schedule or the fixed-rate approach.[128] The Civil Rules Committee recommended the inclusion of many of these factors as a means of guiding judges when the schedule or fixed percentage seems inappropriate.[129] The factors generally address the unique aspects of the litigation at issue, the reasonableness of the parties' behavior, and the considerations of vexatiousness, bad faith, or other improper motive—all legitimate bases for deviating from the schedule according to the case law surrounding former Rule 82.[130]

The amended rule also contains a more controversial factor that allows trial judges to consider "the extent to which a given fee award may be so onerous to the non-prevailing party that it would deter similarly situated litigants from the voluntary use of the courts."[131] The rule's wording targets the *Bozarth* access issue, but it does not articulate any specific standard for trial judges to apply. This vagueness may be intended to avoid the criticism that the "relative ability to pay" and "ability to pay" criteria garnered

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126. Memorandum from Loren Domke, Esq., to Christine Johnson, Esq., Court Rules Attorney, Alaska Court System 1-2 (Oct. 2, 1992) (on file with *Alaska Law Review*).

127. Memorandum from J. Glen Harper, Esq., to Christine Johnson, Esq., Court Rules Attorney, Alaska Court System 2 (Oct. 14, 1992) (on file with *Alaska Law Review*).

128. ALASKA CIV. R. 82(b)(3).

129. See *supra* text accompanying notes 115-116.

130. *See supra* notes 22-31 and accompanying text.

131. ALASKA CIV. R. 82(b)(3)(I).

from the Alaska Bar.[132] However, the Civil Rules Committee rejected even the spirit of the *Bozarth* criteria for the reasons that they would create an unfair lack of uniformity and "would generate too much additional litigation."[133]

Indeed, how will a trial judge be able to determine when an award will have a deterrent effect on subsequent plaintiffs without engaging in an in-depth review of the parties' individual ability to pay? In all likelihood, future adjudicators will need to look at financial statements of losing plaintiffs. As a result, the relative financial strength of such plaintiffs compared to large institutional defendants may be used as a proxy for identifying particular situations where future litigants are likely to be deterred (e.g., the employment law context). This provision is sure to generate a considerable amount of spin-off litigation.

The inclusion of a laundry list of other equitable factors is also certain to generate a new body of case law. On the positive side, setting out the factors in the text of the rule could increase the uniformity of the reasoning process among judges exercising their equitable powers. Accordingly, fee awards might become more predictable. Common sense, however, dictates that subparagraph (b)(3) will spawn numerous appeals where trial judges "failed to take into consideration one factor or another, or placed too much emphasis on some factor or considered a factor which was not truly an 'equitable factor' under [subpart (K)]." [134] Given the sheer number of these factors and their vague wording, virtually any prevailing party will be able to find an avenue to request enhanced fees.[135] Justice Rabinowitz, in his dissent from the court's amendments of Rule 82, foresaw that these new provisions "will unnecessarily and dramatically increase litigation over attorney's fees awards both in our trial courts as well as in this court."[136] Any attorney "worth his or her salt" will request variations from either the schedule or the fixed rate.[137]

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132. See *supra* text accompanying notes 101-104.

133. Memorandum from Christine Johnson, *supra* note 113, at 1.

134. Memorandum from James M. Powell, Esq., to Christine Johnson, Esq., Court Rules Attorney, Alaska Court System 2 (Oct. 9, 1992) (on file with *Alaska Law Review*).

135. Memorandum from Loren Domke, *supra* note 126, at 2.

136. Alaska Supreme Court Order No. 1118, at 5-6 (Jan. 7, 1993) (Rabinowitz, J., dissenting).

137. *Id.* at 6 n.2 (Rabinowitz, J., dissenting).

An additional noteworthy change to Rule 82 involves the addition of a provision that allows the parties to "contract around" the rule privately. The amended rule states that a prevailing party is generally awarded attorney fees "[e]xcept as otherwise provided by law *or agreed to by the parties*."[138] Thus, parties now can decide to adopt the American rule, or some other alternative, if it better serves their mutual purposes. The reasoning behind this provision appears to be that parties are aware of the peculiarities of their transaction or relationship and are therefore better able to tailor a fee arrangement to fit the nature of their anticipated litigation. Assuming that transaction costs are not prohibitively high, and that parties will contract around Rule 82 on occasion, settlement rates will theoretically approach those of jurisdictions with different legal rules.[139] This provision should encourage the Alaska Bar to develop a highly refined body of contractual language that would be widely used and, in some circumstances, more efficient than the existing rule.

Finally, the amended version of Rule 82 alters the treatment of paralegal expenses. Previously, several opinions of the Alaska Supreme Court held that paralegal expenses are a cost item treated under Civil Rule 79(b).[140] Consequently, trial judges often had to handle appeals concerning paralegal costs in a proceeding separate from the attorney fee taxation under Rule 82.[141] Rule 82(b)(2) rectifies this situation by including "fees for legal work customarily performed by an attorney but which was delegated to and performed by an investigator, paralegal or law clerk" as actual fees.[142] This new provision will streamline the process for computing paralegal expenses by treating them as a portion of normal

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138. ALASKA CIV. R. 82(a) (emphasis added).

139. *See* John J. Donohue III, *Opting for the British Rule, or if Posner and Shavell Can't Remember the Coase Theorem, Who Will?*, 104 HARV. L. REV. 1093, 1095 (1991) (discussing the Coase Theorem, which implies that litigants will select a fee-allocation rule that generates greater total expected wealth).

140. *E.g.*, Yurioff v. American Honda Motor Co., 803 P.2d 386, 390-91 (Alaska 1990); CTA Architects v. Active Erectors & Installers, Inc., 781 P.2d 1364, 1367 (Alaska 1989); Smith v. Shortall, 732 P.2d 548, 550 n.1 (Alaska 1987); Atlantic Richfield Co. v. State, 723 P.2d 1249, 1253 (Alaska 1986); *see also* Memorandum from Ed Husted, Lawyer Support Services, to Christine Johnson, Esq., Court Rules Attorney, Alaska Court System 1 (citing Frontier Cos. v. Jack White Co., 818 P.2d 645, 653 (Alaska 1991)) (on file with *Alaska Law Review*).

141. Memorandum from Ed Husted, *supra* note 140, at 3.

142. ALASKA CIV. R. 82(b)(2).

legal fees; trial judges will engage in a single review of all legal services rendered to the prevailing party.[143] In addition to producing greater administrative efficiency, this provision may well reduce the size of legal fees by encouraging firms to use paralegals for genuine surrogate attorney work—at a greatly reduced cost.[144] Finally, as one attorney noted, this revision will eliminate the practice of using paralegals for needless administrative tasks, since it will no longer be possible to obtain reimbursement for these overhead clerical services under Rule 79.[145]

V. THE UNDERLYING RATIONALES FOR FEE SHIFTING IN ALASKA—IS RULE 82 THE PROPER MECHANISM FOR ACHIEVING THESE GOALS?

Although Alaska's fee-shifting system has grown more complex over the years, with a vast body of case law and several amendments, the official purpose of Rule 82 has remained the same: partial compensation of the prevailing party's attorney expenses.[146] The debate preceding the recent amendment to Rule 82, however, confirms that fee shifting remains in effect in Alaska not merely because of its stated purpose, but rather because of its total perceived beneficial effects on the litigation process: a greater level of fairness, indemnity of the winner, a punitive function, a "private attorney general" effect, and a settlement incentive.[147] Despite the desirability of each of these rationales, Rule 82, in its past or present form, is not the most effective mechanism for achieving these results.

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143. Memorandum from Ed Husted, *supra* note 140, at 3.

144. *Id.*

145. Memorandum from John Suddock, Esq., to Christine Johnson, Esq., Court Rules Attorney, Alaska Court System 1-2 (Oct. 3, 1992) (on file with *Alaska Law Review*).

146. *See supra* notes 18-19 and accompanying text.

147. The author has arrived at these rationales by consulting written responses from the Civil Rules Committee Rule 82 questionnaire, see Phillips & Greene Memorandum, *supra* note 83; comments of the Civil Rules Subcommittee, see Memorandum from Christine Johnson, *supra* note 113; and memoranda from the Alaska Bar which helped shape the amended version of Rule 82, see, e.g., Memorandum from Robert M. Libbey, *infra* note 153; Memorandum from Allison Mendel, *infra* note 167. The categories represent the fee-shifting goals most frequently articulated by these sources. *See also generally* Thomas D. Rowe, Jr., *The Legal Theory of Attorney Fee Shifting: A Critical Overview*, 1982 DUKE L.J. 651 (1982).

A. Fairness and Indemnity

Rule 82 was not designed to punish the losing party for pursuing a good faith claim or defense, but rather to indemnify the winner partially.[148] The purpose articulated by the Alaska Supreme Court, on its face, is tautological—justice simply requires partial indemnity.[149] The most persuasive underlying argument for indemnity is that the prevailing party, by virtue of being adjudged legally in the right, should not be required to absorb all of the costs incurred in vindicating his or her position.[150] The problem with this rationale, however, is that the funds used to indemnify come from the losing party's pocket. While the winner may have an equitable justification for reimbursement, the loser often has a cogent conflicting equity: "[a] defeated party . . . may frequently appear to have been justified and reasonable in pressing a strong but ultimately unsuccessful claim or defense."[151] Although the Alaska scheme attempts to accommodate this tension by allowing only partial indemnity, even a fraction of a large corporate defendant's fees is sizeable enough to deter small plaintiffs from using the courts or, in the alternative, to drive them into bankruptcy.

Litigation outcomes are often unpredictable, and the right to have one's day in court is a central concern of the American legal system. Ninth Circuit Judge Andrew Kleinfeld, while still a plaintiffs' attorney in Alaska, observed: "Attorneys' fee awards imply that the loser should have recognized that the winner was right, and not fought the claim. The implication is often unfair in contract (and tort) claims where considerable justice can be found on both sides."[152] The following commentary provided by another Alaska attorney describes the resulting inequity:

> [T]he harshness of the rule as it falls on some persons with legitimate claims for relief, is an inequity that the judicial system can do without. I have seen a number of people driven into

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148. "The purpose of Civil Rule 82 is to partially compensate a prevailing party for the costs and fees incurred where such compensation is justified and *not to penalize a party for litigating a good faith claim*." Malvo v. J. C. Penney Co., 512 P.2d 575, 588 (Alaska 1973) (emphasis added).

149. Rowe, *supra* note 147, at 654.

150. *Id.*

151. *Id.* at 655.

152. Andrew J. Kleinfeld, *On Shifting Attorneys' Fees in Alaska: A Rebuttal*, JUDGES' J., Summer 1985, at 39, 41.

> bankruptcy by an adverse ruling in a case that clearly deserved a determination of the merits. Yet, the cost judgment drove a middle class family with modest means into bankruptcy. Such harsh results inevitably lead to a restriction on the access to our judicial system.[153]

Amended Rule 82 addresses the access issue by fixing the non-monetary judgment recovery at thirty percent of the actual fees and by including a deterrence factor via equitable variation. As discussed previously, however, there still seems to be an imbalance between the size of schedule-based awards, which usually go to prevailing plaintiffs, and fixed-rate awards, which are typically recoverable by prevailing defendants.[154] Moreover, it is questionable to what extent the *Bozarth* access factor[155] will succeed in preventing the prospect of large fee awards from deterring plaintiffs of moderate means from using the courts. There also remains a strong possibility that non-prevailing parties will be forced into bankruptcy merely by bringing a losing claim or defense in good faith. Accordingly, it is debatable whether Rule 82, even as amended, leads to litigation outcomes fairer than those which typically occur under the American rule.[156]

The indemnity argument further breaks down when a party who receives a favorable court judgment becomes a "losing" party because the size of the award does not exceed the amount of a Rule 68 settlement offer.[157] Rule 68 is designed as a settlement device, but to the extent that it shifts attorney fees in addition to costs, it should comport with the articulated partial-indemnity rationale of Rule 82 as well. While one may plausibly assert that trials usually achieve the fair result as to liability, it is a stretch to argue that the amount of monetary judgment accurately gauges the legitimacy of the claim or defense. "It is arbitrary to penalize litigants who made offers within the average [or rejected offers outside the average], but lost because their particular case did not

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153. Memorandum from Robert M. Libbey, Esq., to Christine Johnson, Esq., Court Rules Attorney, Alaska Court System 1 (Oct. 5, 1992) (on file with *Alaska Law Review*).

154. See *supra* text accompanying notes 126-127.

155. *See* ALASKA CIV. R. 82(b)(3)(I).

156. *See* John F. Vargo, *The American Rule on Attorney Fee Allocation: The Injured Person's Access to Justice*, 42 AM. U. L. REV. 1567, 1634-35 (1993) ("Litigation of basic rights [is] not to be discouraged by rules that den[y] access to the courts.").

157. *See supra* notes 59-64 and accompanying text.

produce the average result."[158] Often, the amount of the offer barely exceeds the judgment, but being close makes no difference. "It is like a sporting contest where one side gets the trophy whether the score was 7 to 6 or 7 to 1."[159] Moreover, litigants rely on their attorneys' advice in valuing their claims; but it is the client, not the attorney, who shoulders the burden when the judgment falls short of the Rule 68 offer.

In sum, partial indemnity of the prevailing party is unconvincing as the articulated purpose of Rule 82. Even the Alaska Supreme Court realizes this, since it has carved out exceptions to the rule for public interest litigants,[160] decreased the percentage of actual fees that prevailing defendants are entitled to recover,[161] and added language that allows trial judges to consider equitable factors such as the access issue in setting fee awards.[162]

B. Punitive Function and Deterrence of Frivolous Litigation

Alaska recognizes a common law exception to the precept that only partial fees may be shifted under Rule 82: "[f]ull or substantially full attorney's fees may be awarded if the trial court finds that the losing party acted in bad faith in asserting a claim or defense."[163] This policy resembles the federal courts' bad faith exception to the American rule, which applies when "a party refuses to recognize a clear legal right or engages in bad faith conduct in litigation."[164]

While penalizing bad faith litigation seems justified, it is not clear that fee shifting provides the optimal measure of deterrence or punishment. The strongest scenario supporting this policy is when the misconduct itself causes unnecessary legal expenses. Often, however, even if no additional legal expenses are incurred,

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158. Memorandum from Paul W. Waggoner, Esq., to Christine Johnson, Esq., Court Rules Attorney, Alaska Court System 1 (Oct. 6, 1992) (on file with *Alaska Law Review*).

159. *Id.*

160. *See, e.g.,* Loeb v. Rasmussen, 822 P.2d 914, 921 n.18 (Alaska 1991); Citizens Coalition For Tort Reform v. McAlpine, 810 P.2d 162, 171 (Alaska 1991); Anchorage Daily News v. Anchorage School Dist., 803 P.2d 402, 404 (Alaska 1990).

161. ALASKA CIV. R. 82 (b)(2).

162. ALASKA CIV. R. 82 (b)(3).

163. Alaska N. Dev., Inc. v. Alyeska Pipeline Serv. Co., 666 P.2d 33, 42 n.9 (Alaska 1983), *cert. denied*, 464 U.S. 1041 (1984).

164. *See* Rowe, *supra* note 147, at 661.

vexatious litigation imposes a host of external costs such as delaying other litigants' cases and burdening the court system. Moreover, Rule 82's deterrence effect may depend more on the wealth of the party than on the strength of the claim or defense.[165] The rule will not deter parties who are judgment-proof, no matter how misguided the suit.[166] Similarly, wealthy parties are likely to remain undaunted. However, "[m]iddle income plaintiffs who may have viable and well-founded lawsuits may be deterred because of the potentially disastrous consequences of a fee award against them."[167] Therefore, Alaska's fee-shifting regime may not provide the most effective means of punishment in many contexts.

Another significant problem with the deterrence rationale is that punitive fee shifts under Rule 82 punish the losing party for conduct that is the attorney's responsibility. It is the attorney, not the client, who is trained to decide whether or not a claim has merit. Alaska Civil Rule 11, which directs sanctions at the attorney, is the proper means to combat frivolous litigation.[168]

The purpose of Rule 11 is to encourage the good faith behavior of counsel "by holding them strictly accountable for all

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165. An empirical study of the effects of a two-way fee-shifting statute applied to medical malpractice cases in Florida concluded that plaintiffs dropped more claims under the English rule than under the American rule, but that the tendency of the former to increase defense expenditures suggests that risk aversion, rather than lack of merit, might be the primary incentive for abandoning these claims. Edward A. Snyder & James W. Hughes, *The English Rule for Allocating Legal Costs: Evidence Confronts Theory*, 6 J.L. ECON. & ORG. 345, 377-78 (1990); see also *infra* note 185.

166. One author observes that since successful defendants are unable to collect their fees from insolvent plaintiffs, the Alaska system, in practice, results in a one-way shift in favor of bankrupt complainants. Vargo, *supra* note 156, at 1624.

167. Memorandum from Allison Mendel, Esq., to Christine Johnson, Esq., Court Rules Attorney, Alaska Court System 1-2 (Oct. 15, 1992) (on file with *Alaska Law Review*).

168. Rule 11 provides in pertinent part:

> Every pleading, motion and other paper of a party represented by an attorney shall be signed by at least one attorney of record . . . . The signature of an attorney or party constitutes a certificate by him that he has read the pleading, motion, or other paper; that to the best of his knowledge, information, and belief formed after reasonable inquiry it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless expense in the cost of litigation.

ALASKA CIV. R. 11.

allegations contained in the complaint."[169] Before 1989, the rule mandated that the trial court impose "'an appropriate sanction, which may include an order to pay the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleadings, motion, or other paper, including a reasonable attorney's fee.'"[170] This language is identical to that contained in the federal version of Rule 11.[171] The 1989 amendment to Alaska's Rule 11, however, diluted the strength of this already weak rule by removing the mandatory sanction provision.

Currently, when bad faith litigation occurs, the client typically bears the brunt of the penalty in the form of full attorney fees under Rule 82. In contrast, the attorney often receives a token penalty.[172] In the Civil Rules Committee questionnaire, many respondents commented that deterrence of frivolous litigation was an inappropriate goal of Rule 82 and instead advocated the use of stronger sanctions under Rule 11.[173] The fact that a number of respondents favored more stringent sanctions on themselves, combined with the obvious reality that attorneys are more accountable for the methods of litigation than are their clients, demonstrates that a stronger Rule 11 is a better weapon against frivolous or bad faith litigation than imposing full attorney fee expenses on the hapless client.

C. Private Attorney General Effect

Public interest litigation is another common law exception to the norm of partial fee recovery by the prevailing party. The amendment to Rule 82 preserves this exception,[174] which allows full recovery of fees to prevailing public interest plaintiffs (even if they prevail only on one of many theories) and denies any reimbursement to defendants who win in public interest litiga-

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169. Sanuita v. Common Laborer's and Hod Carrier's Union, 402 P.2d 199, 200 (Alaska 1965).

170. Alaska Civ. R. 11 (amended 1989).

171. *See* FED. R. CIV. P. 11.

172. *See* Keen v. Ruddy, 784 P.2d 653, 659 (Alaska 1989) (rejecting an argument that a $100 Rule 11 sanction was too low compared to the attorney fees imposed against the attorney's client; sanction carried with it a stigma and a message of disapproval, and the trial court reasonably could have considered this penalty sufficient to punish the attorney for his conduct).

173. *See supra* text accompanying notes 108-111.

174. *See* Alaska Supreme Court Order No. 1118, at 4 (Jan. 7, 1993).

tion.[175] The evolution of this doctrine began with the policy decision in *Gilbert v. State*[176] that "it is an abuse of discretion to award attorneys' fees against a losing party who has in good faith raised a question of genuine public interest before the courts."[177] The court reasoned that this holding flowed from the articulated purpose of the rule: "[i]t is not the purpose of Rule 82 to penalize a party for litigating a good faith claim but rather partially to compensate the prevailing party where such compensation is justified."[178] The *Gilbert* decision, however, rests on infirm ground because virtually all litigants, except those found to be acting in bad faith, perceive that they are advancing their claim or defense in good faith and that other parties stand to benefit from their litigation in the future. Nevertheless, in a subsequent case, the supreme court relied upon the questionable logical foundation of *Gilbert* as a basis to authorize full compensation of attorney fees to successful public interest plaintiffs.[179]

The court's reasoning that the private attorney general principle logically flows from the rationale behind Rule 82[180] fails to support adequately the public interest exception. A more appropriate rationale is that public interest litigants need a financial incentive to bring socially beneficial suits when the cost of the litigation exceeds the plaintiff's expected private benefit.[181] If the public interest plaintiff must bear the full cost of the proceeding, the right will be under-enforced. Examples include cases seeking to enforce rights with special social value, occasions when government agencies lack adequate resources to promote the public interest, and claims that will benefit a large number of people if successful.[182] One-way pro-plaintiff fee shifting in civil rights claims at the federal level promotes this private attorney general function.[183]

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175. *See supra* notes 28-29 and accompanying text.

176. 526 P.2d 1131 (Alaska 1974).

177. *Id.* at 1136.

178. *Id.* (citing Malvo v. J. C. Penney Co., 512 P.2d 575, 587 (Alaska 1973)).

179. *See* City of Anchorage v. McCabe, 568 P.2d 986, 993-94 (Alaska 1977).

180. *Id.*

181. *See* Rowe, *supra* note 147, at 662-63.

182. *Id.* at 662.

183. The United States Supreme Court has stated that the central purpose of the one-way pro-plaintiff fee shifting under Title VII is "to vindicate the national policy against wrongful discrimination by encouraging the victims to make the wrongdoers pay at law—assuring that the incentive to such suits will not be

The problem with public interest fee shifting in Alaska, however, is that the exemption fundamentally conflicts with the spirit of the rule. Why should *prevailing* defendants be denied the partial attorney fees to which they are entitled under Rule 82, simply because the case is deemed in the "public interest"? One alternative approach would be to burden the public treasury with both the partial fee award owed to prevailing public interest defendants as well as the difference between the partial and full-fee award owed to prevailing public interest plaintiffs. However, as to the latter, it would be both unfair and impractical to collect the fees from the public rather than the defendants whose very conduct warrants deterrence.[184]

In sum, although the stated purpose of Rule 82 fails to justify the one-sided protection given to special interest plaintiffs, the public interest exception serves an important function—providing a financial incentive for certain types of litigation. Therefore, this "exception" should be retained, but the rule or its stated purpose should be modified to achieve greater consistency.

D. Settlement Incentive

Alaska's fee-shifting arrangement combines partial two-way fee shifting, contingency fee arrangements, and an offer-of-settlement device. The precise impact of Alaska's rules on settlement rates, therefore, differs from that of a pure "loser pays" system, which has been the subject of numerous articles. In order to estimate the possible settlement incentives created by Alaska's unique rules, one can refer to current economic models. However, the complexity of Alaska's fee-shifting scheme makes it virtually impossible, using models that assume risk neutrality,[185] to determine the effect of Rule 82 on the rate of settlement. One point that does emerge is that risk aversion may be a crucial factor contributing to higher settlement rates among middle-income plaintiffs.

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reduced by the prospect of attorney's fees that consume the recovery." Independent Fed'n of Flight Attendants v. Zipes, 491 U.S. 754, 761 (1989) (citing Newman v. Piggie Park Enters., 390 U.S. 400, 401-02 (1968)).

184. *See* Rowe, *supra* note 147, at 673.

185. "Risk aversion," the preference for a certain outcome over a risky one of equal or greater expected value, is a trait common to plaintiffs, while defendants often exhibit "risk neutrality" or "risk affinity." *See* Vargo, *supra* note 156, at 1593.

Law-and-economics scholars have analyzed the theoretical impact of full fee shifting on settlement rates and timing. Circuit Judge Richard Posner and Professor Steven Shavell have developed an economic settlement model which shows how the English rule leads "to the counterintuitive result of lower settlement rates."[186] The model illustrates that fee shifting adds more factors about which the parties can disagree during settlement negotiations. Accordingly, assuming risk neutrality, the parties' bargaining span will change, pushing them farther apart in their settlement effort.[187]

Professor John Hause reaches the opposite result with his own more recent model, which assumes that cases tend to cost more in a fee-shifting jurisdiction.[188] Since fee shifting raises the stakes of the litigation, it follows that parties will spend more on legal costs to influence the outcome.[189] Hause finds that settlement becomes more attractive under a fee-shifting rule because the prospect of higher trial expenditures increases the cost savings from settling, offsetting the increased number of factors upon which the parties potentially may disagree.[190] As legal expenditures increase, parties may also change their predictions regarding their chances of prevailing in court. It is possible that parties may adopt more realistic estimates of the likelihood of success at trial, since the increased legal expenditures will make more information available to them. These more reasonable expectations will bring the parties closer together despite the fact that increased expenditures tend to widen the gap between them. Conversely, the parties may become more optimistic about their chances of success at trial, thereby encouraging them to litigate rather than to settle.[191]

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186. Bradley L. Smith, Note, *Three Attorney Fee-Shifting Rules and Contingency Fees: Their Impact on Settlement Incentives*, 90 MICH. L. REV. 2154, 2155 (1992).

187. Thomas D. Rowe, Jr., *Predicting the Effects of Attorney Fee Shifting*, LAW & CONTEMP. PROBS., Winter 1984, at 139, 157.

188. John C. Hause, *Indemnity, Settlement, and Litigation, or I'll Be Suing You*, 18 J. LEGAL STUD. 157, 176 (1989).

189. The Braeutigam-Owen-Panzar model predicts that absent risk aversion, any move away from the American rule will increase the costs in a contested case. Rowe, *supra* note 187, at 158 (citing Ronald Braeutigam, Bruce Owen, & John Panzar, *An Economic Analysis of Alternative Fee Shifting Systems*, LAW & CONTEMP. PROBS., Winter 1984, at 173, 180).

190. Hause, *supra* note 188, at 176.

191. Rowe, *supra* note 187, at 158.

These highly speculative and conflicting effects render an accurate prediction of the net effect of increased spending rather difficult.[192] The current prevailing opinion among law-and-economics scholars is that the English rule generally leads to higher settlement rates[193] because of the expected increase in trial expenditures and the parties' natural risk aversity.[194] This prediction has only a weak applicability to the Alaska scheme. Since partial indemnity, rather than full taxation of fees, is the standard practice in Alaska, it follows that the increase in trial expenditures will be less than under a pure English rule,[195] thereby reducing the settlement incentive. Consequently, no definitive conclusion can be drawn about the magnitude or direction of the settlement effect of the Alaska system, assuming risk neutrality.

Alaska attorneys also regularly employ contingency fee arrangements, which, to some extent, further complicate settlement incentives. Often, plaintiffs' attorneys will contract for one-third of the judgment, plus the attorney fee expenses obtained. Judge Kleinfeld, while still a practitioner, suggested that the broad support for Rule 82 among plaintiffs' attorneys indicates that they have interests different from those of their clients.[196] Kleinfeld maintained, in other words, that "attorneys on contingent fees almost always benefit economically from settlement rather than trial."[197] Kleinfeld's argument, however, applies to jurisdictions under the American rule as well. The only difference is that under their retainer agreements, Alaska attorneys may receive a small additional settlement bonus in the form of one-third of the schedule-based fee award for settled cases.

Economic modeling also supports the assertion that contingency fee arrangements do not alter the settlement incentive calculus. One commentator predicts the same result of increased settlements in two-way fee shifting in a contingency fee context, assuming that the parties bear the risk of indemnification, rather than their

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192. *Id.*

193. A recent empirical study in Florida, however, concluded that the settlement rate decreases under the English rule, despite the fact that more claims are initially dropped. *See* Snyder & Hughes, *supra* note 165, at 377. The authors attribute this increased preference for litigation vis-a-vis settlement to the theory that "optimistic litigants anticipate shifting their fees to their opponents." *Id.*

194. *See* Hause, *supra* note 188, at 176-77; Smith, *supra* note 186, at 2162.

195. Hause, *supra* note 188, at 177.

196. Kleinfeld, *supra* note 152, at 39.

197. *Id.*

attorneys.[198] This conclusion assumes that the client, not the attorney, bears the risk of paying the opposing party's attorney fees[199]—an assumption which coincides with the current practice in Alaska. Consequently, it is doubtful that the contingency fee arrangement has any greater impact on the settlement incentive in Alaska than it does in jurisdictions using the American rule.

Rule 68, the offer-of-settlement device, certainly affects the settlement process in the Alaska system. While the primary purpose of Rule 68 is to encourage the out-of-court resolution of cases, the offer device could, ironically, have the opposite effect when the parties agree about the odds of finding liability but disagree as to the proper amount of damages. Professor Thomas Rowe observes that such offer devices under an English system introduce a new element of disagreement between the parties; fee shifting becomes linked to the issue of damages rather than simply to the liability result.[200] Although it is uncertain whether Rule 68 increases the rate of settlement, it does provide an incentive to make realistic offers as early as possible in the litigation process, since the offeror may recover fees incurred after the date of the offer.[201] Moreover, the offer device should keep the parties honest in settlement negotiations by encouraging the defendant to estimate a reasonable offer that the plaintiff would have little chance of exceeding at trial, and by allowing the plaintiff to "hold out" for a settlement closer to his or her expected judgment.[202] Earlier and more reasonable settlements, therefore, may be Rule 68's primary contribution to the efficiency of the legal process.

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198. Smith, *supra* note 186, at 2186.

199. Strong arguments exist for placing the indemnification responsibility on the attorney. In addition to the deterrence rationale, *see supra* notes 168-173 and accompanying text, attorneys are able to diversify this risk over their pool of clients, while individual clients are typically one-time players in litigation who cannot bear the risk of indemnification adequately. *See* Note, *Fee Simple: A Proposal to Adopt a Two-way Fee Shift for Low-income Litigants*, 101 HARV. L. REV. 1231 (1988); Smith, *supra* note 186, at 2165.

In contrast, an added burden of attorney indemnification would exacerbate the already strong settlement incentive which attorneys have in contingency fee arrangements. *Id.* at 2166. Additionally, absolving the client of the responsibility for his or her decisions inverts the role of the attorney as an adviser who must ultimately abide by a client's decision to accept an offer of settlement. *Id.* at 2165 (citing MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.2(a) (1984)).

200. Rowe, *supra* note 187, at 167-68.

201. *Id.* at 169.

202. *Id.*

Since the combined effect of Rule 82 and Rule 68 on the rate of settlement is clouded by offsetting effects on both sides, the individual characteristics of the plaintiff and defendant assume overriding significance. In other words, the risk aversion and the marginal utility of wealth of the respective parties become crucial considerations.[203] By increasing the magnitude of parties' potential gains or losses, Rule 82, Rule 79 and Rule 68 combine to raise the stakes of litigation in Alaska. While "upping the ante" may make it easier for plaintiffs to retain attorneys in small cases, it may also "drive out the players whose resources do not allow them to stay at the table for a long enough time for the probabilities to work themselves out beyond a few bad hands."[204] Repeat players, such as large institutional defendants, are able to insulate themselves from loss by diversification, but individual plaintiffs are often one-time participants in the litigation process.[205] Consequently, plaintiffs, especially those of moderate means, are likely to be risk-averse. Fearing a harsh result,[206] risk-averse plaintiffs cannot prudently turn down defendants' offers, even if they are significantly less than the face value of the claim. Amended Rule 82 mitigates this result if the judge varies from the schedule or the fixed rate pursuant to one or more of the listed factors.[207] But if judges do in fact exercise their equitable powers in future cases, thereby causing risk-averse players to feel less compelled to settle, it is difficult to make any general prediction regarding the effect of Rules 82 and 68 on the rate of settlement.

VI. Conclusion

Although problems were evident, the pre-amendment form of Alaska Civil Rule 82 enjoyed strong attorney support. The amended version of the rule specifically addresses the rule's harsh effects on parties of limited means, but the new list of equitable factors adds an additional layer of complexity to a rule that already has been the source of numerous appeals.

To justify its considerable administrative expense, Rule 82 must prove its utility as a vehicle for accomplishing important

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203. *See id.* at 168.

204. Kleinfeld, *supra* note 56, at 52.

205. Rowe, *supra* note 187, at 142-43.

206. *See* Bozarth v. Atlantic Richfield Co., 833 P.2d 2 (Alaska 1992); see also *supra* text accompanying notes 62-64.

207. *See* ALASKA CIV. R. 82(b)(3).

policy objectives.[208] The rule's articulated purpose, partial indemnification of the prevailing party, is unconvincing. Moreover, there are more appropriate means for punishing bad faith litigants, and it is unclear whether any significant increase in settlement occurs, aside from that attributable to risk aversity. Although the rule may reduce the number of claims filed regardless of merit,[209] this result hardly justifies its existence.

The numerous exceptions and factors allowing for equitable variation now overshadow Rule 82's schedule-based simplicity, its most attractive aspect. As a result of attempts to retain some perceived benefits from fee shifting while simultaneously mitigating its harsh effects, the rule has evolved into such a prolix mechanism that it is no longer possible to theorize about its effects on the litigation process with any degree of accuracy. A thorough empirical study of the effects of amended Rule 82 should be conducted as soon as possible.[210] If the rule cannot be shown to achieve any useful purpose, it should either be abandoned or returned to a simpler form that explicitly states its purposes and justifies its policy tradeoffs.

Kevin Michael Kordziel

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208. "[I]t is true that a body of law is more rational and more civilized when every rule it contains is referred articulately and definitively to an end which it subserves, and when the grounds for desiring that end are stated or are ready to be stated in words." O.W. Holmes, Jr., *The Path of the Law,* 10 HARV. L. REV. 457, 469 (1897).

209. *See* Vargo, *supra* note 156, at 1635-36.

210. Apparently, the Alaska Judicial Council is scheduled to conduct just such a study. *See* Alaska Supreme Court Order No. 1118, at 6 n.1 (Jan. 7, 1993) (Rabinowitz, J., dissenting).

APPENDIX

EXCERPTS FROM THE CIVIL RULE 82 QUESTIONNAIRE[211]

(Responses received as of March 15, 1992)

1. Does Civil Rule 82 deter people of moderate means from filing valid claims?

	Yes		No		No Answer	
Plaintiffs' Attorney	69		127		9	
Defendants' Attorney	16		136		12	
Attorney for Both	36		108		14	
TOTAL	121	(23%)	371	(70%)	35	(7%)

2. Does Civil Rule 82 put excessive pressure on moderate income people to settle valid claims?

	Yes		No		No Answer	
Plaintiffs' Attorney	70		124		11	
Defendants' Attorney	21		133		10	
Attorney for Both	35		106		17	
TOTAL	126	(24%)	363	(69%)	38	(7%)

3. Is Civil Rule 82 needed in order to discourage frivolous litigation or do other factors, such as the litigant's own attorney's fees, litigation expenses, and the emotional stress of participating in a lawsuit, effectively discourage such cases?[212]

	Yes		No		No Answer	
Plaintiffs' Attorney	90		81		34	
Defendants' Attorney	90		57		17	
Attorney for Both	70		64		24	
TOTAL	250	(48%)	202	(38%)	75	(14%)

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211. The tabular data summarize the results of the "yes or no" questions from a survey of the Alaska Bar conducted by the Civil Rules Committee in March of 1992. The Alaska Bar Association includes approximately 3,000 members. Full questionnaire results are on file with the Alaska Judicial Council.

212. The numerical results of question three should be disregarded, since the question is written somewhat ambiguously. The high number of "no answer" responses seems to support this conclusion.

4. Should Civil Rule 82 be rescinded?

	Yes	No	No Answer
Plaintiffs' Attorney	32	169	4
Defendants' Attorney	29	132	3
Attorney for Both	26	120	12
TOTAL	87 (16%)	421 (80%)	19 (4%)

5. Should Civil Rule 82 be amended to allow the court to consider:

a. the non-prevailing party's ability to pay the prevailing party's attorney's fees?

	Yes	No	No Answer
Plaintiffs' Attorney	87	107	11
Defendants' Attorney	15	142	7
Attorney for Both	45	97	16
TOTAL	147 (28%)	346 (66%)	34 (6%)

b. the parties' relative ability to pay attorney's fees?

	Yes	No	No Answer
Plaintiffs' Attorney	79	106	20
Defendants' Attorney	13	143	8
Attorney for Both	37	105	16
TOTAL	129 (25%)	354 (67%)	44 (8%)

Getting sued is becoming one of life's inevitabilities.
But it's less inevitable in some states than in others.

If you gotta get sued, get sued in Utah

Received
FEB 0 1994

By David Frum and Frank Wolfe

Ranking the most litigious states

1. District of Columbia
2. Rhode Island
3. Massachusetts
4. New Mexico
5. Nevada
6. Delaware
7. Florida
8. New York
9. New Hampshire
10. Washington
11. New Jersey
12. Connecticut
13. California
14. Maryland
15. Illinois
16. Michigan
17. Pennsylvania
18. Texas
19. Louisiana
20. West Virginia
21. Maine
22. Georgia
23. Missouri
24. Hawaii
25. Vermont
26. Ohio
27. Alaska
28. Alabama
29. Kentucky
30. Arizona
31. Mississippi
32. Minnesota
33. Oklahoma
34. Virginia
35. North Carolina
36. Montana
37. Iowa
38. South Carolina
39. Wyoming
40. Wisconsin
41. Colorado
42. Tennessee
43. Oregon
44. Idaho
45. Nebraska
46. Arkansas
47. South Dakota
48. Kansas
49. North Dakota
50. Indiana
51. Utah

Washington, D.C. is the most litigious place in America; Utah, the least.

WHERE ARE YOU most likely to hear from a lawyer if you're involved in a car accident? If you're deciding where to set up a medical practice, in which state are you most likely to be sued for malpractice? Which state has the highest concentration of trial lawyers?

There's no central database that tells you how many lawsuits there are in most states or how much money plaintiffs are winning, so FORBES decided to take a bold stab at quantifying litigiousness state by state. As far as we are aware, it's the first time anyone has attempted to do anything remotely like this.

To rank the states, we developed five proxies for litigiousness: the percentage of automobile accidents where lawyers get involved; the average cost for one year's malpractice insurance for an orthopedic surgeon; the number of members of a state's trial lawyers association per 100,000 population; how much each state's chief justice spent to win his last election; and the amount the larg st city in each state paid in lawsuits ag inst it in the last fiscal year.

We then ranked the states and the District of Columbia from 1 to 51 in each of the categories. Then we averaged each state's five scores to arrive at a final ranking. When states for one reason or another did not have a score in one of the five categories, we divided their total score by four instead. Where states tied on their overall average, we broke the tie against the state with the lowest mark in any one category: Arizona and Mississippi, for example, had the same average, but since Arizona's worst score was 15 and Mississippi's was 22, we ranked Arizona as the more litigious.

Scientific? Probably not. Fair? We think so.

The lower a state's score, the worse the legal climate. By a big margin, the District of Columbia finished in first place, with Rhode Island, Massachusetts, New Mexico and Nevada rounding out the top five. Utah was a comparably secure last place finisher.

Other highlights:

■ The survey confirms that juries in the city of Detroit are probably the most irresponsible in America. Orthopedic surgeons in Michigan—which ranks number one in medical malpractice litigiousness—pay an average malpractice premium of $100,000 a year, more than eight times as much as the median state in our survey. In Detroit the premium is in excess of $150,000 a year. Premiums for high-risk specialties, like obstetrics, are even higher. Detroit juries are also the most generous in awarding plaintiffs cash when they sue the city—six times as generous as those of the median city, Phoenix.

In showing how much big cities pay to settle lawsuits, we rank by the amount paid per capita. Thus Detroit (pop. 1,028,000) finishes ahead of New York City (pop. 7,323,000).

■ States notorious for their punitive damage awards, such as Texas and Alabama, have the most expensive judicial elections. Texas Chief Justice Thomas R. Phillips, for example, recently spent more than $2 million on his reelection bid. In most cases, the largest source of campaign contributions is trial bar. Does the money influence verdicts? We don't know, but campaign donors must think so.

■ Three states with bad reputations for litigiousness—New York, California and Texas—ranked surprisingly low: New York in 8th place, California in 13th and Texas in 18th. In all three cases, scores improved for the same reason, the relatively small number of trial lawyers in state associations. Omit that number, and New York's average would fall below even the District of Columbia's.

■ Litigiousness can be predicted by geography. Six of the ten most litigious states are in the Northeast. Seven of the ten least litigious states are in the Rocky Mountains or Midwest.

■ Most car accidents are routine affairs that ought to be handled by mail and a phone call or two to your insurance adjuster. But not in Maryland, Massachusetts, New Jersey and the District of Columbia, where more than 60% end up in a lawyer's hands.

■ The cost of malpractice insurance gives a good idea of the cost of malpractice litigation. In some states these averages conceal fantastic local variation: While orthopedic surgeons in rural New York pay some $33,000 a year in malpractice premiums, surgeons in Long Island's Nassau and Suffolk counties must cough up more than $117,000 per year. One caveat: The terms of malpractice insurance contracts vary somewhat from state to state, but—in our view—not so much that they distort the chart.

It should be noted that the sums

Each state's final score is the average of its rank in each of the five categories: auto litigation, malpractice litigation, number of trial lawyers, amount spent by its top judge, and municipal litigation. The lower the rank, the more litigious the state.

here vastly *understate* what litigation actually costs municipal taxpayers. We omitted workers' compensation, even though comp costs are lawyer driven, because they are not reviewed by state courts. We omitted school board and transit system liability, too, because in many smaller cities, one school board and transit system stretch across the entire county.

The municipal liability numbers are also affected by local peculiarities. Seattle ranks high in part because its local electrical utility is municipally owned, making the city liable for its torts. Boise, Idaho ranks as low as it does in part because virtually all the city's roads are owned by the state government—making the state responsible for lawsuits arising from accidents upon them. Some normally litigious states, like Texas, rank rela-

Ranking the states

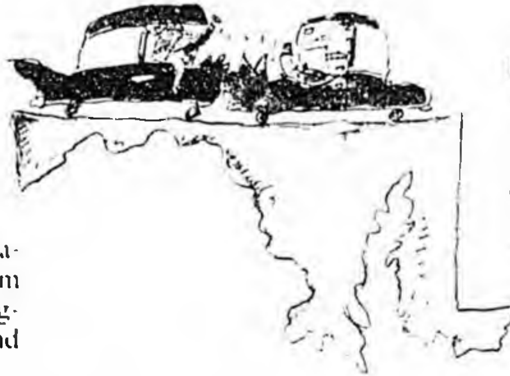
State	% of auto accidents where claimee is represented by an attorney[1]	Rank	Average malpratice premium for orthopedic surgeon	Rank	Members of state trial lawyers association per 100,000 population	Rank	Amount spent by state chief justice on most recent election or retention campaign	Rank	Amount paid by state's largest city to settle liability claims and judgments	Rank
Alabama	15.4%	49	$12,860	26	44.5	17	$670,687	3	$1,000,000	31
Alaska	23.3	39	45,203	5	36.4	29	less than 1,000	20	930,679	30
Arizona	39.4	19	22,307	15	16.4	51	0	23	4,973,713	25
Arkansas	26.7	36	5,388	49	42.5	18	23,852	15	151,644	43
California	58.9	5	35,218	7	16.8	50	less than 1,000	20	57,164,392	7
Colorado	21.9	42	10,943	31	41.4	20	0	23	1,433,005	33
Connecticut	46.9	12	14,729	22	66.9	5	appointed	—	482,024	32
Washington, DC	61.1	3	25,023	10	53.5	12	appointed	—	13,990,000	5
Delaware	53.3	6	14,079	23	65.8	6	appointed	—	417,820	21
Florida	45.3	14	73,788	2	26.3	41	375,983	5	3,500,000	12
Georgia	43.6	17	13,360	24	38.6	26	0	23	2,598,595	17
Hawaii	31.8	28	24,500	12	24.4	44	appointed	—	5,560,489	8
Idaho	27.8	33	10,624	33	38.2	28	852	18	50,656	47
Illinois	47.2	11	21,764	16	21.9	45	178,324	10	36,273,000	10
Indiana	19.9	45	4,350	51	20.0	49	0	23	1,897,313	37
Iowa	16.9	48	9,462	37	39.6	21	less than 250	22	1,311,990	15
Kansas	17.0	47	6,232	47	36.3	30	0	23	870,684	35
Kentucky	24.9	38	10,383	35	46.1	16	51,658	13	NA	—
Louisiana	51.2	7	7,937	42	47.4	15	540,933	4	1,500,000*	34
Maine	33.9	26	10,050	36	73.3	3	appointed	—	362,234*	20
Maryland	65.7	1	19,287	18	31.4	35	NA	—	4,539,115	18
Massachusetts	62.6	2	36,190	6	33.2	34	appointed	—	7,980,000	9
Michigan	22.8	40	108,762	1	21.5	47	250,015	8	32,524,465	1
Minnesota	31.8	29	7,537	44	38.8	24	38,065	14	1,902,399	24
Mississippi	37.9	22	12,952	25	38.9	23	0	23	298,045	40

[1]1987. *Current fiscal year. †Incurred. NA: Not available.

Sources: Insurance Research Council; St. Paul Fire & Marine; member companies of the Physician Insurers Association of America; Forbes.

tively low in this category because their state legislatures have adopted caps on municipal liability, which typically prevent juries from making awards in excess of $200,000 or $250,000 against a municipality.

There are many other local variations. Complications arising from these peculiarities prevented the figures from Columbia, S.C. and Charleston, W. Va. from being calculated in time to be used here.



One locality was suspiciously unwilling to help us. A secretive press aide in the Louisville, Ky. mayor's office refused to divulge that city's liability payouts unless told the contents of our story in advance. Either the Louisville mayor's office is terribly dumb or the aide was hiding something. ■

Ranking the states

State	% of auto accidents where claimee is represented by an attorney[1]	Rank	Average malpratice premium for orthopedic surgeon	Rank	Members of state trial lawyers association per 100,000 population	Rank	Amount spent by state chief justice on most recent election or retention campaign	Rank	Amount paid by state's largest city to settle liability claims and judgments	Rank
Missouri	34.1%	24	$23,395	13	28.3	38	0	23	$3,000,000	14
Montana	20.6	43	10,889	32	53.2	13	$209,304	9	38,685	46
Nebraska	18.6	46	4,359	50	38.6	25	0	23	2,282,741*	16
Nevada	38.4	20	28,739	9	79.0	2	350,198	6	1,092,980	29
New Hampshire	44.8	16	11,148	30	61.3	9	appointed	—	1,069,888	11
New Jersey	60.9	4	22,982	14	33.6	33	appointed	—	1,688,174	19
New Mexico	26.8	35	30,770	8	61.5	8	112,890	11	10,537,000	3
New York	45.1	15	65,451	3	25.0	43	appointed	—	219,000,000	2
North Carolina	32.5	27	7,320	45	57.3	10	65,550	12	310,478*	45
North Dakota	14.5	51	12,032	27	38.5	27	NA	—	93,205	41
Ohio	40.4	18	17,366	21	25.8	42	967,953	2	1,040,853	38
Oklahoma	33.9	25	18,299	19	34.2	32	0	23	1,194,000	36
Oregon	29.9	32	10,415	34	28.1	39	less than 500	21	1,912,864†	28
Pennsylvania	49.2	9	11,904	28	29.5	37	less than 250	22	37,000,000*	4
Rhode Island	49.3	8	46,045	4	54.8	11	appointed	—	898,000	23
South Carolina	48.8	10	6,497	46	34.4	31	appointed	—	NA	—
South Dakota	15.0	50	5,875	48	124.5	1	NA	—	99,044	42
Tennessee	27.0	34	8,057	41	30.7	36	12,054	16	2,169,639	27
Texas	34.6	23	24,868	11	26.5	40	2,646,389	1	7,530,331	26
Utah	20.0	44	7,597	43	21.7	46	NA	—	129,000	44
Vermont	31.0	30	8,564	38	49.4	14	appointed	—	309,888	13
Virginia	45.5	12	8,246	39	42.0	19	appointed	—	439,082	39
Washington	30.5	31	18,258	20	65.7	7	835	19	9,051,655	6
West Virginia	25.8	37	20,502	17	39.0	22	262,464	7	NA	—
Wisconsin	38.3	21	8,111	40	21.4	48	1,914	17	3,600,393	22
Wyoming	22.2	41	11,549	29	70.5	4	0	23	5,416	48

[1]1987 *Current fiscal year. †Incurred. NA: Not available.

Sources: Insurance Research Council, St. Paul Fire & Marine; member companies of the Physician Insurers Association of America; Forbes.

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February 11, 1994

Daniella Loper
Staff Counsel
Judiciary Committee
House of Representatives
State Capitol
Juneau, AK 99811

RE: HR 292

Dear Ms. Loper:

We are pleased to respond to your request for information regarding California medical malpractice reform legislation. California, like many other states, enacted tort reform legislation in the mid-70s in response to the medical malpractice insurance availability and affordability crisis. The California legislation known as the Medical Injury Compensation Reform Act of 1975 (MICRA) enacted the following tort reforms:

- Capped non-economic damages at $250,000.
- Required periodic payments on judgments over $50,000 at the request of either party.
- Established three-year statute of repose and minors statute requiring claims by children under six within three years or prior to eighth birthday.
- Permitted evidence of collateral source recovery and barred subrogation.
- Authorized health care providers to enter into contracts with patients for binding arbitration of medical malpractice actions.
- Established limits on attorney contingent fees.
- Required 90 days notice prior to commencement of a medical malpractice action.
- Immunity for medical peer review proceedings.

In addition, California law provided the following:

- Certificate of Merit to be filed with medical malpractice action.
- Joint and several liability abolished.
- Pure comparative fault system to establish liability among joint tort-feasors.
- Pleading hurdle for punitive damages.
- Confidentiality of medical peer review proceedings.

These provisions have been included in model medical tort reform legislation which are enclosed as Exhibit 1. Although these model provisions may form the basis for a comprehensive medical tort reform bill, modification of the definitions would probably be required to fit your statutory arrangement and expand coverage beyond medical providers.

A number of studies have been done regarding the relative cost of medical malpractice insurance and the impact of tort reform. Although we have been advised by actuaries that it is impossible to quantify precisely the impact of any particular tort reform, it is widely acknowledged that California's MICRA law has made medical malpractice insurance widely available and affordable in California as compared to other states that have not enacted tort reform. Enclosed as Exhibit 2 are a series of charts comparing medical malpractice experience in California, Ohio, New York and Alaska.

Chart 2-1 is a graph showing that California medical malpractice losses have trended downward since the enactment of MICRA in 1975. Chart 2-2 shows the California medical malpractice insurance data used to develop Chart 2-1. This chart demonstrates that over the 17-year period that MICRA has been in effect, medical malpractice costs have only increased 83% in California while US costs excluding California have increased by over 413%. Had California medical malpractice premiums increased at the same rate as the rest of the United States, California physicians and hospitals would have paid an additional $663 million during calendar year 1992 alone. Total savings to date exceed several billion dollars. Chart 2-3 demonstrates that California medical malpractice insurers have been able to keep losses under control and return surplus to policyholders as dividends while achieving an average ratio of expenditures to premium income of 101.2%. The industry benchmark is a ratio of 100% over the course of the normal claims payout period which depends on the statute of limitations and other factors affecting the resolution of claims.

The experience of other states also graphically demonstrates that tort reform helps control medical malpractice insurance costs. Several states such as Ohio enacted medical malpractice tort reforms similar to California and also saw a gradual reduction in malpractice costs compared to the rest of the United States. However, in 1982, Ohio's medical malpractice tort reforms were substantially weakened and its costs have risen dramatically as shown on the enclosed Chart 2-4.

Some states such as New York have not enacted medical tort reforms and their physicians and hospitals have suffered severe increases in the cost of medical malpractice insurance resulting from swings in the severity and frequency of losses as shown on Chart 2-5.

Chart 2-6 indicates that Alaska experience appears to be similar to New York with wild swings in losses driving medical malpractice premiums up from $781,000 in 1976 to $13,439,000 in 1992. This is a 1,620% total increase in the cost of medical malpractice costs in Alaska over 17 years or an average of 26% per year, more than twice the national annual average increase of 11.3% as shown on Chart 2-7 and more than five times the average annual increase in California for the same period.

It should be noted that these state-by-state changes in medical malpractice costs translate into different premium costs for individual physicians and hospitals depending on where they practice. Chart 2-8 presents a comparison of premium costs for seven medical specialties in California to other states which clearly demonstrates that MICRA has kept California premiums significantly lower. California physicians not only pay less than their colleagues in other states, but they have seen a drop in their premiums when adjusted for the cost of living. Chart 2-9 shows that the average California physician pays 60% less today than before MICRA. These savings are passed along to patients and keep health care costs lower as demonstrated by Chart 2-10 which compares health care costs in California and New York.

Members of the House Judiciary Committee may want to carefully read the article titled, "California's Medical Malpractice Crisis" which was first published in 1975 by the National Conference of State Legislatures and Georgetown University's Health Policy Center as part of a report entitled A Legislator's Guide to the Medical Malpractice Issue which is attached as Exhibit 3. Barry Keene, legislative author of MICRA, tells the story from the California Legislature's perspective and recounts the difficulties of enacting tort reform in the face of intense pressure from the contingency fee trial attorneys.

California's medical tort reforms have worked in spite of strong pressure from the trial bar to overturn them in the Courts or Legislature. Enclosed as Exhibit 4 is an article appearing in the California Physician, June 1991, titled, "A MICRA Retrospective," that gives a retrospective of MICRA over the past decade and a half. As the article demonstrates, real savings did not occur for many years until the California Supreme Court upheld MICRA in 1985. Because trial courts refused to apply MICRA before the Supreme Court ruled on the constitutionality of MICRA, insurers were unable to report savings from tort reform and malpractice insurance increased in cost during the early 1980s. The MICRA debate was finally put to rest in 1987 when the California Legislature refused to repeal or weaken MICRA. Since that time, California trial courts have recognized MICRA and policyholders have received substantial "MICRA" dividends amounting to several hundred million dollars. These MICRA dividends were paid by California's physician-owned insurers from loss reserve savings in the late 1980s. During

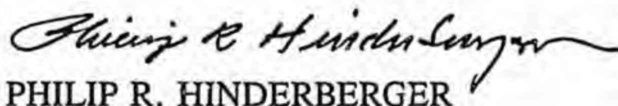
the 1990s, California policyholders have had almost no rate increases and continue to receive substantial MICRA dividends.

Medical tort reform has been recognized as a key component of health care reform in all but one of the major health care bills introduced in Congress. Experts familiar with health care costs believe that physicians have been compelled to undertake expensive diagnostic and treatment procedures in order to avoid the risk of unwarranted medical malpractice actions. Commentators call these practices "defensive medicine" and calculate the cost in billions of dollars annually. Exhibit 5 is a report by the respected health care consulting firm of Lewin-VHI that estimates medical tort reform may result in savings as high as $4.3 billion per year. All of the managed care proposals before Congress including the Clinton Administration bill, contain medical tort reform provisions. The Coalition for Effective National Medical Liability Reform advocates California's MICRA reform as the blueprint for effective tort reform. Its pamphlet entitled, Without True Medical Liability Reform, Health System Reform Is Just a Mirage, is attached as Exhibit 6.

Also enclosed are copies of the MICRA Information Manual dated January 1, 1993 prepared by the Californians Allied for Patient Protection, a coalition of health care and other organizations dedicated to the preservation of MICRA. These materials provide a convincing argument for medical tort reform and the benefits that will be provided to Alaska citizens by a stable marketplace for medical malpractice insurance.

In conclusion, if the Alaska Legislature enacts a comprehensive package of tort reforms along the lines of California's MICRA, the rate of increase in the cost of medical malpractice insurance should over time be brought in line with other states that have enacted similar tort reform. Tort reform should also help eliminate the wild swings in the severity and frequency of losses which will foster a stable marketplace for medical malpractice insurance in Alaska.

Very truly yours,



PHILIP R. HINDERBERGER

PRH/rl

Enclosures

bc: James A. Affleck, M.D., NORCAL Mutual Insurance Company
Brad Cohn, M.D., Medical Insurance Exchange of California
Martin Hatlie, Health Care Liability Alliance
Roger Holmes, Biss & Holmes
Harlan Knudson, Alaska Hospital Association
Jay Michael, Californians Allied for Patient Protection
J. William Newton, NORCAL Mutual Insurance Company
Ray Schalow, Alaska State Medical Association
Art Stanford, NORCAL Mutual Insurance Company
Al Tamagni, Alaskans for Liability Reform
David E. Willett, Hassard, Bonnington, Rogers & Huber
James O. Wood, Tillinghast

COMPARISON OF MEDICAL MALPRACTICE COSTS

IN

CALIFORNIA, OHIO, NEW YORK AND ALASKA

1976 - 1992

EXHIBIT 2

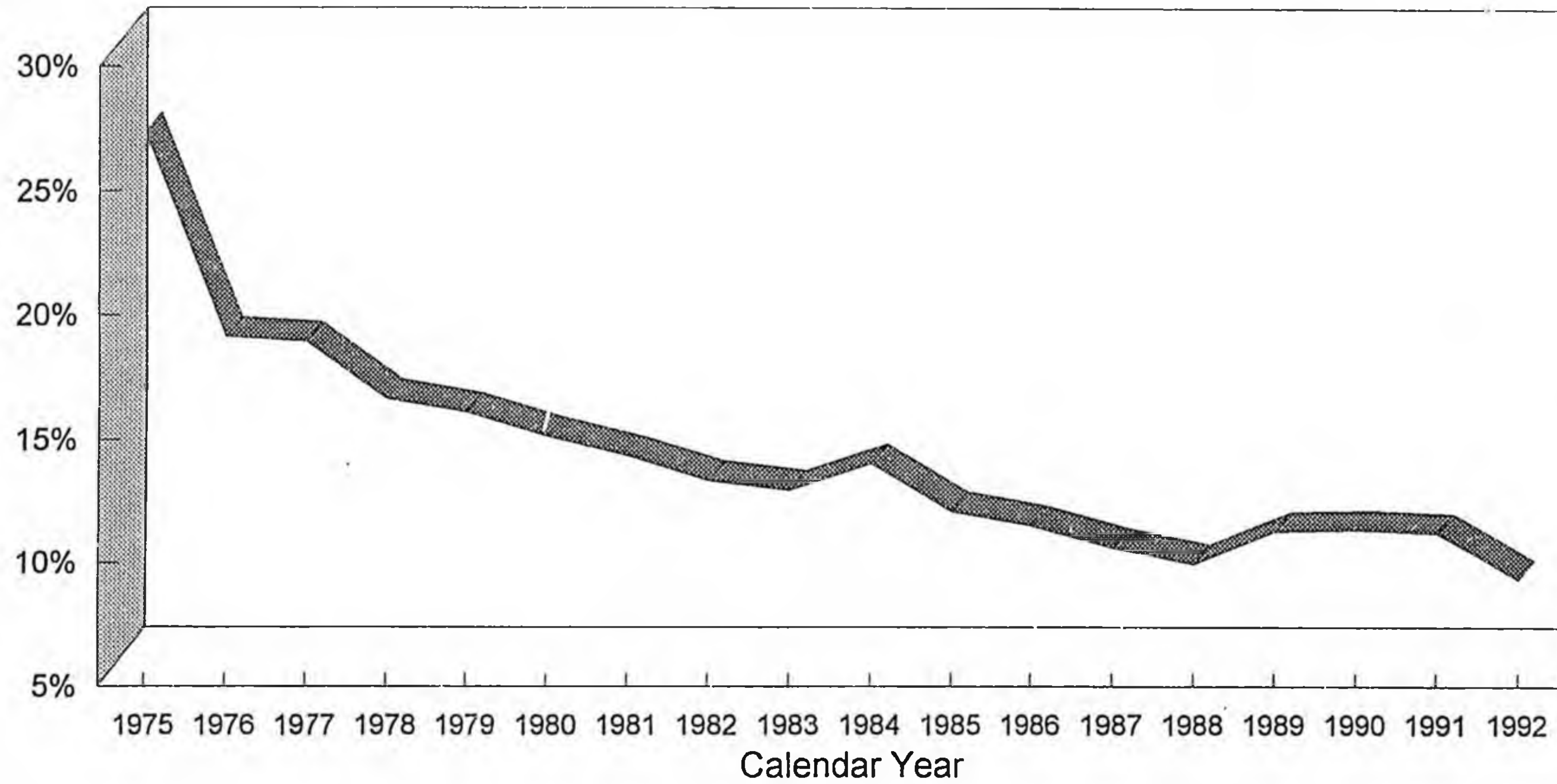


Chart 2-1

California Medical Malpractice Insurance Costs Compared to U.S. Since MICRA - 1976-1992

Year	CA Premium Earned (Millions)	% Change	U.S. Premium Earned (Millions)	% Change	% CA of U.S.Prem.
1976	$288		$1,187		24%
1977	227	-21.2	1,266	+6.7	18%
1978	249	+9.7	1,382	+9.2	18%
1979	239	-4.0	1,235	-10.6	19%
1980	230	-3.8	1,333	+7.9	17%
1981	204	-11.3	1,232	-7.6	17%
1982	211	+3.4	1,361	+10.5	16%
1983	287	+36	1,844	+35.5	16%
1984	375	+30.7	1,835	-0.5	20%
1985	450	+20	2,261	+23.2	20%
1986	629	+39.8	3,435	+51.9	18%
1987	633	+0.6	4,450	+29.5	14%
1988	663	+4.7	5,080	+14.2	13%
1989	633	-4.5	5,120	+0.8	12%
1990	605	-4.4	4,931	-3.7	12%
1991	529	-12.6	4,862	-1.4	11%
1992	526	-0.6	5,138	+5.7	10%

National Association of Insurance Commissioners' Report on Profitability by Line and by State 1976-1992. This report is based on information obtained from insurance company Annual Statements.

Conclusions:

- California medical malpractice premiums have increased from $288 million to $526 million for a total increase of $238 million or 83%.
- U.S. medical malpratice premiums including California have increased from $1,187 billion to $5,138 billion for a total of $3,951 billion or 333%.
- Excluding California, U.S. premiums increased from $899 million to $4,612 million for a total of $3,713 million or 413%.
- Had California premiums grown at the U.S. rate of 413%, California premiums would have increased to $1,189 billion or $663 million above actual 1992 medical malpractice premiums. Therefore, California's Medical Injury Compensation Reform Act (MICRA) saved over $663 million in 1992 alone and several billion dollars since 1975. MICRA has kept the California medical malpractice insurance cost increase an average of 4.9% per year, well below the national average of 11.3% per year.
- MICRA has reduced California's share of US medical malpractice premiums from 23% in 1976 to 10% in 1992.

California Medical Malpractice Insurance
Underwriting Profit and Loss
Since Enactment of MICRA - 1976-1992

Year	CA Premium Earned (Mil)	L.I.	L.A.E.	G.E.	S.E.	T.L.F.	DIV	Annual U.P/L	Cum U.P/L
1976	$288	61.9	35.0	1.7	11.6	-2.8	0.0	-5.3	-5.3
1977	227	38.9	26.5	3.2	6.8	2.3	0.2	+25.7	+20.4
1978	249	41.3	23.4	4.1	10.2	2.4	2.2	+20.0	+40.4
1979	239	42.1	21.2	3.8	8.4	2.5	2.0	+22.9	+63.3
1980	230	44.3	19.9	3.5	8.4	2.6	2.1	+22.7	+86.0
1981	204	61.6	19.9	5.4	9.9	3.2	2.3	-2.5	+83.5
1982	211	81.8	27.6	6.4	10.1	4.0	5.9	-35.9	+47.6
1983	287	70.5	28.7	6.7	10.2	3.1	4.0	-23.6	+24.0
1984	375	92.7	26.7	5.8	10.9	2.7	4.7	-43.4	-19.4
1985	450	80.8	28.7	4.6	10.3	2.8	3.9	-31.1	-50.5
1986	629	68.2	21.9	3.7	9.1	2.6	2.9	-8.5	-59.0
1987	633	63.0	23.6	3.8	10.3	2.6	3.9	-7.2	-66.2
1988	663	52.4	28.6	4.4	9.6	2.8	2.7	-0.6	-66.8
1989	633	39.4	22.1	5.4	9.5	3.1	6.3	+14.2	-52.6
1990	605	35.6	24.5	6.6	7.8	3.0	9.2	+13.3	-39.3
1991	529	9.0	5.6	8.5	8.4	2.8	15.9	+49.8	+10.5
1992	526	39.8	41.1	7.9	8.1	2.0	16.2	-15.0	-4.5
17 Year Average Underwriting Profit or Loss									
Total		923.3	425.0	85.5	159.6	41.7	84.4		
÷17		54.3	25.0	5.0	9.4	2.5	5.0	101.2%	

National Association of Insurance Commissioners' Report on Profitability by Line and By State - 1976-1992. This Report is based on calendar year information obtained from insurance company Annual Statements.

Premiums - California medical malpractice direct premiums earned.
L.I. - Losses Incurred includes losses paid and reserved in current year and change in reserves in prior years.
L.A.E. - Loss Adjustment Expenses includes legal fees paid and reserved in current year and change in reserves in prior years.
G.E. - General Expenses includes all current year salaries, employees benefits, rent, etc.
S.E. - Selling Expenses primarily commissions paid to agents and brokers.
T.L.F. - Taxes. Licenses and Fees - paid to insurance departments. Does not include federal income tax.
DIV - Dividends - includes policyholder cash dividends and premium credits.
U.P/L - Underwriting Profit or Loss - the sum total of L.I.; L.A.E.; G.E., S.E., T.L.F.; DIV.
Cum U.P/L - Cumlative Underwriting Profit or Loss since 1975.

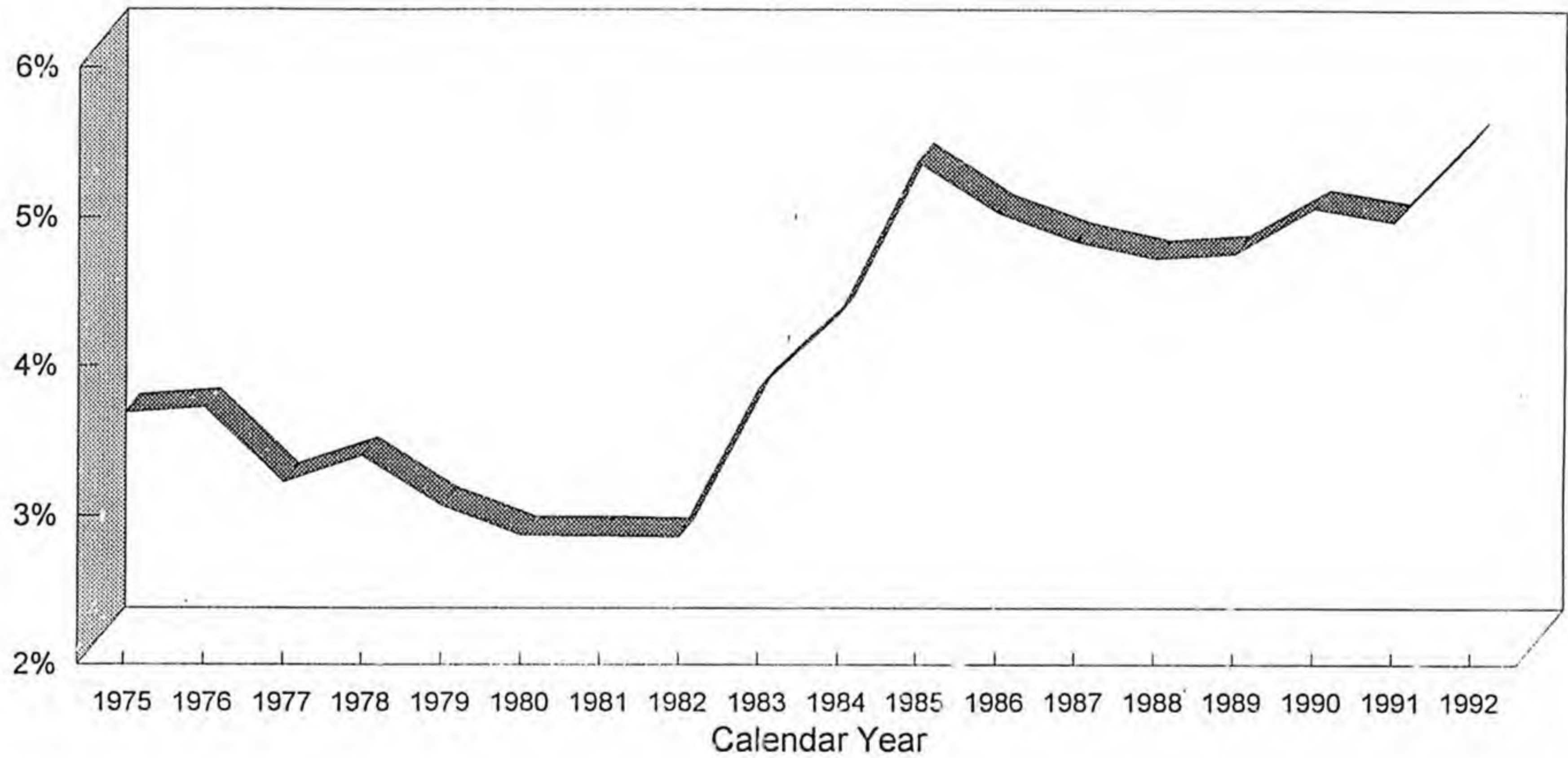


Chart 2-4

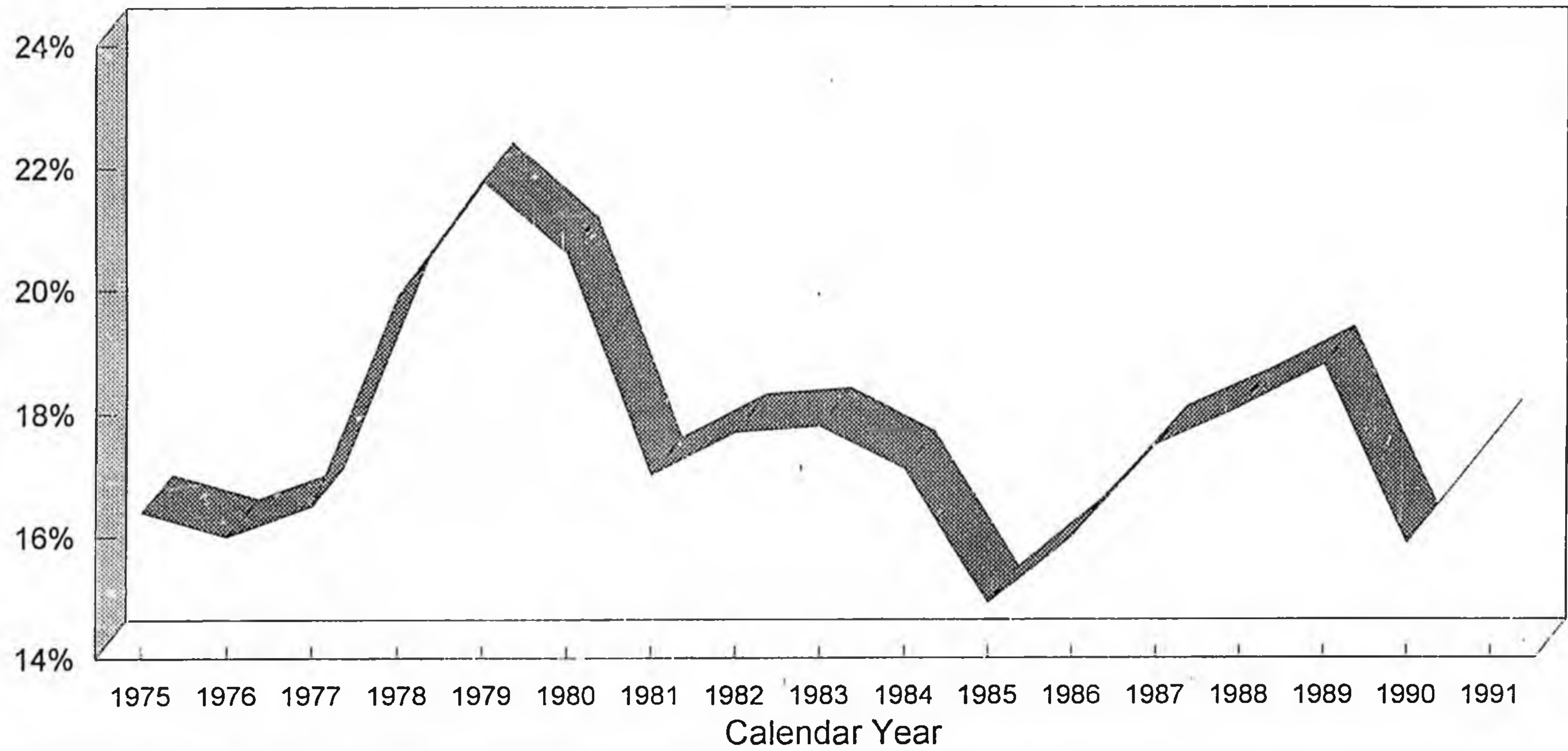


Chart 2-5

Chart 2-6

Alaska Ratio of Paid Loss and LAE to Countrywide

(This chart will be provided)

Alaska Medical Malpractice Insurance Costs

Compared to U.S. and California

1976 - 1992

Year	AK Premium Earned (Thous.)	% Change	U.S. Premium Earned (Millions)	% Change	CA Premium Earned (Millions)	% Change
1976	$781		$1,187		$288	
1977	655	-16	1,266	+6.7	227	-21.2
1978	Not available		1,382	+9.2	249	+9.7
1979	2,233	+240.9	1,235	-10.6	239	-4.0
1980	1,798	-19.5	1,333	+7.9	230	-3.8
1981	2,125	+18.2	1,232	-7.6	204	-11.3
1982	2,276	+7.1	1,361	+10.5	211	+3.4
1983	2,609	+14.6	1,844	+35.5	287	+36.0
1984	3,483	+33.5	1,835	-.50	375	+30.7
1985	4,403	+26.4	2,261	+23.2	450	+20.0
1986	8,480	+92.6	3,435	+51.9	629	+39.8
1986	13,639	+60.8	4,450	+29.5	633	+0.6
1988	15,109	+10.8	5,080	+14.2	663	+4.7
1989	16,341	+8.2	5,120	+.80	633	-4.5
1990	14,983	-8.3	4,931	-3.7	605	-4.4
1991	13,371	-10.8	4,862	-1.4	529	-12.6
1992	13,439	+0.5	5,138	+5.7	526	-0.6

National Association of Insurance Commissioners' Report on Profitability by Line and by State 1976-1992. This report is based on information obtained from insurance company Annual Statements.

Conclusions:

- Alaska medical malpractice premiums have increased from $781,000 to $13,439,000 for a total increase of $12,658,000 or 1,620% overall at an average annual rate of 29%.
- U.S. medical malpractice premiums including Alaska have increased from $1,187 billion to $5,138 billion for a total of $3,951 billion or 333% overall at an average annual increase of 11.3%.
- California medical malpractice premiums have increased from $288 million to $526 million for a total increase of $238 million or 83% overall at an annual average increase of 4.9%.

MEDICAL LIABILITY INSURANCE COSTS

National Medical Liability Reform Coalition

1700 K Street, NW, Suite 906
Washington, DC 20006
Telephone (202) 296-7686
Fax (202) 466-4346

	Arizona Eff. April 1, 1991 Entire State	California Eff. January 1, 1991 L.A. area (4 counties)	Florida Eff. January 1, 1991 Miami area (2 counties)	Illinois Eff. July 1, 1991 Chicago area (9 counties)	Michigan Eff. July 1, 1991 Detroit area (3 counties)	New York Eff. July 1, 1991 Long Island area (2 counties)	Texas Eff. January 1, 1991 Houston area (5 counties)
Anesthesia	$32,000	$12,300	$48,200	$23,000	$47,500	$34,500	$29,000
Cardiovascular surgery	$22,400	$38,000	$110,900	$49,200	$71,300	$65,100	$46,600
Family practice/ Minor surgery, no Ob	$15,400	$8,400	$32,600	$9,900	$34,800	$13,200	$23,200
Family practice/ Major surgery, w/Ob	$29,300	$18,700	$149,500	$20,200	$71,300	$23,400	$32,700
Neurosurgery	$73,900	$51,400	$183,300	$69,700	$154,500	$118,100	$47,900
Obstetrics/ Gynecology	$52,900	$38,000	$149,500	$49,200	$133,900	$101,200	$55,900
Orthopedic surgery	$36,300	$32,300	$110,900	$61,300	$133,900	$89,600	$49,300

1. These costs reflect a typical mature claims made policy of $1 million/$3 million.

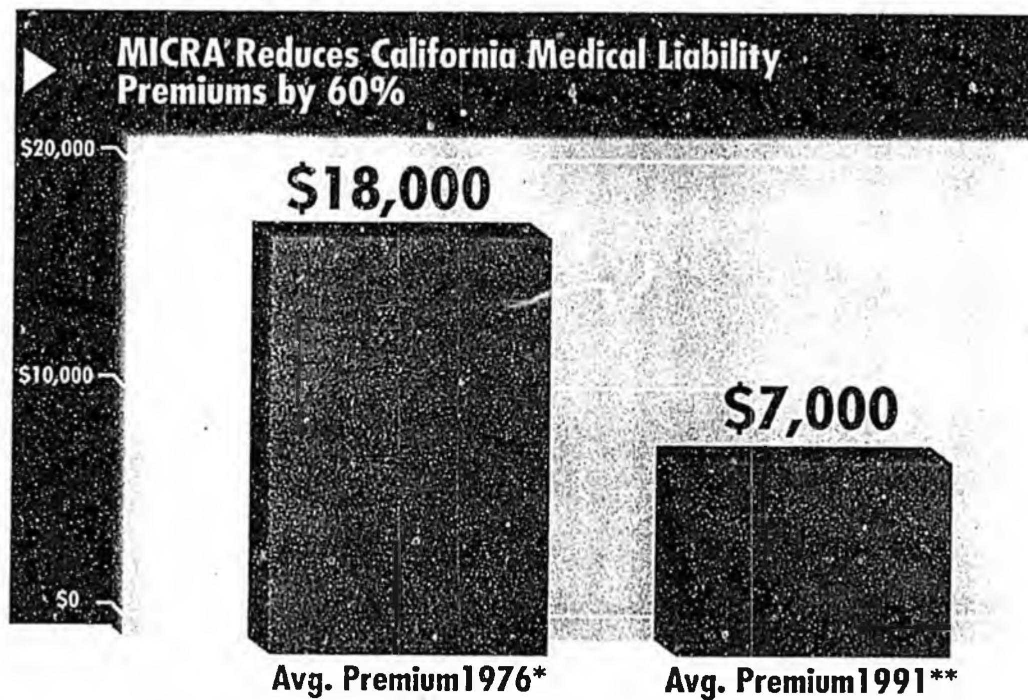
2. Please note: These figures are approximates (rounding to the nearest $100) due to restrictions from the industry.

The National Medical Liability Reform Coalition is a broad-based group of organizations gathered for the purpose of promoting medical liability reform as a key element of health care reform.

Insurance Premiums Cut

MICRA Has Cut Medical Liability Insurance Premiums by 60%

Before MICRA took full effect, California physicians paid an average $18,000 for liability insurance in 1976. By 1991, MICRA had reduced the average liability premium to $7,000 — **a 60% savings.**



— Shown in 1991 dollars

* $7,241 average premium adjusted to 1991 dollars on the December Urban CPI Index

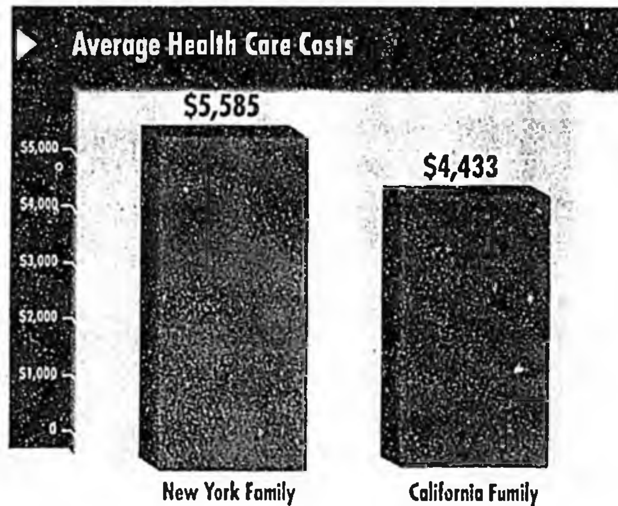
** Dividends from 1990 deducted from 1991 average premium

SOURCE: Physicians Insurance Association of America

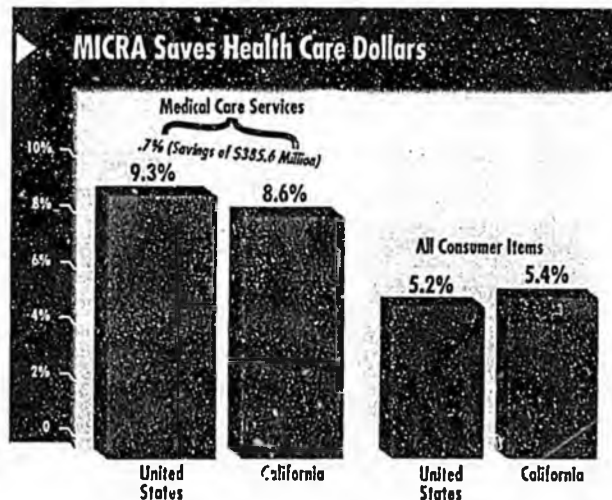
After MICRA: Real Results

MICRA Helps Control Medical Costs in California — Without MICRA, Medical Costs Would Be Even Higher

By controlling the cost of liability insurance, MICRA has slowed the increase of health care costs in California. As illustrated in the first chart, a recent consumer study by "Families USA" shows that health care costs for the average New York family in 1991 were $5,585 — compared to $4,433 for the average California family.



Further, as seen in the second chart, although consumer costs in California generally were higher than the national average in 1991, the state's medical care services index was lower. In 1991, California's medical costs increased less than medical costs for the nation as a whole, saving Californians $385.6 million.



SOURCE:
1. Families USA
2. Source: Consumer Price Index for All Urban Consumers (CPI-U), 1989-1990, based on an average from the Los Angeles and San Francisco Bay Area indexes.

CALIFORNIA'S MEDICAL MALPRACTICE CRISIS

By: Assemblyman Barry Keene, Chairman
Health Committee, California Assembly

EXHIBIT 3

California's Medical Malpractice Crisis

This article was first published in 1975 by the National Conference of State Legislatures and Georgetown University's Health Policy Center as part of a report entitled "A Legislator's Guide to the Medical Malpractice Issue."

California's Medical Malpractice Crisis

by Assemblyman Barry Keene, Chairman, Health Committee, California Assembly

The Insurance Crisis

California's medical malpractice insurance market has been critically ill for many years. Until 1975, however, it remained only partially diagnosed and completely untreated. By May 1975, its symptoms had accumulated to the point that its disease threatened the public health of California.

Wide public attention was first focused on this crisis on January 1, 1975, when the Pacific Indemnity and Star Insurance Companies notified 2,000 Southern California physicians that their insurance coverage would not be renewed. In addition, Argonaut Insurance increased its premiums 380% for 4,000 doctors in Northern California. These actions by the insurance companies were based upon their determination that the market had become too risky and unstable for financially sound underwriting of medical malpractice insurance.

Statistics supported the companies' contention. In determining rates, insurance carriers must have a reasonable estimate of the potential number and size of outstanding claims. In Northern California the number of claims had increased from 11.8 per 100 physicians in 1968 to 21 per 100 physicians in 1972 and 25 per 100 physicians in 1974. In Southern California the number of claims had increased from 13.5 per 100 physicians in 1968 to 16.5 per 100 physicians in 1972 and 26 per 100 physicians in 1974. This represented an increase of almost 200% in claims frequency. The dollar amounts awarded in judgments or settlements had also increased dramatically. The number of awards exceeding $300,000 had been 3 in 1969, 5 in 1970, 9 in 1971, 13 in 1972, 23 in 1973, and reached 34 in 1974. This was an increase of over 1,100%. The combined effect of these two factors was an increase on the average closing cost of a claim from $4,500 in 1969 to over $5,000 in 1974.

An analysis by Western Insurance Information Service indicated that insurance carriers in California writing medical malpractice insurance over a five-year period ending December 31, 1972, experienced an ultimate claim payoff in excess of $150 for each $100 collected in

premiums. Adding insurance carriers' operating expenses and their sales costs increased the ratio to about $180 paid out for each $100 of collected premiums.

Wesley Kinder, California Insurance Commissioner, has stated his belief that premiums charged to physicians in California have been continuously inadequate since 1957. For example, Argonaut Insurance entered the medical malpractice market in 1974, received $8 million in malpractice premiums and paid out $250,000 in claims during its first year of operation. An actuarial "rule of thumb," however, holds that first-year malpractice claims should be only 1% of premium income. It was Kinder's contention, therefore, that Argonaut's malpractice insurance premium rate should h ve been 3 times greater to assure adequate reserves for future claims. This premium rate inadequacy recently led the Insurance Commissioner to limit the future insurance underwriting authority of one significant insurance carrier in California. The carrier was prohibited from renewing any insurance policies until its reserves become sufficient to assure the continued ability to meet claim obligations.

The traditional litany of causes of the crisis has been well publicized. It includes: 1) the changing doctor-patient relationship, 2) the legal rights explosion, 3) the impact of the media, and 4) the increased proficiency of trial lawyers. However, of greater importance is the development of a "no-fault" mentality in society at large and the belief that insurance companies have an unlimited source of funds.

Evidence of changes in "societal attitude" can be seen in the difference between jury awards prior to the publication of the malpractice crisis and their actions subsequent to it. Since the great public outcry concerning the malpractice crisis, jury awards in Los Angeles County have been significantly smaller than in previous years, and there have been significantly more jury awards in favor of the defense. This change can only be attributable to public awareness of the impact of large jury awards upon insurance costs and medical costs in general. In addition, California has witnessed an expansion of legal doctrines that have widened the scope of medical malpractice and have thereby added to the unpredictability of the malpractice insurance marketplace. The three most important shifts in legal doctrines have been: 1) The abolition of the locality rule. In *Gist v French Hospital* 136 Cal. App. 2d 247, 288 P. 2d 1003 (C.A. 2d. 1955) the court threw out the common law locality rule and replaced it with a nationwide standard of practice. This change enabled injured plaintiffs to obtain and use expert witnesses who do not reside in the immediate community. 2) Expansion of *res ipsa loquitur*. In *Clarke v Gibbons* 66 Cal. 2d 399, 58 Cal. Rptr. 125, 426 P. 2d 525 (1967) the court permitted the jury to draw an inference of negligence when the circumstantial evidence was such that it indicates a probability of neg'igence. This lifted much of the burden of proof from the plaintiff, and it had particular impact in cases concerning surgical procedures. 3) Expansion of informed consent. In *Cobbs v Grants* 8 Cal. 3d 229. 104 Cal. Rptr. 505, 502 p. 2d 1 (1972) the court determined that informed consent should be based on the information needs of a reasonable person, not those of an expert.

Another cause of instability in the medical malpractice insurance market is the relatively small number of insureds who bear the initial cost responsibility for the entire patient population. There are at present approximately 46,000 licensed physicians in California, of which approximately 27,000 carry independent medical malpractice insurance. The remaining physicians are self-insured, working for a

governmental entity, or in an institutional setting. The risk of loss is distributed only among these 27,000 physicians. Therefore, significant changes in the number of claims or the dollar amount has a drastic impact on premium rates for this small group. Consumer "pass-on" of costs is largely limited to patients whose health care is not government-financed. For comparison purposes, the automobile insurance marketplace is 48 times larger than the medical malpractice insurance pool of insureds.

In California, the principle market for medical malpractice insurance is provided by the efforts of county medical societies to organize group programs. The majority of California physicians are covered under the two principal groups, Nor-Cal (Northern California Physicians) and So-Cal (Southern California Physicians). Similarly, the California Hospital Association has a group insurance program for affiliated hospitals.

The financial clout provided by this group arrangement introduces an element of serious bargaining into the process of arriving at premiums and terms of coverage. Until recently, insurance carriers were willing to engage in this bargaining process because of the benefits of offering medical malpractice insurance. The insurance carriers received a tremendous initial dollar flow with incurred losses not expected for a number of years. The investment potential of such favorable cash flow was substantial.

However, competitive bargaining on insurance underwriting has resulted in a pattern of instability. For instance, in 1970 the Southern California Physicians switched from the Nettleship Company to Hartford, and in 1974 from Hartford to Travelers. This switch was due to the fact that Nettleship requested a substantial increase in medical malpractice insurance rates. Hartford and Travelers were willing to enter the market without any rate increase in the belief that the investment potential to the premium dollar would exceed any loss incurred. (Presently, Travelers is requesting a 350% increase in premiums.) This frequent change in carriers has made the development of critical statistics difficult if not impossible. This factor, coupled with California's McBride-Grunsky Open Rating Act (which governs insurance carriers in California and simply requires post-premium rate review at the option of the State Insurance Commissioner), made early detection and understanding of the crisis impossible.

The Political Crisis

Suggested solutions to the medical malpractice insurance crisis are highly dependent upon whom is defining the problem. The legal societies in California, including the California Trial Lawyers' Association and the State Bar, have been very adamant in their position that the cause of the current crisis has been the unrestricted investment policies of insurance companies accompanied by rampant medical malpractice by physicians. The collapse of the stock market was therefore put forward as the catalyst for the carriers' financial woes. However, a detailed analysis by the Department of Insurance and the Auditor General failed to substantiate the assertion. These studies indicated that insurance companies were incurring a $1.50 loss for each premium dollar collected between 1967 and 1972, which was a relatively healthy investment period for the American economy. Further, on the argument that the cause of medical malpractice is malpractice itself, evidence is also very murky. A study commissioned by Johnson and Higgins, an insurance brokerage firm in California, indicated that more multiple suits were brought

against board-certified physicians (presumably the best-educated or most qualified) than non-board certified physicians.

The medical community has asserted that the main causes of the malpractice insurance crisis were the unscrupulous activities of trial lawyers and their high contingency fees. The facts belie this claim. Although in recent years California has experienced a veritable explosion in legal rights, as more and more citizens turn to the courts for social redress, other civil actions in California increased at a rate exceeding the rise of malpractice suits for the same period.

The insurance industry has remained relatively silent, perhaps believing that the legislative process is incapable of resolving this dilemma or, in the case of some companies, out of a desire to leave the marketplace entirely, in which case silence is strategically the best posture.

Legislatively, the first response to the rising cost of medical malpractice insurance occurred in the fall of 1972, when the Assembly established the Select Committee on Medical Malpractice. It was the duty and function of the committee to look into the causes of medical malpractice and propose solutions. (Select committees are investigative committees and have no authority to hear or vote upon bills. They provide guidance and information for the standing policy committees.)

The Select Committee acted as a focal point for public attention on the malpractice issue for the first 3 years of its existence. It held public hearings on this issue, but it developed a somewhat narrow perspective and did not perceive the magnitude of the crisis California was about to experience.

In January 1975, with this magnitude painfully evident, the leadership of the Assembly (the Speaker, the Majority Leader and appropriate chairmen) met to discuss the crisis and possible legislative solutions. At this time responsibilities were delegated to the various committees depending upon their area of expertise.

Responsibility for a short-range solution to the question of access to insurance was delegated to the Finance Insurance and Commerce Committee. The approach eventually agreed upon was the establishment of a Joint Underwriting Association. Under this mechanism, should there be a finding by the Insurance Commissioner that insurance is unavailable, all liability insurance carriers in the state would be required to participate in a Joint Underwriting Association. The JUA would be a separate state entity required to guarantee insurance to doctors at actuarially sound rates.

It was recognized, however, that the cost question cannot be resolved through a JUA. The responsibility for long-range planning to deal with this basic issue was delegated to the Assembly Health Committee. Up to this point, the problem had seemed relatively uncomplicated. In February, 1975, extensive hearings were conducted by the Select Committee on Medical Malpractice, but the nature and extent of the crisis remained obscure and individuals discussed political palliatives rather than substantial solutions.

In January, Argonaut shocked Northern California doctors with its proposed 350% increase in malpractice rates.

By April, the first true political alarms began to sound. California's physicians were considering a walkout in earnest.

On May 1, despite the fact that a JUA bill was on its way to the Governor, physicians in Northern California went on strike. Medical care came to a virtual halt. Doctors, believing that they could not absorb enormous increases in malpractice rates, much less pass them on to their patients, refused to practice. Day and night press attention was directed to the crisis. The first wave of public sympathy was clearly for the doctors. Physician crisis committees were formed in counties throughout the state, as doctors moved to organize their membership into a strong political lobbying force. The political atmosphere electrified.

After two weeks of the strike, word spread among the physicians that the legislature was in fact considering a more comprehensive approach than the JUA bill. Public support for the strike lessened noticeably. The medical community successfully directed its efforts toward a special session of the legislature to deal with the crisis; and ended the strike. Not the least important factor was the general announcement that the Assembly Health Committee, with the cooperation of medical and hospital representatives, was at work on the long-range bill that was to become Assembly Bill 1.

Toward A Solution

The initial research into the medical malpractice crisis commenced in January of 1975. At that time all current literature was examined and requests were made to various interest groups for more substantial information. Som. of the most important foundational information came from the Department of Insurance, which analyzed the costs associated with the litigation of malpractice cases. The department was able to break down the premium dollar into component parts for premium years 1962 through 1972. Results were that at least 46% of the malpractice dollar was consumed by litigation-related costs, 20% was by administrative costs (including premium taxes, brokerage fees, employee salaries, and other costs associated with running a business), and only 34%, at most, of the premium dollar was received by the plaintiff as direct compensation for injuries suffered. This was extremely alarming in light of other insurance benefit structures. By comparison, California law requires 67-1/2% of the premium dollar for workmen's compensation to be returned to workers in the form of compensation for injuries suffered. The inescapable conclusion was that the existing system for resolving medical injury disputes, costly as it was, did not even protect the injured victim.

Our first concern was to review the process of litigating malpractice disputes to determine why 46% of the premium dollar was associated with legal expenses. We concluded that a malpractice case is extremely difficult to prove, demands a great deal of research into causal factors and exhausts a tremendous amount of time on the part of the attorney. Part of the difficulty is that inherent risks are associated with medical treatment. Therefore, it has become the burden of the plaintiff's attorney to distinguish injuries

attributable to physician's negligence from injuries that are within the normal statistical risks of the procedure. It was clear that as long as the compensation system is based on a theory of negligence, the system of litigation itself will be abnormally expensive.

We realized that there were two options facing the legislature: we could provide additional sources of money for the system, or the distribution of existing monies could be done in a more rational manner. As to the first option, monies to fund the medical malpractice system were obviously limited. Physicians had already indicated that they would refuse to pick up any additional medical malpractice insurance costs. We knew that the patient population of California could no longer afford increases in medical bills, and we knew that the Governor (who had repeatedly announced a tight budget, no-new-taxes policy) would not be willing to use general funds to pay for malpractice premium increases. There appeared, therefore, to be no source of additional funds for the system.

We were left with the alternative of evaluating the current system and reallocating the funds in a more efficient manner. To this end, Assemblyman Keene introduced Assembly Bill 926. AB 926 was the progenitor of AB 1 (of the extraordinary session), which was to become California's major malpractice legislation.

AB 926 represented a radical overhaul of the current system for litigation of medical malpractice disputes. It established an independent commission to review medical injuries based upon a worker's compensation type of no-fault system. Limited compensation was provided for all injuries which were the unanticipated results of medical intervention or unreasonable omission. Attorneys' fees were severely restricted, as they currently are under workmen's compensation, where the attorney's burden of proving negligence has been removed. Patients' rights to recovery for non-economic losses, chiefly "pain and suffering," were severely limited in the belief that there are limits to what society can afford in an area of great subjectivity in which it is not always possible to compensate with dollars.

The radical approach in AB 926 was based on the view that the cost of medical malpractice insurance was threatening the stability of the entire health care delivery system in California. A statistical study of medical malpractice cases for 1974 indicated that only 6% of the claims received 67.4% of the awards. In other words, the medical malpractice insurance system provided large benefits for only a small number of California citizens, while it was extremely expensive for a great majority of users of the health care system, perhaps to the point of denying access to some. The escalating costs associated with the system have their most severe impact upon low income and middle class citizenry, particularly those without health insurance to soften the blow. In addition, a great number of California's Medicaid (Medi-Cal) recipients, many of whom are senior citizens, were being informed by doctors that they would no longer be accepted as patients. The Medi-Cal reimbursement rate failed to provide the overhead costs associated with their care, much less the additional burden of large increases in medical malpractice insurance premium rates. Therefore, AB 926 attempted to equalize the form of compensation so that the cost burden would not continue to be inequitably distributed.

Extensive dialogue with the Governor and the leadership of the Assembly and Senate indicated that this approach was much too radical and would not be acceptable. Therefore, when the Special Session was called in May (primarily at the urging of the Assembly leadership), Assemblyman Keene prepared AB 1 as a comprehensive attempt to reform the malpractice insurance system rather than junk it.

AB 1 provided substantial reforms in the area of health care quality control, tort law and insurance review. A general policy (and, as will become evident later, *political*) decision was made that all interested parties must sacrifice in order to reach a fair and rational solution to the insurance crisis. These included physicians, lawyers, insurance companies and patients alike. AB 1 was drafted to include all reforms in order to prevent any one interest group from sabotaging any single-objective bill.

The Keene Bill

In terms of *medical quality control*, the bill reorganizes and restructures the Board of Medical Examiners into an efficient and more powerful Board of Medical Quality Assurance, expands the number of lay representatives on the Board, and eliminates "lifetime licensure" by requiring the continuing education of all physicians in California. It establishes a central file reporting mechanism to assure that doctors who are successfully sued or are disciplined by hospitals are reported to the Board and are immediately investigated to determine their competency. Local district review committees are expanded, given new teeth and non-physician consumer and provider members are added. A system for investigating consumer complaints is established. Delays in implementation of administrative discipline during court appeals are largely eliminated. Health quality control provisions were essential to regain public confidence in the health care delivery system, and to assure that incompetent doctors are not allowed to practice and generate lawsuits. Although the malpractice crisis cannot be solely attributable to bad doctors, a very bad doctor can be very expensive to the system. In California, an infamous Sacramento orthopedic surgeon is reported to have botched some 50 major back surgeries in the last four years. This physician has already cost his insurance carrier over $6.1 million, and there are 30 remaining outstanding claims.

The second general area of reform is that of *tort law*. AB 1 places limitations on *attorney fees* — some have gone well over a million dollars in California — to assure that the plaintiff receives the bulk of the money awarded in a medical malpractice action. The scale in contingency fee agreements range from 40% of the first $50,000 to 10% of any award over $200,000. In part, this reflects the belief that an attorney should not be able to get a windfall if a severely-injured "perfect client" walks into his office. In such cases, it is unconscionable to make the attorney a partner in his client's pain and suffering.

AB 1 also establishes *periodic payments* for any award in which future damages exceed $50,000, to prevent windfalls to non-dependent heirs in case the patient dies in advance of the actuarial prediction.

The measure tightens the *statute of limitations* to assure that claims are brought in a timely manner and to prevent the endless "tail" long associated with medical malpractice disputes.

AB 1 permits the introduction into evidence of *collateral sources* of recovery to preclude double recoveries for the same injury (both malpractice and workman's compensation or private insurance payments, for example).

The bill assures doctors the right to a *90-day prior notice* of a patient's intent to sue to enable the physician to effect a medical or financial solution short of litigation, if possible.

Further, AB 1 encourages and facilitates the *arbitration* of medical malpractice disputes by specifying uniform language to be used in binding arbitration contracts to assure that the patient knows what he is signing and what its ramifications are.

Perhaps the most controversial tort law change was the *limitation on "pain and suffering."* As indicated earlier, we were faced with a moral dilemma. Unless we took drastic steps we were denying patients access to reasonably-priced health care in California; yet if we did, in addition to curtailing a system that provides inordinate benefits to a few, we might run the risk of undercompensating some of those few. We decided to limit the "pain and suffering" portion of awards to $250,000.

Many attorneys questioned the constitutionality of these tort reforms, arguing that we were discriminating against a certain class of claimants and restricting their rights. It was our argument that these reforms fall within the legitimate health, safety and police authority of the state. It is our duty to balance the needs of the individual against the public good in general. There is an analogous argument in the area of defamation cases. Under current California law, one cannot recover for general damages in a defamation suit unless one can show special damages. The argument is that free speech is so important that society does not want any undue burden placed upon it. In our view, health care and access to it is also so essential that steps must be taken to assure its continued availability.

The last major area of reform in the bill deals with *insurance.* First, we prohibit insurance companies from discriminating against doctors who choose to arbitrate disputes rather than try them in a court of law. Many insurance carriers have refused to sell insurance to doctors who seek the right to arbitrate.

More importantly, we open up the malpractice insurance system in California to public scrutiny. Any insured who experiences an increase of 10% or more in his medical malpractice insurance has the right to demand a public hearing before the Insurance Commissioner of the State and participate in a cross-examination of the insurance company as to the reasonableness of the proposed increase. The Insurance Commissioner is given full power to subpoena any documents, individuals or data necessary to make a finding on whether the rate is reasonable. If he finds it is not, he may rescind it. In summary, no longer will insurance rates be established "in the dark" without careful public scrutiny.

Under a companion measure (SB 24), the Insurance Commissioner may create, if private companies withdraw from the market, a non-profit joint underwriting association with an extended life, whose rates are set by a panel of independent actuaries and which is required to offer 2 years of claims made insurance with a guaranteed occurrence rider to be picked up at the end of that time.

The Legislative Process

Since the bill demanded sacrifices from all parties, all parties were opposed to some segment of the bill. Physicians cried out against additional health quality control. Attorneys complained about tort reform. Malpractice carriers opposed the insurance provisions.

How could a bill with so much opposition get through the California Legislature and receive the signature of the Governor? This tormented staff and concerned members alike for the next six months. First, the process was facilitated by the fact that the Governor declared a special extraordinary session of the Legislature to deal solely with the issue of medical malpractice. This focused the attention of the Legislature on the issue and allowed staff to work on the question almost full time. The Governor, in his proclamation of May 1, 1975, set forth several issues which he felt the Legislature should address. Assembly Bill 1 dealt with most of these issues. The Governor called for equal sacrifices; AB 1 demanded such sacrifices.

The bill was introduced by Assemblyman Keene on May 19, the first legislative day following the proclamation. The Speaker of the California Assembly, who is given great discretion in selecting the appropriate committee for the hearing of a bill, considered several alternatives, finally selecting Judiciary, a decision that would become very important in the long history of the bill. The Judiciary Committee is composed of eleven members, nine of whom are members of the State Bar.

The State Bar acted in a very conservative manner through the entire medical malpractice crisis. In late April of 1975, it established a select committee to investigate medical malpractice. The committee was to make recommendations to the State Bar on proposed changes in tort law and other areas deemed necessary. The policy of the Bar was that no action or position should be taken until the committee was back with its report.

At the same time, the posture of the California Trial Lawyers' Association was to blame the insurance crisis on the insurance companies themselves. It continually raised the issue of insurance rate "rip-offs" to pay for tremendous losses in the stock market. Its "villain" was the profit and loss portfolios of insurance companies.

We needed some facts. The State Auditor General undertook, at the request of the California Assembly, an extensive investigation into the losses and profits of insurance companies. The chief conclusion was that malpractice insurance companies are on the verge of bankruptcy principally due to significant increases in medical malpractice claims in recent years. According to the study, rates demanded by insurance companies appear to be actuarially reasonable. Although the Insurance Commissioner and other administrative spokesmen were willing to address this issue over and over again, the Trial Lawyers' Association was never willing to accept this verdict. It was far easier to deal with the villain of insurance company finances than with the substantive cost issues raised in the system of handling malpractice disputes.

As we waited for the report of the State Bar Association's Committee on Medical Malpractice, we proceeded with hearings before the Assembly Judiciary Committee on AB 1. It is highly questionable whether the committee was able to completely divorce itself from its own professional bias, however subconscious. The bill was severely amended in that committee (the press said it was "gutted") in order to limit the impact of the proposed tort reforms. However, the members could not kill the bill outright because of the public outcry that would have developed.

This public factor must be stressed again. Perhaps one of the most significant political forces involved in the medical malpractice crisis was the ability of local doctors to arouse their patients and have those patients *demand* substantial reform. Members of both the California Assembly and Senate were literally swamped with thousands of letters from constituents demanding immediate reform. It was the political force of these constituents which provided the life blood of AB 1.

AB 1 soon became identified in the press as *the* moving bill, the only bill that would address itself significantly to all the issues involved in the crisis. The California Medical Association (CMA) was willing to support AB 1, even though it was uncomfortable with the health quality reforms, because its members realized that tort reforms were essential to the future of medicine in California. (Indeed, the bill did contain all eight points that the CMA had sought in terms of tort reform.) Many Assembly and Senate members desired more stringent health quality controls. This might have been possible had not the Judiciary Committee so severely watered down the tort reforms in the bill, thus eliminating the power necessary to bargain with the doctors.

An additional political impetus behind AB 1 was the concern that the doctors would again go on strike, bringing medical care in California to a standstill, and reducing the possibility of a reasoned solution. The doctors were organized, the doctors were meeting, and the doctors were capable of going on strike with merely a day's notice. No one can be sure, but such a strike would likely have had widespread support among the non-sick populace of California. To that group the Legislature had to demonstrate determination and a capacity to respond.

It was apparent that the State Bar would not develop any great sympathy for its position among the population. The State Bar undermined its own position by not accepting many of the suggestions proposed by its own committee on medical malpractice, some of which paralleled the reforms in AB 1.

AB 1, although amended, survived the Assembly Judiciary Committee and moved with relative ease through the Ways and Means Committee. On the Assembly Floor, it cleared with a tremendous majority (67-8), although the CMA withdrew support due to the amendments.

In the State Senate, the bill was sent to the Insurance and Financial Institutions Committee, which was more responsive to the doctors' outcries and perspective. The bill was again substantially amended, this time to address many of the desires of the medical societies and the demands being articulated in constituent letters. As the bill cleared this policy committee, it was "reinvigorated" to virtually its ultimate form upon enactment. During and immediately following the July recess, in an attempt to

satisfy technically the needs of the various interested groups, AB 1 was amended many times. However, the substantive provisions of the bill remained intact, and the measure bore remarkable similarity to the strong form in which it was first introduced.

In September, the bill came back to the Assembly for concurrence on Senate amendments. After an indescribably bitter controversy for several days over whether to "further refine" the bill in a conference committee (where it would also undergo the risk of again being emasculated), AB 1 was overwhelmingly endorsed by the Assembly (60-19). The bill was then sent to the Governor, who signed it twelve days later.

SOME POLITICAL LESSONS

Reflecting on the conception, advocacy, and successful passage of AB 1, a number of key political judgments appear cumulatively to have made the difference between shipwreck and clear sailing:

1. We pushed for a *comprehensive approach*. There were several reasons: First, no piecemeal solution to the problem was possible. Second, by pitting the various concerned and powerful interest groups against one another, while preserving the delicate balance among them, we had a better chance of getting something out. This is called the "equal bite" theory behind AB 1. Third, it was essential to have a bill of sufficient magnitude to command media attention and concentrate public support. AB 1 was supported by the California Medical Association but it was also supported by consumer groups, union organizations, senior citizen groups and county boards of supervisors. In short, the comprehensive nature of AB 1 assured great public sympathy in support of the bill and precluded any attempt by one interest group to kill it in any specific committee.

2. We arranged *early discussions with the Governor* so that he would have no good political basis on which to veto the bill. The momentum behind a special session required that, in his call, he set forth his proposals for dealing with the problem. However, this was *after* we had discussed our view of it with his advisors and had achieved agreement on most points.

3. We were able to obtain *support from the leadership* of both houses, so that all competing bills were diplomatically laid to rest. We needed the exclusivity not only of public support and media attention, but of the special interests who soon recognized AB 1 as "the only game in town."

4. We convinced the leadership of the Senate to refer the bill to a *neutral committee*, the Insurance and Financial Institutions Committee, even though there was an incomplete subject matter connection. We could not have hoped to bring about change had the measure been referred to a lawyer-dominated committee in both houses. In such committees, there is an unavoidable built-in bias. Our fate in the Assembly was such that we wanted no repeat in the Senate.

5. We prodded the actuaries of the insurance companies and the Department of Insurance to come up with statistical information which showed the *impact of the tort reforms* in AB 1 on the proposed

malpractice insurance rate increases. We had to show the public that there would be some impact and that the sacrifices were necessary to achieve the desired goal. We finally got a general agreement that the bill might in time drop premium levels by about 30-40 percent and contain help to future costs.

6. We recognized that *time and reason were on our side.* Time, because it enabled Assembly members to develop an increasing appreciation of the full magnitude of the problem — a likely breakdown in the state's health delivery system, or at best the denial of care to the economically marginal. It was perceived as a problem for which we had the temerity to propose a solution that was, at least, well thought out. Reason was on our side because the existing system absolutely dictated change. Even if it were not a medical disaster for the rural patient, the Medicaid patient, the acute care patient, the high risk patient, and the economically marginal patient, it was a consumer disaster in terms of the half-billion dollars per year spent on defensive medicine in California, and a disaster for the *lawyer's* injured client who probably receives (in actuality) less than twenty or thirty cents out of each malpractice premium dollar paid in.

7. We learned to *reconcile vastly differing perspectives.* We spoke with people who told us that malpractice insurance is a doctor's problem, failing to recognize that costs are passed on to the patient; with people who were willing to consume our energies searching for a villain when there is none; with people who had *the* magic solution when in reality they lacked basic knowledge of the subject matter and were forever re-inventing the wheel; with people who had very narrow points of view related to their own particular discipline; with people who demanded an iron-clad guarantee that we had the solution; with people who tried to blackjack us into a response; and finally with some people who were totally unappreciative of our efforts on their behalf.

Conclusion

AB 1 was a complex bill to write, and an extremely difficult bill to pass. While its provisions represented many compromises, the net result was a more decisive, stronger measure than any of the protagonists imagined would emerge or had a right to expect. While AB 1's long-range reforms begin the process of changing the medical malpractice insurance system, dialogue will continue in the California Legislature on further changes and refinements.

The crisis is not yet over, but because of AB 1 there is a renewed basis for confidence that the legislature and the democratic process can perform in a reasonable and prudent manner under the intense pressure that such a crisis can produce.

A MICRA RETROSPECTIVE

By: David E. Willett, J.D.

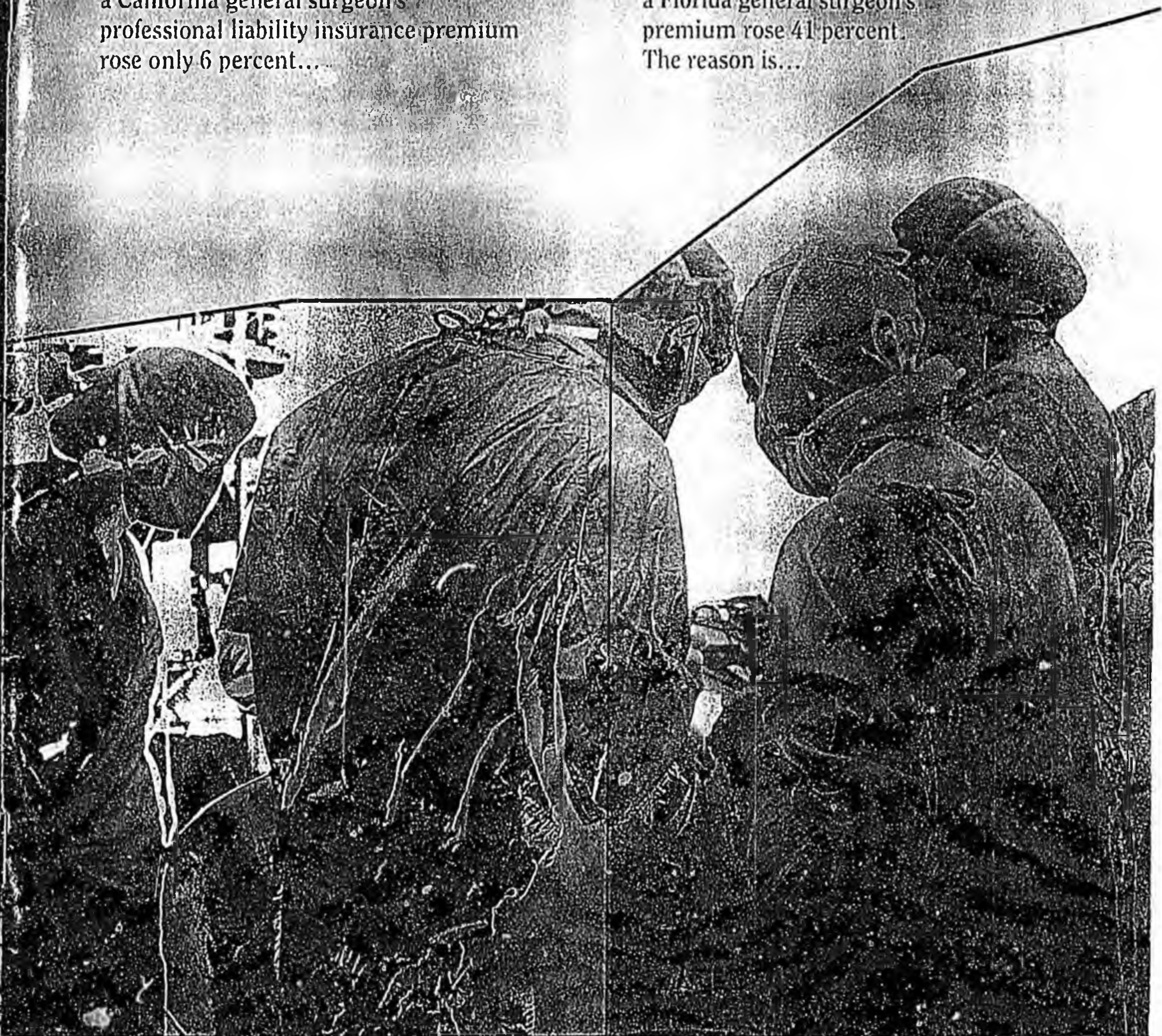
EXHIBIT 4

CALIFORNIA PHYSICIAN

June 1991 California Medical Association's Monthly Magazine

During a 3-year period, a California general surgeon's professional liability insurance premium rose only 6 percent...

During the same period, a Florida general surgeon's premium rose 41 percent. The reason is...



THE MICRA DIFFERENCE

A look at how the Medical Injury Compensation Reform Act of 1975 has saved professional liability insurance in California—*page 36*

By David E. Willett, J.D.

A MICRA RETROSPECTIVE

An insider's look at the landmark tort reform law that saved the state's professional liability insurance

n 1975, a professional liability insurance crisis erupted in California, threatening the closure of medical practices throughout the state because of high premiums and unavailable coverage. In a short time, the crisis spread throughout the nation. California's solution was the Medical Injury Compensation Reform Act of 1975 (MICRA), an historic piece of legislation that made insurance available and affordable in the state. Other states have not been so lucky.

Protecting MICRA is a top priority for California physicians. Events leading to MICRA's passage, and premium comparisons in other states, explain why MICRA is so important.

The insurance stranglehold

Early in this century, professional liability suits were infrequent. When a physician was sued, CMA's predecessor organization, the Medical Society of the State of California, provided members with both a lawyer and, for some period of time, indemnity coverage as a membership benefit. Later, as malpractice suits became more commonplace, commercial carriers began to provide this coverage. Periodically, crises would erupt as these carriers ran into difficulties. However, the 1975 crisis surpassed prior experience.

In the years immediately prior to 1975, most California physicians were covered under group programs sponsored by local medical societies, underwritten by commercial carriers. One program existed north of the Tehachapis, and the other covered southern California, except for those physicians insured under a relatively small CNA program in San Diego and Riverside counties. By 1975, the southern California program was underwritten by Traveler's, and the northern California program was underwritten by Argonaut.

The 1975 crisis was not the first sign of problems. There were legislative inquiries in 1965 and again in 1972. No significant legislation resulted. In January 1975, the California Legislature

During the legislative campaign for the Medical Insurance Compensation Reform Act in 1975, CMA developed a comprehensive campaign for the bill's passage. Pictured below are ads that were part of a statewide advertising campaign that CMA developed and placed in the state's major newspapers and magazines.

was considering a report from a Select Committee appointed in 1972, when the crisis began to erupt. Until then, members of the Legislature admit that they did not perceive the magnitude of the crisis California was about to experience, despite medicine's warnings.

The crisis began to reveal itself in January 1975, when Argonaut proposed a 350-percent increase in northern California rates. Travel r's then demanded an increase of the same magnitude. Physicians found these premiums unaffordable. By April, physicians throughout California were making plans to close their offices, because few could risk practicing without professional liability insurance. On May 1, many Bay Area physicians suspended their practices. Although arrangements were made to provide emergency treatment, health care was becoming unavailable.

Governor Jerry Brown had remained aloof from the issue, saying he was not convinced that the problem warranted a legislative solution. Various ad hoc physician organizations emerged in different parts of the state. CMA invited leaders to participate with association leadership, including three officers assigned to work full-time to obtain a solution. On May 16, Governor Brown finally called for a special session of the Legislature.

There were several reasons why California physicians could not obtain affordable professional liability insurance.

- Suits were becoming increasingly frequent, with increased specialization, changes in the physician-patient relationships, technological advances, and increased (and sometimes unreasonable) patient expectations.
- Legal innovation and judicial expansion favored plaintiffs and made liability more likely.
- Professional liability is a difficult risk to insure. Claims may not materialize until years after treatment. This long tail and the prospect of catastrophic losses are unsettling to carriers, who fled the field when adverse experience was recognized.

Affordable insurance still was not available. So physicians themselves organized four new companies, essentially not-for-profit, as MICRA's legislative journey came to a close.

- The insurance base is very small: In 1975, a mere 27,000 physicians and fewer than 600 hospitals had to provide all the funds needed to pay escalating awards.

AB 1XX, which eventually carried MICRA's provisions into law, was introduced on May 19, 1975, but did not pass until September. In the interim, medicine, as well as all the special-interest groups affected by the reform proposals, participated in furious debate. The reform provisions that CMA demanded were ultimately included. A political price for passage was the inclusion of provisions creating the Board of Medical Quality Assurance (now the Medical Board of California) and a structure that included mandatory reporting of verdicts, settlements, and medical staff disciplinary actions.

Even though Governor Brown refused to sign AB IXX, the bill was allowed to become law, together with a clean-up bill, SB 24XX. However, passage of this legislation did not automatically end the crisis. Affordable insurance still was not available. So physicians themselves organized four new companies, essentially not-for-profit, as MICRA's legislative journey came to a close. For survival, these companies would depend upon MICRA's promise of meaningful tort reform.

What MICRA comprised

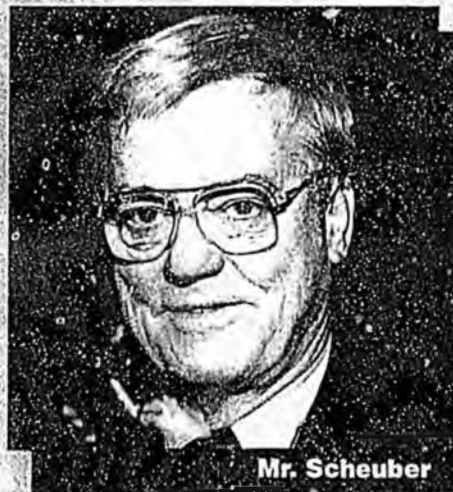
MICRA contained six tort-reform provisions. The four major

Insurers paint gloom

Physicians' professional liability premium rates would soar if the Legislature were to modify the Medical Injury Compensation Reform Act of 1975 (MICRA), officials from California's doctor-owned professional liability insurance companies say.

The carriers unanimously credit the MICRA reforms—specifically the $250,000 cap on so-called pain and suffering awards, attorneys' contingency fee limits, and periodic-payment schedules for awards—for the companies' ability to offer California physicians low premium rates, relative to what doctors pay in other parts of the country.

"If we didn't have MICRA, we could go back to the crisis years of the '70s," when physicians' rates skyrocketed more than 300 percent and commercial insurance companies abandoned their physician policyholders, says William Scheuber, president of Medical Underwriters of California, which is the operating company of Medical Insurance Exchange of California (MIEC).


Mr. Scheuber

In those years, "there was unlimited exploitation by the plaintiffs' bar," Mr. Scheuber explains. With no caps on the amounts on jury awards in malpractice cases, or on fees that trial attorneys charged injured plaintiffs, "the motivation they had to create liability cases—when none really existed—was overwhelming."

The fact that the doctor-owned companies in California "have returned millions and millions of dollars in dividends to policyholders" demonstrates their strength and success, Joseph Sabella, M.D., CEO and chairman of The Doctors' Company, says. "We meet our obligations. The underpinnings of

Dr. Sabella

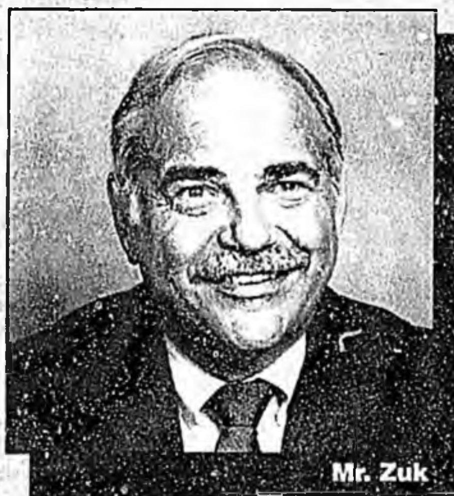
that success are the MICRA reforms: Without them, this would not have occurred."

"If you took MICRA away, the whole foundation would collapse," Dr. Sabella predicts. "If you took away important parts of MICRA, there would be a partial collapse, which would be very serious."

picture of life without MICRA

Donald Zuk, CEO and president of Southern California Physicians Insurance Exchange (SCPIE), cited two other indicators that prove MICRA's effectiveness: The diminishing frequency of malpractice claims and the actual decrease in professional liability rates over the past couple of years.

"MICRA has had a tremendous impact in California," Mr. Zuk says. "The proof is so overwhelmingly obvious that it's hard to imagine anyone—

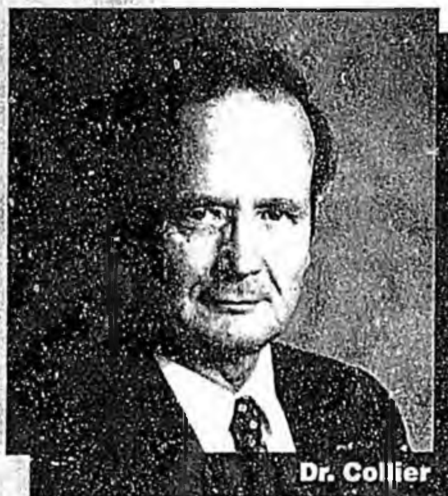


Mr. Zuk

other than someone with a vested interest, basically the plaintiffs' attorney who's out to make a buck—could deny that MICRA has been a terrific help in controlling frivolous and unwarranted litigation."

Any modification to MICRA "will adversely impact the delivery of medical care in California," NORCAL's Chairman Duane Collier, M.D., says. "Medical malpractice insurance will be less available and premiums will be sky high.

"NORCAL has aggressively promoted MICRA in its day-to-day claims operations," Dr. Collier adds. "Tools

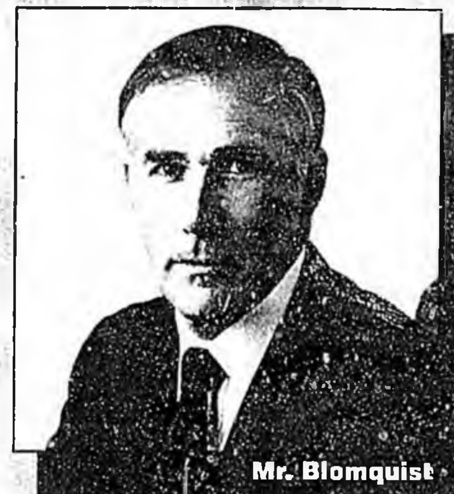


Dr. Collier

that are not used get rusty. We want our lawyers to understand MICRA and to use it effectively to protect our insureds."

Cooperative of American Physicians/Mutual Protection Trust (CAP/MPT), an interindemnity arrangement that provides professional liability protection, has also come to depend on MICRA for the way it does business. "Without MICRA, our organization would not have been able to reduce its open lawsuits through arbitration for five straight years, nor would we have been able to give refunds to our membership for four straight years," Carl Blomquist, CEO of CAP/MPT, says.

Although the agreement between organized medicine and the trial lawyers to keep MICRA intact runs through Dec. 31, 1992, the state's doctor-owned professional liability



Mr. Blomquist

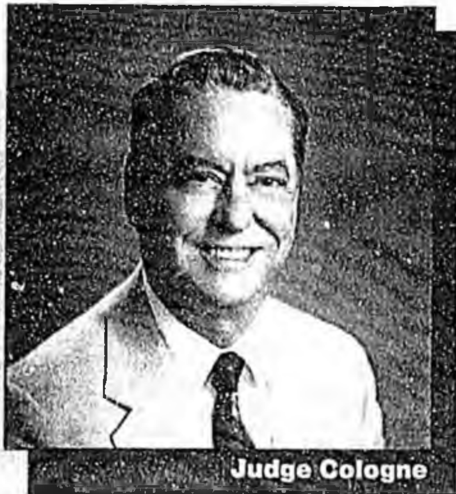
carriers are already discussing strategies to preserve MICRA.

Both independently and through lobbyists, the doctor-owned insurance companies are making sure state legislators understand MICRA's benefits.

The California Association of Professional Liability Insurers (CAPLI), a political action committee set up by The Doctors' Company, MIEC, SCPIE, and NORCAL in 1987, plans to operate very closely with CMA, "adhering to the letter of that agreement, as well as the spirit of it," until its 1992 expiration, CAPLI's lobbyist Judge Gordon Cologne says.

Legislative leaders gave CAPLI "a firm commitment" that no action will be taken on MICRA this year, Judge Cologne says. "Assembly Speaker Willie Brown (D–San Francisco) and Chairman of the Senate Judiciary Committee Bill Lockyer (D–Hayward) have both indicated that they will help us observe the agreement," he says. "To the extent that they're able to, we have their wholehearted support."

CMA, CAHHS Form MICRA Monitoring Committee


Judge Cologne

The California Medical Association–California Association of Hospitals and Health Systems AC Committee was formed in 1988 to ensure that *amicus curiae* briefs are filed in important cases affecting the Medical Injury Compensation Reform Act (MICRA). Especially since MICRA's constitutionality was decided, the courts increasingly have been faced with questions concerning its implementation. "It is crucial that the courts asked to interpret MICRA have a complete understanding of their decision's implications," Catherine Hanson, CMA's legal counsel, says.

In addition to CMA, the California Association of Hospitals and Health Systems and the California Dental Association (on whose behalf the briefs are filed), the current program participants include most of the major medical, dental, and hospital professional liability insurance carriers in California and several prominent self-insured HMOs, hospitals, and medical groups.

The committee's activities have been extremely successful. At the committee's request, a number of cases with adverse implications for MICRA have been

Judge Cologne says the legislators have respect for the agreement between the medical and legal professions and their attempt to honor it. "They're not going do anything to violate the understanding the two professions have with each other as long as that agreement is in place," he says.

CAP/MPT is working with the Association of California Tort Reform, a group that includes utility companies, manufacturers, a railroad company, and some health-related associations. Mr. Blomquist of CAP/MPT says the group "is looking for the extension of MICRA on a broad base." He expects the organization will be particularly persuasive with the legislators, because its varied membership illustrates the fact that professions other than medicine are interested in upholding MICRA.

The carriers agree that MICRA's wholesale destruction is unlikely; however, they are concerned that the trial lawyers will "chip away" at the reforms, primarily by attempting to increase the $250,000 limit on pain and suffering awards.

Although the limit pertains only to court settlements, increasing the cap would have "an umbrella effect over all the cases, the 97 or 98 percent of cases that settle short of trial," Dr. Sabella of The Doctors' Company says. "If the cap is raised for the purposes of trial, it will have a negative effect on our ability to negotiate claims closures at reasonable prices."—*Joan Hess*

provisions are repeatedly cited as a national standard for tort-reform. They include:

- **A $250,000 limit on recovery for noneconomic losses,** defined as "pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damages." There is no limit on recoveries for economic or "out-of-pocket" losses. Despite strident objections, the Legislature's decision that this is a fair limit stands up to scrutiny. Blockbuster awards for serious economic losses are not precluded and, indeed, are increasing. There is increasing sentiment that pain and suffering awards, because they are so speculative in nature and can be so large, are out of place in a system that must compensate for injury. Finally, by bringing awards for pain and suffering under control, this cap made insurance available to physicians, and thus to patients who might otherwise find no resource to pay settlements or awards.
- **Periodic payment of future damages of more than $50,000** at the request of either party achieves two goals:
  - If the patient should die, so that the need for future medical treatment, other future expense, or future pain and suffering never occur, the money is not "earned"—least of all by heirs who would otherwise receive it. The elimination of such windfalls leaves such money available for other claims.
  - More importantly, limiting payment of future damages to the plaintiff's lifetime makes it possible to apply actuarial principles and to fund awards by purchasing annuities that provide periodic payments at much lower cost than lump-sum payments to successful plaintiffs. An important benefit is that annuity payments offer the plaintiff security that does not exist when large sums of money are given to individuals unprepared to manage those funds safely.
- **Contingency fee limits** are particularly resented by plaintiffs' lawyers. The original limits were increased as of Jan. 1, 1988, as part of CMA's "truce" with the trial lawyers. Current limits are 40 percent of the first $50,000, 33-⅓ percent of the next $50,000, 25 percent of the next $500,000, and 15 percent of any amount more than $600,000. The same limits apply to settlements and judgments after trial. Before MICRA's passage, 40 percent contingency fee agreements were common, and even 50 percent agreements existed.
- **Collateral-source payments, such as payment of medical expenses under health insurance or Workers' Compensation, can now be described to juries.** Previously, defense counsel could not tell juries that losses claimed by the plaintiff had actually been reimbursed by others. This provision avoids double recoveries; another MICRA provision prohibiting

decertified (that is, wiped off the law books), including:

- *Jordan v. Long Beach Community Hospital*, which had ruled that the $250,000 cap applies per plaintiff rather than per action.
- *Orellana v. Mejia*, which had ruled that post-judgment interest accrues until periodic payments come due, thereby vitiating the purpose of the periodic payments statute.

The committee has also been successful in having cases with helpful language certified for publication, for example:

- *Gorman v. Leftwich*, which properly interpreted the periodic payments statute.
- *Weinholz v. Kaiser Foundation Hospitals*, which ruled that the new higher contingency-fee limits do not apply to fee agreements entered into before Jan. 1, 1990.

Finally, the committee has been successful in getting courts to adopt arguments contained in its AC briefs. For example, *Woods v. Young* (holding that the notice of intent to sue statute only tolls statute of limitations for 90 days from the date the notice is sent, and then only if it is sent in the last 90 days of the statute) in large part tracks the argument made in the committee's AC brief.

One of the committee's goals is to identify MICRA cases before they reach the appellate court level so that the committee can help physicians and other defendant health care providers address the legal issues that will be presented to the court.

Individuals who are involved in such cases may request the committee's assistance by sending a letter identifying the issue, or issues, that they believe the AC Committee should address, indicating the approximate time frame within which an AC brief would have to be filed, and enclosing copies of the relevant pleadings. The letter should be addressed to: Gregory M. Abrams, California Medical Association, P.O. Box 7690, San Francisco 94120-7690.

For further information about the Medical Injury Compensation Reform Act, CMA has published a definitive MICRA manual. Revised annually, the *MICRA Implementation Manual* contains a detailed summary of the MICRA statutes and court rulings, further interpreting this historic tort reform legislation. *Information:* 415/882-5175.

subrogation lien claims by collateral source payers protects the patient.

- **Other MICRA provisions** redefine the statute of limitations in an effort to close loopholes that the courts have created over the years and to require the prompt assertion of claims. MICRA also requires 90 days notice to physicians or other providers, prior to filing malpractice suits. Although useful, the State Bar's refusal to punish offenders has significantly emasculated the statute. Finally, MICRA recognizes and implements arbitration agreements that the parties willingly adopt.

A much-embattled law

Once MICRA became law, it was the subject of great uncertainty for the next decade. Once passed, it should have been the law of the land. However, the plaintiff's bar, represented by the California Trial Lawyers Association, began a continuous barrage, contending that MICRA was unconstitutional. Many plaintiffs' lawyers ignored such MICRA provisions as limits on contingency fees. Worse, many trial judges refused to recognize MICRA. Physicians and their liability carriers lived with the constant fear that appellate rulings would invalidate MICRA. These concerns were aggravated by Governor Brown's appointment of Rose Bird as Chief Justice of the California Supreme Court, because she had previously advised the Governor to veto the legislation.

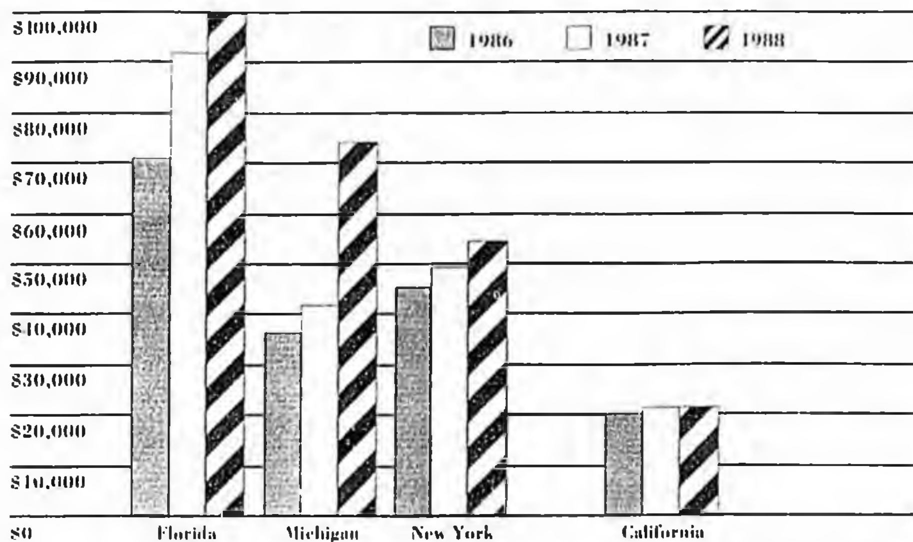
It took nearly 10 years to find out what the California Supreme Court would do with MICRA. The Supreme Court's first decision came in 1984 in *American Bank and Trust Co. v. Community Hospital of Los Gatos-Saratoga* (1984) 36 Cal.3d 359. That decision, upholding MICRA's constitutionality, came only after a stormy course. The original plaintiff, a patient burned in the shower, received a verdict of more than $198,000. The trial judge, not impressed with MICRA, refused to order periodic payment of the damages. Eight months later, the plaintiff died, and her heirs thus received the windfall, which MICRA's periodic-payment provision was intended to avoid. Nonetheless, when the hospital appealed, the Court of Appeal ruled AB 1XX unconstitutional. The opinion was written by Justice Miller, who had opposed MICRA as Chairman of the Assembly Judiciary Committee when AB 1XX was before the Legislature.

In March 1983, an initial Supreme Court decision held that MICRA's periodic-payment provision was unconstitutional, at least where hospitals were concerned. The opinion was criticized immediately and was withdrawn by the Supreme Court, which then granted a rehearing. The Court's eventual 4–3 decision upholding MICRA was authored by Justice Kaus, with Chief Justice Bird writing a dissenting opinion.

The Court examined and dismissed each constitutional objection to periodic payments. The majority, once it found that MICRA is rationally related to a legitimate state interest, refused to second guess the Legislature. The Court upheld the State's authority to enact MICRA because the Legislature

> ... was responding to an insurance 'crisis' that had arisen in a particular area. The problem, which was the immediate impetus to the enactment of MICRA, arose when the insurance companies which issued virtually all of the medical malpractice insurance policies in California determined that the costs of affording such coverage were so high that they would no longer continue to provide such coverage as they had in the past. Some of the insurers withdrew from the medical malpractice field entirely, while others raised the premiums which they charged to doctors and hospitals to what were frequently referred to as "skyrocketing" rates. As a consequence, many doctors decided either to stop providing medical care with respect to certain high risk procedures or treatment, to terminate their practice in this state altogether, or to "go bare", i.e., to practice without malpractice insurance. The result was that in parts of the state medical care was not fully available, and patients who were treated by uninsured doctors faced the

Premium Comparisons of Doctor-Owned Companies
Mature Claims-Made Rates for $1/3 Million Limits
General Surgery



Source: Medical Insurance Exchange of California

There has been very little change in California premiums during the past decade. Generally, premiums range from $4,000 to $50,000 annually for $1 million to $3 million cove age. MICRA is the reason.

prospect of obtaining only unenforceable judgments if they should suffer serious injury as a result of malpractice.

The *American Bank & Trust Co.* decision broke the almost 10-year logjam, although there was still uncertainty about the constitutionality of the $250,000 limit and other MICRA provisions not specifically before the court in *American Bank & Trust*. In February 1985, the California Supreme Court upheld the limit on contingency fees in *Roa v. Lodi Medical Group* (1985) 37 Cal.3d 920. This case was of particular interest to CMA. CMA and other *amici curiae* who joined with CMA provided the only opposition. There was no separate representation for the minor child in this "bad baby" case, whose lawyer complained that the $93,795 awarded him under MICRA—for a policy limits settlement of approximately $500,000 after service of a single set of interrogatories and without a single deposition—was inadequate compensation.

Despite feverish support for the plaintiff from other members of the contingency bar and retention of constitutional law professor Laurence Tribe in a last-ditch appeal to the U.S. Supreme Court, the limits were upheld. Contrary to the arguments of the plaintiff's bar against the contingency-fee limit, capable representation remains available to plaintiffs, and malpractice suits continue to be filed.

Finally, a few weeks after the *Roa* decision, the California Supreme Court upheld the $250,000 limit in *Fein v. Permanente Medical Group*, (1985) 38 Cal.3d 137. Settling the last important issues of constitutionality, the court also upheld MICRA's "collateral source" provision as a protection against "double recoveries."

MICRA's far-reaching impact

MICRA has brought unparalleled stability to the professional liability insurance market in California. Premiums are significant, but insurance is affordable. Physicians can choose among several strong and solvent carriers. There has been very little change in California premiums during the past decade. Generally, premiums range from $4,000 to $50,000 annually for $1 million to $3 million coverage. MICRA is the reason.

In contrast, Florida has no effective tort reform. In 1983, in the metropolitan areas of Dade and Broward counties, premiums ranged from approximately $4,300 to approximately $38,000. Premiums doubled in those counties every two years and reached $19,400 to $192,000 by mid-1987. The rate for obstetrics was $165,320. General surgeons paid more than $96,000. Even in rural Florida, the rate for general surgeons was over $50,000 by 1987, more than twice the California premium. In New York, surgeons paid almost $59,000 in 1987, and in Michigan, the rate for general surgeons was approximately $81,000.

There has been some recent reduction in premiums elsewhere, assisted by a soft insurance market and political compromises in highly regulated jurisdictions. In metropolitan Florida, one company has reduced rates to "only" $13,498 for family practice, $96,023 for obstetrics, and $139,020 for neurosurgery.

MICRA is a national model for effective tort reform, cited frequently by researchers in the field. Proposed federal legislation, both as described by President George Bush and as contained in the Hatch bill (SB 489), is based on MICRA's provisions. For the most part, other states have seen limited tort reform. California is the only major jurisdiction where significant tort reforms are the basis for stable, affordable insurance programs, underwritten by companies unlikely to flee the field if the pendulum swings again. Maintaining MICRA is the best protection for the future. CP

Mr. Willett, who is a partner in the San Francisco law firm of Hassard, Bonnington, Rogers and Huber, is CMA's outside legal counsel. He was involved in MICRA's development.

Addressing the Myths & Misconceptions about Personal Injury & the Civil Justice System

Compiled by
The Alaska Academy of Trial Lawyers

January 1993

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Preface

We have recently celebrated the Bicentennial of the Bill of Rights of the American Constitution. That Constitution and those of the States, including Alaska, declare as fundamental, the right to jury trial and equal access to civil justice for all.

And yet today our civil justice system and the rights of injured victims and consumers are under attack. Politicians in search of solutions to such complex matters as runaway medical costs, the budget deficit and America's competitiveness in the market, oftentimes skew statistics to perpetuate unfounded myths and misconceptions about our legal system in an attempt to pin the problem on lawyers and the injured victims they represent. The multi-million dollar propaganda efforts of insurance companies and their corporate colleagues have borne fruit in biased judges, alienated juries, regressive state and federal legislative efforts, and a social environment permeated by an uncaring attitude toward the rights of the injured victims.

For more than a decade, the legislative debate over the "liability insurance crisis" has assumed that a crisis existed and focused on restriction of the rights of victims of negligence to recover fair compensation to resolve that crisis. Despite any hard data to support their claims, representatives of the insurance industry have asserted that restriction of victims' tort rights will result in lower liability insurance rates. In response to these assertions, the Alaska Legislature has adopted some of the most severe restrictions of those rights of any state in the country.

In 1989, then Speaker of the House, Sam Cotton, at the request of several fellow representatives, formed the Alaska Liability Insurance Task Force. The task force was comprised of legislators and members of medical, insurance, consumer and legal organizations familiar with liability insurance issues. The most significant finding from the data collected by the task force was that, with some exceptions, there is no liability insurance crisis in Alaska.

Although there were minor differences in the conclusions reached in the various studies collected by the Liability Insurance Task Force, the general consensus was that, at best, restrictions on the rights of victims to receive fair compensation through the tort system have had only a "modest", if any, impact on liability insurance rates. More importantly, the consensus among the scholars was that state legislatures should direct their attention away from the tort system and towards alternative solutions to resolving any existing liability insurance problems.

What these studies did not address is the extent to which the public is forced to financially support those tort victims who have been disenfranchised from the legal system because of existing restrictions on tort recovery and the extent to which this gap would widen if further restrictions on tort victims' rights were enacted.

ACCESS TO JUSTICE

RIGHT OF TRIAL BY JURY -- THE FOUNDATION OF OUR SOCIETY

A fundamental guarantee in the Alaska State Constitution.

- A Guaranteed Right: Article I, Section 16 holds that in civil cases where the amount in controversy exceeds $250, the right of trial by jury is preserved.

The jury, as conscience of the community, promotes safety and equity.

- Juries Promote Safety: Over 5 million Americans serve on juries each year. As the conscience of the community, their decisions determine guilt or innocence, safety and security, life and death. Countless improvements aimed at preventing injuries and saving lives might never have occurred without trial by jury and its time-tested ability to bring about changes for the better.

- A Triumph of American Democracy: According to the consumer group, Public Citizen, "The right to collect damages through the civil justice system is one of the great triumphs of American democracy. It allows anyone, no matter how poor, to challenge the largest corporation or government agency and reclaim compensation for wrongful injuries. It forces wrongdoers to change their products and practices to prevent further injuries and avoid further liability."[1]

Critics of the jury system are the most likely to request a jury trial.

- The Ultimate Irony: The loudest critics of the jury system are insurance companies and the defendants they represent in personal injury litigation -- corporations, local government, and doctors. Ironically, the party most likely to request a jury trial in personal injury litigation is the defendant. In fact, insurers almost always demand a jury trial.

TORT RESTRICTIONS DO NOT REDUCE INSURANCE RATES

Evidence indicates that tort restrictions have no significant impact on insurance premiums or availability.

- Insurance Services Office (ISO) Says "NO REDUCTION": A 1987 ISO study determined that tort "reforms" enacted in 1986 would have little or no impact for the majority of liability claims filed with insurers.[2] In October 1986, ISO determined that

its rates would not reflect recent state tort restrictions because ISO was unable to determine any cost effect of the tort law changes.[3]

• Insurers Say "NO REDUCTION": Insurers required to provide Washington State Insurance Commissioner Richard Marquardt with evaluations of the effects of tort reforms on proposed rate filings indicated that there was no way to make such a determination, and that the 1986 law would have a minimal effect on rates. Responses from insurers in other states indicate that tort restrictions do not resolve insurance price fluctuation, reduce rates or increase availability.[4]

• Washington State Insurance Commissioner Says "NO REDUCTION": In 1987, Commissioner Marquardt told a U.S. House committee, "It is difficult, if not impossible, to pin a price tag on tort reform or to even assess accurately its effect on insurance availability and affordability. Based on our research, by the middle of 1986, general liability rates had begun to stabilize throughout the United States -- not just in the states that had adopted tort reform.[5]

• 1991 Washington Insurance Commissioner Report Says "NO REDUCTION": A 1991 report by Marquardt to the Legislature notes that insurance rates in recent years have stabilized and coverage is more readily available, however, tort changes cannot be credited as the reason. Insurers still find it difficult to quantify the impact tort reform on insurance rates. A 1989 law requiring insurers to consider investment income in setting rates was projected to have a much greater impact on insurance rates than changes in the tort system.[6]

• Best's Says "NO REDUCTION": A 1989 Best's Review article on a presentation by David B. Mathis, CEO of Kemper Reinsurance, quoted Mathis as saying, "The only way to achieve stability in the market is through adequate price levels. First of all, despite the publicity it has received, tort reform has turned out to be a non-event in terms of its impact on the big picture.".[7]

A case history -- medical negligence restrictions have little impact on rates.

• 1970 Limitations Fail: A study of medical negligence legislative limits passed in various states from 1974 to 1978 concluded that the changes, either individually or collectively, did not reduce or stabilize insurance rates.[8] Following adoption of MICRA in 1975, California's medical liability insurance premiums continued to rise (increases of 16% to 337% between 1980 and 1986.) Indiana, which adopted the most restrictive medical negligence laws of any state, had premium increases of 53% to 116% during the early 1980s.[9]

• The Crisis of 1985-1986: Despite the fact that tort restrictions had little or no effect on resolving the so-called crisis of the 1970s, a number of states passed laws restricting medical negligence actions during the mid-1980s when liability premiums began to skyrocket.

• Rate Reduction Not Due to Liability Restrictions: Nationwide, medical liability premiums began dropping early in 1989 due to a reduction in claim filings and a reduced increase in the costs to settle claims.[10]

THE LITIGATION CRISIS: DEBUNKING THE MYTHS

Personal injury cases represent a small percentage of the courts' workload.

• The courts are overburdened with over 18 million civil lawsuits filed in state courts each year: This 18 million dollar figure includes millions of routine cases such as small claims, traffic and other ordinance violation cases, domestic relations, estate and contract matters. The most recent figures from the National Center for State Courts show that the number of tort cases filed in state courts was less than half a million, or less than three percent of all state filings.

• Federal Courts: Studies of federal tort filings show lawsuits are on the decline. Over the last thirty years, tort cases as a percentage of federal civil cases dropped by nearly half, from 38.4 percent in 1960 to 20.1 percent in 1990. Product liability litigation is shrinking even faster. It has been reported that federal product liability cases, other than those involving asbestos, have been shrinking steadily in recent years, falling 40 percent between 1985 and 1990.

If there is a "litigation explosion," it is being driven by businesses suing businesses, not by personal injury actions.

• Businesses Suing Businesses: According to a University of Wisconsin study, federal litigation between corporations has increased astronomically, growing more than 1000% between 1971 and 1986.[11]

• State Courts: According to the National Center for State Courts, tort filings are not increasing at a faster rate than other major categories of civil filings. The most dramatic increases in civil cases are real property and contract cases, not torts.[12]

• Federal Courts: Nationally, between 1979 and 1987 contract cases filed in Federal District Courts more than

tripled and property cases quadrupled -- far exceeding growth in personal injury filings.[13]

Most cases are resolved prior to trial.

• Most Cases Are Settled: Only 5% of all personal injury cases filed in state courts go to trial. Complex actions, such as medical negligence cases, are more likely to go to trial than cases such as automobile personal injury (11% of medical negligence cases filed result in trials). Most cases are settled, withdrawn or dismissed prior to trial. 6% of all personal injury cases are uncontested by the defendant.[14]

LARGE JURY VERDICTS ARE UNCOMMON

Huge jury verdicts, such as million dollar verdicts, are the exception rather than the rule.

• Huge Verdicts are Rare: Huge personal injury payouts are a rarity. The largest settlements and verdicts are made to the most seriously injured victims.[15] If anything, juries are very cautious and reticent to adequately compensate injured persons. The multi-million dollar advertising campaigns of the insurance industry have used anecdotal information to make the public feel guilty about fairly compensating persons negligently injured by others.[16]

• Million Dollar Verdicts are Uncommon: According to Business Week, "Over the past 14 year in our nation of 240 million people there has been only 1,642 awards of $1 million or more. Furthermore, two-thirds of the 1,642 cases involved victims who suffered either permanent paralysis, brain damage, amputations or death."[17]

• Alaska Personal Injury Verdicts are Lower than National Verdict Average: Alaska personal injury verdicts currently average 8.1% below national verdict values.[18]

• The Most Severely Injured Persons Receive the Higher Verdicts: Product liability and medical negligence victims generally sustain more severe injuries and are more likely to receive a larger jury verdict. While the 1988 average verdict for personal injury litigation in U.S. state courts was $89,622, the highest average verdict was in the area of medical negligence ($146,831).[19]

Jury verdicts can be reduced -- the actual payout to the plaintiff may be less than the jury verdict.

• Verdicts Can be Reduced on Appeal or Settlement: The actual payout to the plaintiff is reduced after the trial verdict in about 20% of cases. The larger the verdict, the greater the likelihood that the verdict will be reduced. Of the cases where a verdict is reduced, the average actual payout is about half (53%) of the original verdict amount.[20]

"HORROR STORIES" MAKE BAD PUBLIC POLICY

Use of outrageous and atypical examples to create the impression of abuses and/or weaknesses in the civil justice system are common. Cases cited by tort critics alleging frivolous lawsuits and excessive jury verdicts are very often misleading and inaccurate.

Some examples of "horror stories":

• The Pure Fabrication -- The Lawn Mower and the Hedge Story: A widely-circulated story given in the mid-'80s as an example of our litigious society told of a man who successfully sued a lawn mower manufacturer for injuries suffered while using one of their lawn mowers to trim his hedge. In fact, this case is fictitious. It does not exist. It was a fabrication of tort reform proponents.

• Failure to Disclose All Pertinent Facts -- The Phone Booth Near the Road: In 1986, President Reagan noted that it was absurd for a California man to recover damages from a telephone company because he was in one of their booths when it was struck by a drunk driver.[21] The facts conveniently left unstated included: 1) The company knew the booth was too close to the street because it had been hit before; 2) complaints had been filed with the telephone company stating that the booth was difficult to exit because the door jammed; 3) the trial court had granted a lower court summary judgment to the company, but the California Supreme Court remanded the case to the lower court because the risk of injury was foreseeable by the telephone company; and 4) the case was ultimately settled.[22]

• Not Appropriately Placing Blame - Beware of Horse Manure: In 1987, a CBS "60 Minutes" segment focused on a lawsuit against a ladder manufacturer in which the plaintiff recovered $300,000. According to the manufacturer, the plaintiff was injured when the temperature increased from 20 to 40 degrees and the ladder slipped because it had been placed in a manure pile. "We didn't warn him about the viscosity of horse manure," said the manufacturer. To their credit, "60 Minutes" ran a follow-up segment in which a number of

alleged tort horror stories were rebuked. In re-examining the ladder story, reporter Ed Bradley noted, "Several jurors...told us the viscosity of horse manure had nothing to do with their verdict. They said they were persuaded by the plaintiff's contention that the ladder was defective, and that's why he was injured."[23]

• The Tort System Works -- The Psychic and the CAT Scan: A Philadelphia jury awarded $1 million to a woman who claimed she lost her psychic powers after undergoing a CAT scan. In fact, the woman had warned the doctor of previously having had an adverse reaction to a similar procedure. She then suffered anaphylactic shock when the procedure was performed. The jury that returned a $988,000 verdict had been instructed to disregard the woman's alleged loss of earnings because she was no longer able to "read auras." The judge found the verdict excessive and ordered a new trial. This case demonstrates that the safeguards in the process work.[24]

THE COSTS OF PERSONAL INJURY

INJURED PERSONS BEAR THE BURDEN OF PERSONAL INJURY

The injured person bears the brunt of the cost of injury.

• The Injured Person Pays First: Whether or not an injured person is reimbursed for a personal injury from another source, the initial cost of the injury is borne by the injured person and his or her family. The costs of injury include medical bills, lost wages and property damage. Personal injury often causes additional losses, such as the inability to pay bills (the house, the car), increased debt obligations and interest payments, and increased stress on family relationships. The burden of locating reimbursement for medical, wage loss, and other costs of injury falls on the injured person.

• When Defendants Don't Pay and Victims Can't, Taxpayers Do: Most personal injury cases involve significant medical and related expenses. When the victim can't pay and the defendants aren't required to fully compensate for injuries, the uncompensated cost of care is usually borne by government agencies -- in other words, by you and me as taxpayers.

• 38% of Economic Damages are Paid Out of Pocket: The total annual economic loss associated with nonfatal injuries in the U.S. is $175.9 billion. 38% of this total economic burden is not reimbursed by any outside source and is paid for out-of-pocket by those who are injured. 64% of wages lost due to injury are not

reimbursed and are borne exclusively by those injured.[25]

Personal injury liability compensation does not pay for the actual cost of injuries.

• Only a Small Number of Victims Receive Personal Injury Liability Compensation: Only 10% of all accident victims receive personal injury liability compensation. The personal injury system plays a greater role in compensating motor vehicle injury victims. Those injured in motor vehicles are more likely to receive personal injury liability compensation (31%) compared to persons injured in some other manner.[26]

CIVIL JUSTICE SYSTEM PROMOTES SAFETY IN AMERICA'S ECONOMY

TORT LAW IMPROVES AMERICAN PRODUCTS

The tort system saves lives, reduces injuries and promotes public safety.

• Product Liability and Tort Law Promote Safety: There are huge benefits of the current tort system. Businesses devote greater attention to safety. There is a heightened consumer perception that products are safer and of higher quality. Workplace and other injuries have been reduced resulting in thousands of lives saved and millions of injuries prevented. The existence of these very large benefits should give policymakers cause for careful reflection as they are pressed to weaken product liability and tort law in general. Reducing the costs of the system may reduce the benefits and leave society worse off.[27]

• The Tort System Contributes to a Competitive Society: Without a strong tort law, the ethical corporation would have a competitive disadvantage and would be tempted to put profits before public safety. The American focus on safety in conjunction with punitive damages will produce the top quality products needed to compete in the international marketplace. "Our analysis suggests that the rules of product liability make a good deal of economic sense."[28]

• Punitive Damage Awards Do Not Undercut United States Competitiveness: Perhaps nothing is more grossly exaggerated than claims about punitive damage awards, particularly in product liability cases. The most comprehensive study ever conducted on punitive damages in product liability cases -- a survey of the past 25 years -- indicated just 355 cases in the entire country. That's only ten per year for the entire country. The

median punitive damage jury award was $1.5 million, with post-trial activity sharply reducing the median amount actually paid to $250,000. The study also found that 82 percent of businesses assessed punitive damages subsequently implemented safety measures such as product recalls or improved warnings and instructions.[29]

• Harmful Products are Removed or Altered: Examples of unsafe products which have been removed from the marketplace due to the tort system include the Dalkon Shield, asbestos, flammable baby clothes, and unsafe infant formula. Examples of products redesigned to improve safety resulting from the tort system include the Ford Pinto, safety devices on machinery and childproof caps.[30]

• Product Liability Expense Adds Little Cost to Consumer Goods: A new study by the National Insurance Consumer Organization (NICO) found that product liability expenses added but a tiny amount to the cost of consumer goods. The total cost of product liability insurance amounts to 0.14 percent of the cost of the more than $1.8 trillion worth of retain sales in the U.S. in 1991. The study used insurance industry data which broke out liability premiums as a separate line item for the first time.[31]

Insurers reap benefits while projections of future losses have decreased.

• A Shift Toward Defendants: During the mid-80's judicial decisions in product liability cases nationwide shifted toward defendants. Dismissal of product claims and new legal grounds for defendants have increased during the past half decade.[32]

• Insurers Continue to Make Big Profits: While projections of future losses have decreased, insurers' reserving practices and insurance rates have not. Why? Insurers are focusing on restricting state and federal liability laws. They can't claim a need for change while recognizing reduced losses and greater profits.[33]

• Insurers Use Natural Disasters to Raise Rates: The day Hurricane Andrew rolled into Miami, a top insurance company executive for American International Group, issued a memo to regional presidents and vice presidents saying "This is an opportunity to get price increases now. We must be first and it begins by establishing the psychology with our own people."[34]

Claims that the tort system stifles innovation is a ruse.

• Dangerous Products Kept From Market for Good Reason: Tort restriction proponents claim that the threat of litigation keeps products off the market. When Consumer Union examined the list of products being held from the market, the reasons they were pulled of the market were based on valid safety concerns. For example, the Jeep CJ-7, which tends to roll over at low speeds, and an anesthesia gas machine for which the manufacturer had failed to conduct tests of the design of critical components, were on the list of products pulled from the market because the tort system was "stifling innovation".[35]

• Corporate Report Says Liability Suits Do Not Impede Competition: "The most striking finding is that the impact of the liability issue seems far more related to rhetoric than to reality...For the major corporations surveyed, the pressures of product liability have hardly affected larger economic issues, such as revenues, market share, or employee retention...Where product liability has had a notable impact - where it has most significantly affected management decision making - has been in the quality of the products themselves."[36] In addition, numerous federal agency studies of industry competitiveness conducted during the 1980's fail to mention the liability system.

The cost of liability claims is minor compared to the GNP.

• The Cost of Liability Claims v. U.S. Productivity: The total compensation from tort liability claims to persons with nonfatal traumatic injuries in the U.S. amounts to only three-tenths of one percent of the Gross National Product of the United States.[37] The total cost of all commercial liability insurance premiums in the U.S. in 1990, including general liability, automobile liability, and umbrella insurance was only $48 billion, less than 1% of the U.S. Gross National Product.[38]

MEDICAL NEGLIGENCE FACTS vs. MYTH

MEDICAL NEGLIGENCE CLAIMS -- THE REAL FACTS

Lawsuits protect the public -- the benefits outweigh the costs.

• Restrict Patients' Rights at Our Peril: One very important aspect of medical negligence litigation is the useful examination of the practice of medicine itself. Because the buyer of medical care cannot be expected to evaluate the quality of medical care, the market cannot adequately identify incompetent health care providers. "The data suggest that to eliminate or seriously restrict

a patient's right to file a malpractice claim is a step we would undertake at our peril."[39]

• Medical Negligence Standard of Care: Under Alaska law, a physician is responsible for the harm caused when the physician fails to use reasonable care in providing medical care. Other professionals, such as architects, bankers, and lawyers are also required to exercise reasonable care in their professional activities.

The frequency and severity of medical negligence claims has remained relatively constant.

• Closed Claim Study in Minnesota: The Minnesota Insurance Commissioner conducted a study of medical negligence insurance claims filed in Minnesota, North Dakota and South Dakota. The study examined all claims filed from 1982 to 1987 for the two largest medical negligence insurers in the region. 27% of the claims were closed with a payment average of $54,629; the median was zero. Only one-tenth of one percent of the claims resulted in a payment exceeding $1 million, and only 4% exceeded $100,000. Of the 3% of cases that actually went to trial, the defense prevailed in 81 percent of them. In the 20 favorable jury verdicts for the period, no pain and suffering damages were awarded. No cases involved punitive damages. A final note on the Commissioner's study: Saint Paul announced a rate cut of 25 percent on its medical malpractice premiums in Minnesota.[40]

• Unjust Payments are Rare: A new study of medical malpractice cases finds that, despite popular belief, unjustified payments are rare. The study is one of the first systematic attempts to asses the quality of care in malpractice cases and was based on 8,231 cases filed in New Jersey over the past 15 years. The data came from the state's doctor-owned insurance company and the authors contend that their findings are relevant to the nation as a whole. In concluding that unjustified payments are not the norm, the study contradicts the conventional wisdom among doctors, which is that malpractice litigation is a lottery and that verdicts often depend on the whim of jurors.[41]

• Stable Rate of Frequency: The Minnesota closed claims study identified little measurable change in claim frequency over a six year period. The frequency rate was actually greater in 1983 than in 1987 and the average payment appeared to be decreasing over the period of the study. In fact, the study concluded the "data does not substantiate the litigation explosions assertion."[42]

Liability claims without merit are not compensated, and the size of the payment is commensurate with the severity of the injury.

• The System Works: The findings of a closed claims study of obstetric claims from a large physician-owned insurance company between 1982 and 1988 indicate that non-meritorious claims were not compensated. Where a claim was paid, poor physician judgment was the primary source of error and "the size of the settlement was commensurate with the seriousness of the injury." The study concluded that "These results should help to reassure physicians who are concerned that the tort process itself is unjust. Frivolous claimants do not, as a rule, prevail."[43]

Rather than seeking large settlements, most injured patients sue for other reasons.

• Lack of Communication -- What Really Happened: According to a recent survey of 187 families who filed suits against physicians, the primary reasons for pursuing litigation were to find out what happened.[44] Poor communication by medical personnel with the patient was often cited by respondents. In addition, a prior relationship with a medical provider did not protect the provider from legal action. Physicians are finding that apologizing reduces litigation and promotes quick resolution of claims. Douglas Phillips, President of the Physicians Insurance Association of America, said that "Communicating with the patient is probably the most important aspect of loss prevention."[45]

Very few incidents of medical negligence result in a claim.

• Few Negligently Injured Patients Receive Liability Compensation: Only one in every ten incidents of medical negligence result in a liability claim, and only one in twenty-five receive compensation through the liability system.[46] Is this evidence of litigiousness -- that 70 or 80 percent of the people injured by an incompetent or negligent act do nothing about it?

Elderly and minority patients are at a greater risk of being injured by medical negligence.

• Increased Risk of Being a Negligence Victim: In a study of New York hospital discharges, patients with the highest risk of being injured due to medical negligence included elderly patients, minority patients in hospitals that treat a high proportion of minorities, patients in

government-operated hospitals and patients in non-teaching hospitals.[47]

PHYSICIAN DISCIPLINE SYSTEM DOES NOT REMOVE BAD DOCTORS

The cause of medical negligence is medical negligence -- negligent doctors committing preventable errors.

• New York Study: A Harvard study reviewed 30,121 hospital patient discharges from 51 New York state hospitals in 1984. Of these, 280 patients included an adverse event which was caused by negligence. It is estimated that 27,177 cases of medical negligence occurred in New York during 1984, resulting in 6,895 deaths and 877 instances of severe permanent disability. Only 1 in 8 injured patients filed suit and only 1 in 16 received any liability compensation.[48]

• Many Deaths are Preventable: Physicians reviewing 182 hospital deaths in 12 hospitals found that in at least 14% of the cases examined, the deaths could have been prevented. In addition, a small number of factors caused most of the preventable deaths.[49]

A small number of physicians are responsible for most of the negligence.

• Florida: 4% of the physicians practicing medicine in Florida have had 2 or more liability claims filed against them. This group is responsible for 42% of the total claims paid out from 1975 - 1986.[50]

• Illinois, Pennsylvania and Texas: 2% of all physicians practicing in Cook County, Illinois (sued 6 or more times) were defendants in 36% of the medical negligence litigation from 1973 to 1986. 57% of the physicians were not named in any lawsuit and 79% of those sued during this period were named only once or twice.[51] Studies in Pennsylvania[52] and Texas[53] had similar results.

Medical disciplinary boards do a very poor job of regulating physicians.

• New York: The New York Office of Professional Conduct takes an average of 236 disciplinary actions annually compared to an estimated 27,000 cases of medical negligence occurring each year.

• A National Disgrace: An estimated quarter million injuries and death resulted from medical negligence in American hospitals in 1988. Medical disciplinary boards in the U.S. issued an annual average of only 1,481

serious disciplinary actions against physicians from 1987 to 1990.[54]

MEDICAL NEGLIGENCE INSURANCE -- COSTS AND PROFITS

Medical liability insurance is less than 1% of the total cost of health care.

• Premiums vs. National Health Care Costs: Insurance companies argue that liability expenses are a primary factor in skyrocketing health care costs. The facts refute this allegation. In 1989, medical negligence insurance premiums in the U.S. were $5 billion.[55] National health care expenditures for 1989 were $604 billion.[56] Thus less than 1% of the national cost of health care can be attributed to medical liability premiums.

• The Texas Experience: A recent study commissioned by the Texas Hospital Association, the Texas Medical Association and the Texas Trial Lawyers Association concluded that medical liability costs -- insurance premiums and damages from lawsuits -- make up less than 1 percent of health care expenditures in Texas, consistent with national findings. The study found that reforming the medical professional liability system would have minimal cost savings impact on the overall health care delivery system in Texas.[57]

• Losses Paid vs. National Health Care Costs: Nationwide, only 43% of medical negligence insurance premiums earned -- $2.14 billion or one third of 1% of the cost of health care -- were paid out for all losses in 1989.[58] Insurers are retaining 57% of the premiums earned.

Medical negligence insurance is highly profitable for both private and physician-owned insurance companies.

• National Data: In 1989, the net profit of medical negligence insurers in the U.S. was 27.9 cents for every dollar of premium earned. From 1985 to 1989, insurers' annual average profit on medical negligence insurance was 9.2% of premiums earned.[59] Between 1985 and 1990, the net worth of medical liability insurance companies more than doubled from $835 billion to $1,691 billion.[60]

• Minnesota Study: A study of medical negligence closed claims from 1982 to 1987 by the Minnesota Commerce Commissioner found no increase in claim frequency, loss payments and loss expenses. Yet, premiums tripled resulting in a determination that St. Paul Companies --

the nation's largest medical liability insurer -- was substantially overcharging policyholders. St. Paul agreed to refund $1.5 million to physicians in Minnesota.[61]

• Physicians Sue Insurer For Excessive Premiums: In 1989, physicians in Colorado won a $4.1 million judgment against PHICO Insurance Company. The court found that the insurer created a sense of crisis and panic to justify a large premium increase.[62] Physicians in Virginia also sued PHICO for illegal conduct when the company canceled thousands of doctors policies in 1986.

• Physician-Owned Companies: An investigation by the Arizona New-Times revealed that MICA, a doctor-owned company, paid out only 30 cents of every dollar it took in. In addition, the company received a 36% rate hike in 1987. Despite a reduction in lawsuits in 1987 and its own data showing claim frequency decreasing, the company still projected increased lawsuits for 1988.

MEDICAL NEGLIGENCE RESTRICTIONS ARE NO SOLUTION

Tort restrictions will not resolve the problems of access to health care.

• The Tail Wagging the Dog: Due to the high cost of health care, a large number of Americans have no health care coverage. Blaming medical liability costs, which are less than 1% of the cost of health care, for the problem of health care access is ludicrous. Altering less than 1% of the health care costs would have no significant impact on the total cost of health care.[63]

• Reasons for Costs of Medical Care: There are numerous reasons for the increased cost of medical care, including technological advances, increases in population, increased wages as well as general and medical inflation. In a recent GAO report, medical liability costs are not even mentioned as a contributing factor of increasing health care costs.[64]

• Restrictions on Compensation Don't Work: Conventional wisdom about medical liability is not supported by the facts. Limits on verdicts and attorney's fees will not curb the incidence of litigation. Nearly 80% of the injured patients receiving liability compensation have economic losses which exceed the compensation received. This percentage is even greater for settlements. Limits on compensation will only exacerbate the current short fall.[65]

ENDNOTES

1."The Assault on Personal Injury Lawsuits: A Study of Reality Versus Myths", Public Citizen, August 1986.

2.Claim Evaluation Project, Conducted by Hamilton, Rabinovitz and Alschuler, Inc., Commissioned by Insurance Services Office, Inc., April 1987.

3.Insurance Services Office, Chief Executive Circular 2, October 3, 1986.

4.See Findings & Summary of 1990 Alaska Liability Insurance Task Force.

5.U.S. House Subcommittee on Commerce, Consumer Protection, and Competitiveness, remarks by Washington Insurance Commissioner Richard Marquardt, October 7, 1987.

6."A Study of the Effect of Tort Reform on Insurance Rates and Availability and Its Impact On the Civil Justice System", Report to Washington State Legislature, Insurance Commissioner Dick Marquardt, January 1991.

7.Best's Review, July 1989.

8.Frank Sloan, "State Responses to the Malpractice Insurance 'Crisis' of the 1970s: An Empirical Assessment", Journal of Health Politics, Policy and Law, Winter 1985.

9.Case Study on California, U.S. Government Accounting Office, December 1986 and Case Study on Indiana, U.S. Government Accounting Office, December 1986.

10.James R. Schiffman, "Medical-Malpractice Insurance Rates Fall", The Wall Street Journal, April 28, 1989.

11.Marc Galanter and Joel Rogers, "The Transformation of American Business Disputing? Some Preliminary Observations", Institute for Legal Studies, University of Wisconsin, January 1991.

12.State Court Caseloads in 1989, National Center for State Courts, 1991 edition.

13.Marc Galanter and Joel Rogers, "The Transformation of American Business Disputing? Some Preliminary Observations", Institute for Legal Studies, University of Wisconsin, January 1991.

14.David Rottman, "Tort Litigation in the State Courts: Evidence from the Trial Court Information Network", State Court Journal, Fall 1990).

15."The Assault on Personal Injury Lawsuits: A study of Reality Versus Myths", Public Citizen, August 1986. (Cites numerous studies and data including Rand Corporation and Jury Verdict Research sources).

16."The Manufactured Crisis: Liability Insurance Companies Have Created A Crisis and Dumped It On You", Consumer Reports, August 1986.

17."The Explosion in Liability Lawsuits is Nothing But a Myth", Business Week, April 21, 1986.

18.Personal Injury Verdict Survey, Alaska Edition, 1991.

19.David Rottman, "Tort Litigation in the State Courts: Evidence From the Trial Court Information Network", State Court Journal, Fall 1990.

20.Deborah R. Hensler, et. al., "Trends in Tort Litigation: The Story Behind the Statistics"; and The Rand Corporation, Institute for Civil Justice, 1987. (Cites two other 1987 Rand Studies).

21."Accident Victims Strike Back", Seattle Times, July 24, 1986.

22.Bigbee v. Pacific Telephone and Telegraph Co., 665 P.2d 947, (Cal. 1983).

23."Insurance Crisis", CBS, "60 Minutes", January 10, 1988.

24."Horror stories", ATLA Briefing Book, 1991 update.

25.Deborah R. Hensler, "Compensation for Accidental Injuries in the United States", Rand Corporation, Institute for Civil Justice, 1991.

26.Deborah R. Hensler, "Compensation for Accidental Injuries in the United States", Rand Corporation, Institute for Civil Justice, 1991.

27."The Benefits of the Modernization of the Tort Law in the Context of the Social Movement for Improved Safety and Quality in the National Economy", Consumer Federation of America, September 1987.

28.Michael Rustad, Professor of Law, Suffolk University Law School and Thomas Koenig, Professor of Sociology, Northeastern University, testimony before the U.S. Senate Committee on Commerce, Science and Transportation (opposition to federal product liability restrictions), September 19, 1991.