



1-1-1988

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## Recommended Citation

Jeffrey O'Connell, *Correct Diagnosis of the Ills of Liability Insurance-and a False Cure: A Comment on the Reports of the Federal Tort Policy Working Group*, 63 Notre Dame L. Rev. 161 (1988).

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# A Correct Diagnosis of the Ills of Liability Insurance — and a False Cure: a Comment on the Reports of the Federal Tort Policy Working Group

Jeffrey O'Connell\*

## I. The Updated Report

In February of 1986, the Tort Policy Working Group of the United States Department of Justice published its report entitled "Report of the Tort Policy Working Group on the Causes, Extent, and Policy Implications on the Current Crisis in Insurance Availability and Affordability."<sup>1</sup>

The Report, in substance, found a crisis in tort liability insurance, particularly in two areas, product liability and medical malpractice, leading to lack of availability and affordability of liability insurance. The Report examined an exponential rise in litigation, especially in the two crisis areas, and blamed the raging ill of the tort system on the uncertainty of trying to predict: (1) when and (2) for how much would courts impose liability for personal injury. In supporting this thesis, the Report purported to document the rise of personal injury liability litigation in the United States in recent years, especially in the two crisis areas.<sup>2</sup>

The Report, in turn, was strongly contested by, for example, reports emanating from the National Center for State Courts Study<sup>3</sup> and the National Association of Attorneys General.<sup>4</sup> In general, such critics of the Tort Policy Working Group purported to show that the crisis in the availability and affordability of personal injury liability insurance was not due to rising litigation (which supposedly had remained relatively constant over the years) but to: (a) the conspiratorial machinations of the insurance industry trying to create an artificial crisis out of which would grow "tort reform" denying accident victims their common law rights; (b) attempts by the insurance industry to recoup, through higher prices, amounts it had lost through a combination of its investment and underwriting practices in a cycle when the industry wrote risks at prices that were too low in order (hopefully) to reap a more than correspondingly

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1 The Working Group consists of senior Reagan Administration officials of eleven federal agencies, seven of whom are the chief legal officers of such agencies. (Hereafter cited as "1986 REPORT").

2 *Id.* at 45-47.

3 NATIONAL CENTER FOR STATE COURTS, STATE COURT CASELOAD STATISTICS: ANNUAL REPORT, 1984 (1986). (Hereafter cited as "STATE COURTS.")

4 PUBLIC CITIZEN, THE ASSAULT ON PERSONAL INJURY LAWSUITS: A STUDY OF REALITY VERSUS MYTH; AND ANALYSIS OF THE CAUSES OF THE CURRENT CRISIS OF UNAVAILABILITY AND UNAFFORDABILITY OF LIABILITY INSURANCE (1986) (prepared for the National Association of Attorneys General by a task force headed by a former Attorney General of Massachusetts, Francis X. Bellotti) (hereafter cited as "PUBLIC CITIZEN.") See also the final paragraph in note 8, *infra*.

higher return on investments from the resulting cash flow of premium dollars. A subsequent drop in investment income, it was argued, then left insurers short in paying for the losses they had agreed to cover at premiums that, as an underwriting matter, were too low and (c) inadequate regulation of insurance, which had been wrongly delegated to the states by the McCarran-Ferguson Act<sup>5</sup> despite the manifestly interstate nature of the insurance.

Next, in a surrebuttal published under the title *An Update on the Liability Crisis*,<sup>6</sup> the Tort Policy Working Group undertook to answer its critics and update the story of personal injury liability insurance in the United States.

This latest report is a very able — if ultimately flawed — effort.<sup>7</sup> With a lucid and imaginative command of complex data, the Report arguably succeeds in confirming both the fact and causes of the tort liability crisis according to its 1986 thesis, while corollarily answering its critics and their opposing thesis. In an impressive compilation and command of daunting empirical data, the 1987 Report seeks and seems to demonstrate convincingly that the difficulties plaguing personal injury liability insurance especially for product liability and medical malpractice are caused by the uncertainties in establishing projected claim frequency and average claim cost.

In connection with its attempt to prove that the tort liability crisis is caused by uncertainty as to the imposition of tort liability and not by conspiratorial<sup>8</sup> investment or regulatory factors, the Report makes the point that:

empirical testing can only disprove hypotheses: If the implications of a particular hypothesis are inconsistent with the data, the hypothesis can be rejected, but since any given set of data may be consistent with the implications of a number of hypotheses, a particular hypothesis can never be empirically proven.<sup>9</sup>

5 Ch. 20, 59 Stat. 33, 34 (1945) (codified at 15 U.S.C. § 1012 (1982)).

6 AN UPDATE ON THE TORT LIABILITY CRISIS: TORT POLICY WORKING GROUP, March, 1987 (hereafter cited as "UPDATE.").

7 For another lucid — and even more consistently sound — analysis of the insurance crisis, see Abraham, *Making Sense of the Liability Insurance Crisis*, 48 OHIO ST. L.J. 399 (1987).

8 Some thirty consumer groups, for example, formed an association called The Coalition for Consumer Justice to oppose tort reform being proposed by the insurance industry and its institutional insureds. The coalition's president, Joan Claybrook, a colleague of Ralph Nader, stated that the purpose was to "counteract a nationwide lobbying campaign by the insurance industry to limit the legal limits of innocent consumers and victims." NATIONAL UNDERWRITER (Prop. & Cas. ed.) March 14, 1986, at 4. According to Jay Angoff, an official of the National Insurance Consumer Organization, another Nader group, in testimony before a U.S. Senate committee, "Our organization thinks that the reason for the shortage of insurance is that the insurance companies have been mismanaged in the past." N.Y. Times, March 2, 1986, at 20, col. 6. According to Robert Hunter, head of the National Insurance Consumer Organization, (speaking of the insurance industry), "At the top of the cycle [they] write [policies for] everybody, no matter how bad, and at the bottom [they] cancel everybody no matter how good. It's a manic-depressive cycle," TIME, March 24, 1986, at 25. Ralph Nader himself saw an attempt at a mini-reversal of the American Revolution in the machinations of Lloyds of London whom he accused of trying to force the United States to reduce accident victims' rights under American common law. As Nader put it, "the London insurance market is acting like 'King Lloyd', reviving memories of that earlier British tyrant, King George." J. O'CONNELL & C. KELLY, THE BLAME GAME 109 (1986).

9 UPDATE, *supra* note 6, at 17 n.25.

It seems best, therefore, to take up the Report's attempt to disprove certain theses and then to move to the Report's attempt to support other theses.

### A. Collusion

As the Report puts it, "[i]t has been asserted that a principal cause of the crisis has been concerted, anticompetitive actions by insurers to raise prices in certain lines of property-casualty insurance or even to refuse to write such insurance."<sup>10</sup> According to critics of the insurance industry, the purpose of such collusion is: (a) to be able to raise prices and (b) to be able to convince legislatures that tort reform restricting the rights of injured parties is necessitated by the crisis created by rising prices.<sup>11</sup> However, the Report argues that collusion seems an unlikely cause of the insurance crises, given: (1) the large number of insurance companies, (2) the relative ease of insurers in quickly and easily acquiring "the necessary licenses and expertise to either begin selling their existing lines of insurance in new states or to provide new lines in the states in which they are already licensed,"<sup>12</sup> (3) the additional relative ease of institutional insureds (such as manufacturers or medical societies) substituting self insurance for buying insurance from insurance companies<sup>13</sup> and (4) the lack of market concentration in property-casualty insurance.<sup>14</sup>

<sup>10</sup> *Id.*, app. at 1.

<sup>11</sup> See *supra* note 8 and accompanying text.

<sup>12</sup> UPDATE, *supra* note 6, app. at 8.

<sup>13</sup> *Id.*, at 6.

<sup>14</sup> The Report uses the Herfindahl-Hirschman Index (HHI) which is "an index of market concentration calculated by summing the squares of the market shares of all the firms in the market. It varies from near 0 (extremely unconcentrated) to 10,000 (total monopoly). [The higher the HHI], the smaller the number of firms and the more unequal their market shares." *Id.*, app. at 9, n.17.

The highest HHI for [a]ll [p]roperty-[c]asualty was 229 in 1985. Even if [m]edical [m]alpractice and [o]ther [l]iability [including product liability] were valid antitrust markets and competitors [were] limited to just current sellers of those lines, their highest HHI's would be 663 and 278. These are low HHI values. The 1984 Department of Justice Merger Guidelines, for example, indicate that mergers raising the HHI to a level under 1,000 are not a cause of competitive concern. These low levels of market concentration imply that successful collusion among property-casualty insurers is highly unlikely, even in the absence of any legal prohibitions.

Finally, even if collusion were likely in this unconcentrated market because . . . [of antitrust immunity under either the McCarran-Ferguson Act or state law], there are several reasons why the current availability-affordability problems cannot be blamed on collusion. First, the antitrust immunities have applied to all lines of insurance since at least 1945, with de facto immunity since the 1869 decision of the Supreme Court in *Paul v. Virginia*, [75 U.S. (8 Wall) 168 (1869)] while the crisis is of relatively recent origin and is occurring in only a few lines. Second, collusion cannot explain unavailability: firms do not collusively raise prices above costs and then refuse to sell the product. Third, collusion as an explanation for the large price increases observed in recent years is directly contradicted empirically by both the fall observed over that period in the ratio of premiums to underwriting costs . . . and by indications of significant underperformance by property-casualty firms in recent years in the stock market . . .

*Id.*, app. at 9-10.

Concerning these allegations of conspiracy, the report of the New York Governor's Advisory Commission on Liability Insurance states as follows:

First, we want to make clear that we have found no signs of any form of insurance industry "conspiracy" of the kind that has been alleged in some quarters. We have encountered no evidence that there was a collectively arrived at decision to manipulate or abandon the market. Had there been such a decision, the corollary presumption would be that insur-

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

The Updated Report outlines the hypothesis that imprudent business practices have caused the insurance crisis stating:

[L]ower initial premiums could be made up by the higher investment income that could be earned on those premiums between the time they were collected and then they would be required to pay . . . for . . . covered losses. Insurers would be able — and in a competitive market, would be forced — to lower their rates. In this scenario, falling interest rates in 1985 and 1986 resulted in an unanticipated decline in investment income. Insurers facing large anticipated casualty losses found themselves with investment income insufficient to cover these losses, and were forced to turn to their only remaining source of funds — current policy-holders — whose premiums escalated rapidly. In sum, it is theorized that the additional income from recent, very substantial premium increases has been sought by insurers to compensate for unexpected declines in investment income. Theoretical analysis suggests that if property-casualty insurance markets are competitive — and the concentration data presented above support that assumption — it would not be possible for insurers to recover sunken losses due to

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ers would have played a different role in the development and handling of this crisis. Given that it is impossible to prove a negative, we cannot, of course, totally rule out the possibility that such a conspiracy might have been developed, or that some firm somewhere may have attempted to engage in some form of collusion or market manipulation. Establishing absolute certainty in such a matter is not a task that this Commission is equipped to undertake. We simply conclude that we have discovered no evidence that would warrant an assertion that a conspiracy occurred, and that there are strong theoretical and practical reasons to suggest that it did not.

Contemporary economic theory holds that in an industry of this kind, with a highly fragmented structure, a lack of significant market share concentration, and an absence of high barriers to entry, an effective conspiracy is highly doubtful at best. The potential for price leadership phenomena or other forms of oligopolistic behavior in an industry as splintered and competitive as this one is virtually nonexistent, so that an effective conspiracy would be difficult if not impossible to pull off. Indeed, the aggressive and ultimately excessive and destabilizing price of competition of the early 1980's is testimony to the extraordinary competitiveness of the industry and its difficulty in achieving any discipline in the marketplace. And, on the affirmative side of the coin, we have neither turned up any evidence that would suggest collusive behavior, nor can we find evidence that the actual course of events has benefitted any particular firm or faction in the industry.

While we have carried on no inquiry that employed subpoena power or other such investigatory devices, we can report that it is neither suggested by our research, nor does it strike us as fundamentally plausible, that the actions of some willful cabal have placed a major role in the development or prolongation of the crisis. The industry has been effective in using the crisis to promote changes in the tort law. But this does not constitute evidence of a conspiracy to manipulate the market. And, more fundamentally, it does not affect the forces that produced the crisis or the merits of the issue of what should not be done about it.

We observe in passing that the medical malpractice insurance experience of the last decade reinforces our view of the implausibility of the conspiracy thesis. During the nationwide crisis that struck that line in 1974-75, there were also charges of insurer conspiracy. The solution proposed was to form a doctor-owned mutual insurance company that would replace the alleged conspirators with consumerinsurers who would have no incentive to conspire. In fact, of course, although the doctor-owned company has almost half the medical malpractice market, the behavior of that market with respect to insurance rates, availability and affordability in the years since has been if anything more objectionable to the insureds than has been true in commercial insurance lines.

past pricing mistakes by charging higher, super-competitive premiums to current policyholders, especially if new insurers, not suffering from previous errors could profitably undercut the inflated premiums of the old insurers.<sup>15</sup>

The Report examines three types of state intervention: (1) regulation of prices (to see to it that the consumer is not overcharged); (2) regulation of quality (to see to it that the insurers remain financially stable and solvent), and (3) regulation of risk pools (so as to widen them in order to in effect redistribute wealth).<sup>16</sup> As to price regulation, the Report states that despite considerable research on the effects of regulation on the prices charged by property-casualty insurers, no consensus has emerged as to whether regulation has raised prices or not. Studies going both ways are cited.<sup>17</sup> As to regulation of quality and the size of risk pools, while the Report concedes a possible effect on insurance costs, it concludes:

... for all three types of state regulation, while significant research on their effects in the specific crisis lines is lacking, timing alone suggests the lack of a significant, or at least exclusive, connection. In the mid 1970s there was a crisis in medical malpractice insurance . . . . The 1980s brought another crisis in Medical Malpractice, as well as in several other lines of property-casualty insurance. If regulation were to blame for these crises, one would expect to find that regulation increased during or slightly before each crisis and slackened at other times. This, however, does not appear to have been the case. The lack of any apparent correlation between changes in regulation and the development of a resolution of availability-affordability problems in particular states indicates that state regulation is not directly to blame for the current crisis.<sup>18</sup>

15 UPDATE, *supra* n.6, app. at 10-11.

16 Regulatory requirements that insurers must provide, or otherwise help pay for, coverage for inner city residents or those with AIDS are examples of expanded risk pools.

17 *Id.*, app. at 12-13.

18 *Id.*, app. at 16. As to the argument by consumer advocates and trial lawyers for more regulation of insurance as a solution to the ills of tort law, note that New York State has traditionally had far and away the best insurance regulation in the United States. Granted the presence of other variables, it is at least worth noting that New York has been as much—or more—plagued by the tort liability crisis compared to other states (as documented by the working group). UPDATE, *supra* note 6 at 92-96. Professor Spencer Kimball of the University of Chicago Law School, long the country's leading authority on insurance regulation, does not believe that switching to Federal regulation by repealing the McCarran-Ferguson Act will improve the situation. At least insurance regulation, he argues, has a ranking priority in the states as the only major industry subject principally to state, and not federal regulation, whereas it would be just another chore added to a long list of regulated industries for the federal government (already in the midst of a worldwide trend of deregulating what it has responsibility for). (For a crisp journalistic summary of that trend, see N.Y. Times, July 19, 1987 at 3, col. 1.) Admittedly, Kimball has characterized the "typical [state] insurance code as rubbish heap without parallel in the law-making of modern man." Kimball, *Introduction: Unfinished Business in Insurance Regulation*, 1969 WISC. L. REV. 1019 (1969). But these days even liberals may be inclined to doubt that regulations from Washington or Albany (not to mention Santa Fe) can price insurance better than insurance executives can. Recently, the New York Governor's Advisory Commission on Liability Insurance recommended what it termed maxi-minimum price regulation, purporting to limit wide fluctuations in insurance prices to counteract notorious and recurrent underwriting cycles. GOVERNOR'S ADVISORY COMM'N, *supra* note 14, at 93-98. But for a perceptive attack on such proposals as unworkable, see Stewart, *One Vote Against Flex-Band Rating*, NATIONAL UNDERWRITER (Prop. & Cas. ed.) Feb. 9, 1987, at 12, cols. 1-3. There are, says Stewart, too many "pricing points" for regulators, with or without flex-rating, ever to effectively control prices. Those

### C. *Insurance Pricing*

Before turning to the Report's attempt to ascribe the crisis in tort liability insurance to uncertainty as to projected claim frequency and average claim cost, it may be helpful to refer to another lucid and convincing study analyzing the degree to which the insurance industry can be blamed for irresponsible pricing of tort liability insurance, especially in the crisis lines. Trial lawyers, consumer advocates, legislators and insurance commissioners can purport to demonstrate that insurers are overcharging for insurance at any given point, by variously estimating: (1) future claim frequency and average claim costs; (2) what returns the insurer can expect to earn on premiums collected, pending payment of claims and (3) what the availability of reinsurance will be, etc. The New York State Governor's Advisory Commission on liability insurance commenting on how an insurer estimates an appropriate premium stated:

Until an insurer knows what its actual costs for paying claims in the future are, it must estimate them. It does so by using its experience to establish reserves to cover what it predicts that unpaid or unreported, and the costs involved in adjusting those losses will be . . . . Complicated actuarial arguments can be and are advanced as to whether a given insurer's predictions are reasonable. But there is never any question that they either are or can be anything more than estimates, nor is it asserted that critics or regulators can argue for anything firmer than alternative estimates. The truth cannot be known with certainty until the years have passed and the actual claims have been filed and paid.

Indeed, the actual level of payments can be greatly influenced by events that occur between the policy year and the point that a claim arises.<sup>19</sup> The interpretation of liability law can change, rampant price inflation can alter the cost of medical treatment, policy language can be construed in the light of new circumstances, or many other influential factors can intervene to change the cost complications of a given volume of coverage outstanding . . . .

[W]hen all is said and done, the actual costs attributable to . . . underwriting are not only unknown but unknowable with precision. Where controversy has arisen, the choice is between estimates, not between facts. This does not make the argument any less heated, but it establishes the outer bounds of ambition in this matter . . . . [N]obody can know what it will turn up a decade or more from now that actual underwriting costs have been . . . .<sup>20</sup>

The New York Report correctly indicates that neither insurers nor "those looking over their shoulders"<sup>21</sup> can know whose estimates are

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pricing points can come in the form of coverages, deductibles, experience rating, dividends, financing arrangements, underwriting criteria, etc.

19 The above is true for "occurrence" policies which cover liability for events taking place during the policy period, irrespective of when a claim arising from an event is filed. Although most policies written are still of the occurrence type, some are now written on a "claims made" basis, meaning the policies cover liability for claims filed during the policy period irrespective of when the event took place. Obviously under a claims made policy, the time lag between collection of the premium and payment of a claim is greatly shortened. For a discussion of "claims made", see K. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* 50-51, 58, 113, 210 (1986).

20 GOVERNOR'S ADVISORY COMM'N, *supra* note 14, at 55-56.

21 *Id.* at 60.

right. And in that situation, it behooves those of us looking over the shoulders of those who are actually betting their own money on the estimates to be wary of insisting that *our* estimates be substituted for theirs.

#### D. Tort Liability as the Cause

This gets us to the variable of appraising future average claim cost and claim frequency as the underlying cause of the tort liability crisis. Granted once again the point that empirical testing cannot prove hypotheses, but only disprove them,<sup>22</sup> the Working Group nevertheless purports to confirm that the crisis in tort liability insurance has been due to uncertainty surrounding when and how such liability is to be imposed — especially for medical malpractice and products liability.

According to the Report, citing figures from Rand Corporation's Institute of Civil Justice, there has been "an extraordinary growth" in civil jury awards recently, especially in the crisis areas of medical malpractice and products liability. As an example, the average medical malpractice jury award in Cook County, Illinois increased, in inflation-adjusted dollars, from \$52,000 in 1960-1964 to \$1,179,000 in 1980-1984, with San Francisco having a corresponding increase from \$125,000 to \$1,162,000. Product liability awards showed a similar "extraordinary increase."<sup>23</sup> Along with increasing average jury awards, plaintiffs have also greatly increased the percentage of cases they win which go to trial. In product liability cases in Cook County and malpractice cases in both Cook County and San Francisco, plaintiffs have approximately doubled the percentage of cases tried which they win in front of juries from roughly one-fourth in 1960-64 to one-half in 1980-84.<sup>24</sup>

The Report takes special note of the further and especially significant increase in million dollar jury awards. The Institute of Civil Justice data indicates that 65% of the total dollar amount awarded by juries in all personal injury cases in Cook County were awarded in verdicts of a million dollars or more, and yet the million dollar cases represented only 2.8 percent of all plaintiff's personal injury jury verdicts.<sup>25</sup>

22 UPDATE, *supra* note 6, app. at 17 n. 25.

23 *Id.* at 33.

24 *Id.* at 34.

25 *Id.* at 37, citing M. PETERSON, CIVIL JURIES IN THE 1980s, TRENDS: IN JURY TRIALS AND VERDICTS IN CALIFORNIA AND COOK COUNTY, ILLINOIS 37 (1987). The Report notes that critics of the Working Group's 1986 Report raised objections to the Report's use of *average* (or *mean*) rather than median jury verdicts to show the extraordinary growth in jury awards with the concomitant effect on jury availability and affordability. The average jury award is derived by dividing the total number of such awards, whereas the median award is the dollar level at which half the awards are at or below and the other half at or above. Thus assuming three awards — for \$50,000, \$150,000 and \$1,000,000 — the average award would be \$400,000 whereas their median would be \$150,000. Those criticizing the Working Group's Report argue that using the median jury award fails to demonstrate a substantial change in verdicts over the past twenty years. It is their contention that average jury awards, by including a small number of "high end" verdicts, distort the picture. *Id.* at 39. In reply to that, the Report states:

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



The Report also notes the rise in verdicts for pain and suffering. It points to data estimating that an average of 80% of entire awards involving more than \$100,000 in noneconomic damages is for the noneconomic component of the damages. The Report further notes estimates that from 28 to 50 percent of all amounts paid in medical malpractice damages is attributable to noneconomic damage awards in excess of \$100,000.<sup>26</sup>

The Report further notes the threatening rise of punitive damages. While admitting that punitive damages are infrequent, the Report concludes they are not as rare as often supposed.<sup>27</sup> Beyond this, the Report's assertions on punitive damage, while plausible, unlike much of the Report are not supported by empirical evidence. According to the Report, plaintiffs' lawyers have little, if anything, to lose by claiming punitive damages.<sup>28</sup> The Report further notes that claims for punitive damages, bottomed on claims of defendants' egregious conduct, contribute to the acrimony of the litigation, thus lessening reasonable settlement negotiations.<sup>29</sup> Furthermore, the Report argues, the imposition of punitive damages can be so random and fortuitous that, even if they are reversed or diminished on appeal, they arguably further contribute to the inability of insurers to assess their likely exposure to risk.<sup>30</sup>

As to the study by the National Center for State Courts purporting to challenge the rising amount of tort liability litigation, the Update's main point is that the Working Group's earlier Report focused on crisis areas — namely product liability and medical malpractice, but also including such coverages as municipal liability. Because the State Courts' study provided no separate data for such areas, but instead cumulated those claims along with all other tort claims (including auto cases), the

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accurate projection of the average award or settlement would allow the insurer or self insurer to determine its actual exposure if it could also accurately project the number of settlements and awards it would have to pay.

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

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

UPDATE, *supra* note 6, at 40.

26 UPDATE, *supra* note 6, at 38, n. 31.

27 According to the Report, nearly one out of every eight (12%) of the plaintiffs' product liability verdicts in San Francisco handed down in 1980 and 1984 included an award of punitive damages. *Id.* at 49.

28 As one British judge put it, "gross negligence is ordinary negligence with a vituperative epithet," *Grill v. General Iron Screw Collier Co.*, [1866] L.R. 1 C.P. 600, 603 (and plaintiffs' lawyers in framing pleadings find vituperative epithets very easy to come by).

29 UPDATE, *supra* note 6, at 49-50.

30 *Id.* at 50-51.

Center's conclusion that there was no overall "litigation explosion" does not really address such areas as products liability and medical malpractice. Indeed, even a small reduction in auto accident cases (attributable to enactments of no-fault auto insurance)<sup>31</sup> would more than mask a large increase in products and medical cases.<sup>32</sup>

The Report also notes that critics of its February, 1986 Report have questioned the Report's use of data from federal district courts in that federal data represents only a small percentage of all trial tort claims and are in other ways unrepresentative. The Report states:

In the absence of meaningful data on case filings in State court in areas such as product liability and medical malpractice, the Federal District Court data compiled by the Administrative Office of the United States Courts provide the most accurate data on the growth in filed cases. While federal cases represent only a fraction of all tort cases in either of these categories, there is no reason to believe that they do not accurately reflect what is happening in the State courts.<sup>33</sup>

Finally in its criticism of the tort system, the Report points out how inscrutable are recurring attempts to apply tort liability standards to particular cases — focusing, as an example, on repeated and frustrating attempts by the courts to define such variables as the cost-benefit ratio involved in determining whether a product is "defective." The Report further focuses on the case of *O'Brien v. Muskin Corp.*,<sup>34</sup> a product liability case concerning an above-ground swimming pool with an inner vinyl liner. The manufacturer had attached a warning on the side of the pool reading, "DO NOT DIVE." Nevertheless, the plaintiff (found to be a trespasser) dove in the pool, filled to a depth of about 3 1/2 feet, and sustained a serious injury. His claim for liability was based on a failure to adequately warn him of the risks of diving and the use of the pool's vinyl liner. Although the trial court allowed the failure to warn claim to go to the jury, it disallowed the design claim based on the use of the vinyl liner on the grounds that even the plaintiff's expert witness had to admit that he knew of no alternative liner materials for above-ground pools.<sup>35</sup> The New Jersey Supreme Court reversed the trial court's decision as to the defective design claim based on the fact that even though the plaintiff could not show a wiser alternative design, he could win in a product liability suit if he could convince the jury that "the risk posed by the pool outweighed its utility."<sup>36</sup> Commenting that the *O'Brien* case illustrates the degree to which unpredictable imposition of tort liability relates to the unavailability and unaffordability of liability insurance, the Report

31 According to Raymond Stahl, Senior Vice President of the Traveler's Insurance Co.: "There has been a substantial change in our 'mix' of lawsuits. Ten years ago, automobile injury suits were two-thirds of our inventory. Thanks to no-fault insurance laws, today auto suits are only half of what they were." Mulholland, *Industry Problems Causing Unnecessary Legal Expenses*, NATIONAL UNDERWRITERS (Prop & Cas. Ins. ed.), June 6, 1981, at 8, cols. 3-4.

32 UPDATE, *supra* note 6, at 44.

33 *Id.* at 46.

34 94 N.J. 169, 463 A.2d 298 (1983).

35 *Id.* at 301.

36 *Id.* at 306. But see N.J. STAT. ANN. § 2A:58C-3 (West 1987), enacted after *O'Brien* and providing manufacturers with a possible defense against liability if there was no feasible alternative design.

states, "[i]ncreasingly, insurers and potential defendants find it extremely difficult, if not impossible, to predict liability."<sup>37</sup> In effect, the Report seems to argue, although the tort liability system is supposed to detect and discourage unreasonable behavior, providers of goods and services increasingly find the legal system lacking the capacity to be reasonable.

## II. The Report's Flaws

If the Update is (and confirms that the earlier Report was) right in key aspects of the diagnosis of the ills plaguing personal injury liability insurance as stemming from uncertainty concerning projected average claim cost and claim frequency, it is nonetheless wrong (as was the earlier Report) on proposed cures. The Report discusses in considerable detail the implementation of the various reforms which the original task force recommended including: (1) elimination of joint and several liability;<sup>38</sup> (2) limitations on noneconomic damages;<sup>39</sup> (3) modification of the collateral source rule;<sup>40</sup> (4) use of periodic payments for future damages;<sup>41</sup> (5) limitations upon attorneys' contingency fees<sup>42</sup> and (6) changes in regulation of the insurance industry.<sup>43</sup> The Report goes on to indicate the frustrations felt by many at the inefficiency of tort reforms enacted by the many states.<sup>44</sup> The Report further recommends specific statutory language to refine and correct often inadequate reforms on these scores enacted by state legislatures.<sup>45</sup>

### A. A "Return to 'Fault'"?

In essence, the Report says, given time, these reforms will probably have some effect. It takes comfort in the experience in California where medical malpractice reform has slowed the increase in malpractice premiums compared to New York and Florida, both states which have not enacted similarly stringent medical malpractice reform.<sup>46</sup>

However, the point is that merely slowing the rate of insurance increases (even assuming the California experience is all that encouraging) is not what society should be striving for. The Working Group's original 1986 report listed as the first of the eight reforms for tort change, "[returning] to a fault-based standard for liability" and "[basing] causation findings on credible scientific and medical evidence and opinions."<sup>47</sup>

But the law on the books already requires fault. Proving a product defective is very similar in the typical case to proving the product negli-

37 UPDATE, *supra* note 6, at 58.

38 *Id.* at 68.

39 *Id.* at 69-70.

40 *Id.* at 70-71.

41 *Id.* at 71-72.

42 *Id.* at 72.

43 *Id.* at 73-74.

44 *Id.* at 75.

45 *Id.* at 78-87.

46 *Id.* at 93-94.

47 *Id.* at 88, citing the Working Group Report, 1986 REPORT, *supra* note 1, at 60.

gently manufactured.<sup>48</sup> That strict liability for products, even in extremely liberal instances of application as in the *O'Brien* case,<sup>49</sup> is not the key part of the problem for tort liability is illustrated by the fact that the problems plaguing medical malpractice insurance — governed by negligence *not* strict liability standards — are equal to or greater than those plaguing product liability. Further, courts in every state endorse black letter law requiring that causation findings be based, in the words of the Working Group's recommendation, "on credible scientific and medical evidence and opinions." Although the Tort Policy Working Group undertakes statutory language as to all its other recommendations, neither in its first or updated report does it undertake to draft language to implement its two principal recommendations: to return to a fault criterion and to require credible scientific evidence. That in effect acknowledges that the problem of tort liability is not the language of the criteria imposing liability. Rather it is that the language itself (whether the term in question is "defect," "contributory negligence," "assumption of risk," etc.) is by definition protean, subject to myriad meanings as applied in infinitely varied fact situations. Abuses in law rage not only in liberal states like New Jersey but in conservative states like Virginia, which has not even adopted comparative negligence, not to speak of the admittedly more extreme (but still only marginally important) interpretations of "defect" exemplified by *O'Brien*. The expansion of tort law is not due, as the Working Group would have it, to some conspiracy of trial judges and compliant juries, manipulated by skillful plaintiff's lawyers. Rather it is due to the fact that people who are genuinely injured (or at least who can be plausibly made to seem so by skillful counsel) are presented to jurors with often plausible theories of defendant's product or conduct being somehow at fault under inherently vague criteria. These criteria are definable much more precisely than we lawyers now define them (whether by common law, Restatements, legislation, regulation, whatever) so long as a fault criterion — narrowly *or* broadly defined — is retained.<sup>50</sup>

### B. *The Pressure to Compensate Losses*

Ironically, although the Working Group does not note it, the expansion in personal injury liability occurs whether society is more or less affluent. The more affluent we are the more jurors are inclined to view with sympathy the few of us consigned to misery by an accident (as long as a plausible case of protean tort liability can be made), but the less affluent we are (as in West Virginia, for example) the more juries seem inclined to redistribute liability insurance dollars to alleviate at least isolated instances of misery.<sup>51</sup> Ironically, too, the Reagan Administration arguably adds to the problem by opposing the expansion of social legis-

48 Cf. *Henderson v. Ford Motor Co.*, 519 S.W.2d 87 (Tex. 1974); J. O'CONNELL, *THE LAWSUIT LOTTERY* 176-82 (1979); P. Keeton, *Product Liability and the Meaning of Defect*, 5 ST. MARY'S L.J. 30, 38 (1973).

49 See *supra* note 34 and accompanying text.

50 J. O'CONNELL & C. KELLY, *THE BLAME GAME*, 123-24 (1986); see also *supra* notes 47-48 and accompanying text.

51 See R. NEELEY, *WHEN BUSINESS COLLIDES WITH THE COURTS* 91-92, 139-44, 147-49 (1986).

lation thereby adding to the temptation of judges and jurors to distribute income to the needy by the only means available to them, namely tort liability. However, adding to networks of social and private insurance will arguably only exacerbate tort liability insurance ills by financing further and more aggressive tort litigation by those insulated from dire need by such expanded nontort insurance (coupled with hiring a lawyer on a contingent fee) — and therefore no longer induced to settle for lower and quicker amounts.<sup>52</sup> This seems to have been the experience under no-fault auto insurance as it sometimes seems to serve to subsidize and thereby expand the tort liability it was designed to replace.<sup>53</sup> Even stronger evidence on this score is provided by the exponential rise of third-party liability suits by recipients of workers' compensation. Thus almost half of all product liability payments (42%) are made to recipients of workers' compensation, already the beneficiaries of our most comprehensive and generous scheme of social insurance.<sup>54</sup> Nor will expanded social insurance necessarily lessen the appeal of injured victims to impressionable jurors. Although medical expenses may thereby be more likely to be covered, no one expects that middle class wage loss will be covered by social insurance in the indefinite future, and it is wage loss that comprises the biggest bulk of economic loss of serious injury cases.<sup>55</sup>

Also, the effect of the kinds of incremental reforms advocated by Working Group for lowering premiums is arguable at best. One Califor-

52 On the relative payouts from all forms of insurance, including social and private health and disability as well as liability insurance, see O'Connell & Baker, *Compensation for Injury and Illness: An Update of the Conard - Morgan Study*, 47 OHIO ST. L. J. 913 (1987); O'Connell & Guinivan, *An Irrational Combination: The Relative Expansion of Liability Insurance and Contraction of Loss Insurance* (forthcoming).

53 O'Connell & Joost, *Giving Motorists a Choice Between Fault and No-Fault Insurance*, 72 VA. L. REV. 61, 72 (1986). But see U.S. DEP'T OF TRANSP., COMPENSATING AUTO ACCIDENT VICTIMS: A FOLLOW-UP REPORT ON NO-FAULT AUTO INSURANCE EXPERIENCES 113-18 (1985), indicating that reduced caseloads for the courts under no-fault insurance are due not only to thresholds banning smaller suits but to the fact that for many payment of economic losses by no-fault makes "a lawsuit unnecessary." *Id.* at 116. Apparently some are induced to litigate more aggressively because of no-fault and some to litigate not at all. In all likelihood those with bigger losses will be in the former category. O'Connell & Joost, *supra* this note. See *infra* note 54.

54 INSURANCES SERVICES OFFICE (ISO), PRODUCT LIABILITY CLOSED CLAIM SURVEY: A TECHNICAL ANALYSIS OF SURVEY RESULTS 63 (1977) [hereafter cited as "ISO PRODUCT STUDY"]. That it is larger losses that lead to aggressive pursuit of tort claims, aided by no-fault 'subsidies', is indicated by the fact that the product liability claimants with work related injuries, although receiving 42% of total payment, constituted only 11% of product liability claimants for personal injury. The average product liability payment made for work-related injury was \$97,884, as opposed to an overall average of \$24,752. *Id.* at 60. See also O'Connell, *Transferring Injured Victims, Tort Rights to No-Fault Insurers*, 1977 U. ILL. L.F. 749, 766 n.63.

55 The consistency of the mix of medical versus wage loss in various types of cases has been striking: For medical malpractice cases, 70.8% of injury losses have been wage loss, 27.1% medical loss and 2.1% other expenses. INSURANCE SERVICES OFFICE, REPORT OF THE ALL-INDUSTRY COMMITTEE, SPECIAL MALPRACTICE REVIEW: 1974 CLOSED CLAIM SURVEY, TECHNICAL ANALYSIS OF SURVEY RESULTS 54 (1976). For product liability cases, 72.0% of injury losses have been wage loss, 22.5% medical loss, and 5.5% other expenses, ISO PRODUCT STUDY, *supra* note 54, at 45, 48. These figures closely match those for serious automobile accidents of 74% of injury losses for wage loss, 22% for medical loss, and 4% for other losses. See U.S. DEP'T OF TRANSPORTATION, MOTOR VEHICLE CRASH LOSSES AND THEIR COMPENSATION IN THE UNITED STATES: A REPORT TO THE CONGRESS AND THE PRESIDENT 6 (1971); the auto figures were computed using the losses listed in Table 2 for Medical Expense, Wage Loss and Other Expenses. As to paid claims (as opposed to losses) for medical malpractice the General Accounting Office recently reported as follows:

nia medical malpractice defense lawyer cited the following as an example of the frustrations accompanying recent tort reform:

I supported the tort reforms in California, limiting pain and suffering damages and contingent fees, plus deducting collateral sources, etc. But one effect has been, in my view, an increase in defense costs. It works this way: every serious injury tends to find a legal home, i.e. a lawyer. But in the old days, the big case was more likely to go to an experienced attorney who knew how to appraise both the liability and damages. He also knew how to pursue the case, including how to take depositions, etc. Now, with the limits under the tort reform legislation, many cases are turned away by the better plaintiffs' lawyers who cannot afford to try to handle marginal cases in view of the lesser value that tort reform has imparted to those cases, both in the form of damages and plaintiff's counsel fees. So those cases end up in the hands of second, third, and fourth tier lawyers who know little of how to appraise or handle such a case, endlessly complicating the process from the point of view of defense counsel, including the matter of depositions, negotiations, and practically every other phase of the case. Who would have thought it?<sup>56</sup>

### C. *Beyond Availability and Affordability of Insurance*

But even if the reforms make liability insurance somewhat more available and affordable, the key problems of tort liability for personal injury are not — and never have been — availability and affordability. It is difficult to determine whether we spend too much on personal injury compensation in the United States. The famous California Medical Association study indicated that tort liability pays an almost infinitesimally

Table 3.5: Total and Average Amount of Patient Economic Losses by Categories

"Amount" in millions

Categories	Economic Losses <sup>a</sup>			
	Amount	Percent	Average	Highest
All claims	\$4,531.3	100.0	\$113,227	\$10,463,000
Medical expenses				
Incurred as of claim closing	282.3	6.2	7,055	560,000
Anticipated future	919.2	20.3	22,968	4,000,000
Wage Loss				
Incurred as of claim closing	163.6	3.6	4,078	1,000,000
Anticipated future	1,526.2	33.7	38,137	3,000,000
Other <sup>b</sup>				
Incurred as of claim closing	87.4	1.9	2,184	1,400,000
Anticipated future	1,552.6	34.3	38,796	9,999,999

<sup>a</sup> Only represents claims for which data were provided and, therefore, are representative of about half of the universe of claims.

<sup>b</sup> Other expenses include such items as housekeeping services, vocational rehabilitation, travel, and home renovation. U.S. GENERAL ACCOUNTING OFFICE, REPORT, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984 44 (1987).

<sup>56</sup> Personal oral communication to the author.

small number of those injured in hospitals.<sup>57</sup> (If that report is to be believed, the tort system is the health care provider's best friend, shielding it from massive exposure to liability for losses inflicted by it.) Moreover, the same is arguably true of products liability.<sup>58</sup> However, the key problems of tort liability are not so much the number of dollars we spend, but what we do with them. Any way one looks at it — whether the sums are too big or too small — they are large and they are being wildly wasted under tort law.<sup>59</sup> Many injured parties are not paid at all, many are paid far more than their actual losses; for everyone huge delays are the norm and the percentage going to lawyers and expert witnesses are, as the report itself indicates, staggering.<sup>60</sup> In this connection, though, it is curious to see the Reagan Administration, of all people, advocating wage controls, as they do for plaintiff's personal injury lawyers.<sup>61</sup> Given all the uncertainty and complexity of establishing tort liability (repeatedly referred to and documented by the Tort Policy Working Group in both its reports) and the possible riches involved in personal injury litigation (also documented) who is to say that plaintiffs' lawyers are overpaid, versus, say, defense lawyers, surgeons, rock singers, investment bankers, athletes, etc?

The worst combination of any social arrangement is waste coupled with want. But that is the essence of the personal injury tort system, with so many injured parties either not paid, underpaid, or overpaid and with so much payment channeled into transaction costs.

Nor of course is that terrible combination of waste and want limited to the crisis areas of medical malpractice and product liability insurance. Since these cases are the most complex, the situation is worse there, as the Updated Report — and especially its imaginative Appendix — lucidly help to demonstrate. The waste and want pervading the tort system are inherently the function of an insured event that is so uncertain, entailing determinations of fault and the value of pain and suffering, two variables not present in any other form of insurance at least to any significant extent.<sup>62</sup> It is true that disability insurance pays small scheduled amounts,

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57 CAL. MEDICAL ASS'N AND CAL. HOSP. ASS'N REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY (D. Mills ed. 1977).

58 NAT'L COMM'N ON PRODUCT SAFETY, FINAL REPORT 74 (1970); J. O'CONNELL, ENDING INSULT TO INJURY 18 (1975).

59 Many observers—especially those with a "Law & Economics" bent, point to the redeeming merit of tort law in aiming at optimal deterrence of unsafe activities. See, e.g., W. LANDES & R. POSNER, THE ECONOMIC STRUCTURE OF TORT LAW (1987). But see *supra* note 37 and accompanying text. For more on deterrence, see *infra* note 73 and accompanying text.

60 UPDATE, *supra* note 6, at 52-53.

61 *Id.* at 86-87.

62 J. O'CONNELL & C. KELLY, THE BLAME GAME 123-25 (1986). If, one might ask, the criteria of fault and pain and suffering are the keys to the unmanageability of tort liability insurance, why do auto liability rates show much less volatility than rates for medical malpractice and products liability? UPDATE, *supra* note 6, app. Table 4. There are two explanations. First, auto insurance is spread over millions of rather uniform driving risks, whereas health care providers and product manufacturers are (relatively) few and much less homogeneous than drivers, with concomitant difficulty in spreading huge risks over a few and varied insureds. Secondly, auto insurance is often sold with relatively low limits (the required minimum in most states is \$10,000 or \$20,000 per person, with many motorists buying minimum or no more than twice the minimum and very few carrying \$1 million or more in coverage). This means far less exposure for insurers to relatively large numbers of big "outrider"

e.g. \$5,000, for defined injuries such as amputation, but to the extent workers' compensation entails substantial payment of scheduled benefits for a broad range of losses beyond medical expense and wage loss, it takes on the difficulties of tort liability.<sup>63</sup>

The problem with all the reforms proposed by the Working Group's 1986 Report and its Update is that little is proposed to change that situation. By not only retaining, but insisting on a revitalized fault criteria, the need for lawyers on both sides to battle over issues of fault remains. Of course, one can purport to cut these costs by arbitrarily limiting what the lawyers on one side can be paid, but if one hasn't changed the nature of their tasks, justice is not served. If one were to make it much less necessary to hire lawyers (as no-fault auto insurance and workers' compensation do) then there is justification for cutting attorneys' fees. Indeed, under no-fault auto, it seems to happen automatically, with less need for lawyers and less for them to do when they are needed.<sup>64</sup> But note that all the changes proposed by the Working Group in its initial and updated Reports either make it harder for injury victims to be paid (with a corresponding decrease in their attorneys' fees) or pays them less after they meet more restrictive tort criteria.

In this connection, the Working Group's initial and updated Reports speak of the present evolving tort regime as moving toward a no-fault system.<sup>65</sup> To the extent they mean that plaintiffs can recover under recent tort law more easily than in earlier days, there is something to it. But to imply that the tort system has become a grand and easy giveaway is dead wrong. One must keep in mind that recovery in tort for personal injury is still, after all the recent changes cited by the Working Group, a very difficult task, facing years of effort and huge chances of disappointment. As noted earlier, the Updated Report itself cites figures indicating that defendants win approximately one-half of the cases going to a jury verdict.<sup>66</sup> That is scarcely a no-fault system. Moreover, the failure rate in court has a manifestly depressing effect on chances for — and the amounts of — settlements without going to court.

The Updated Report asserts:

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verdicts against deep pockets, the phenomenon which drives so much of the raging medical malpractice and product liability insurance systems. See *supra* note 24 and accompanying text.

Thirdly, auto accidents happen in certain, limited, physical ways, compared to more exotic product and medical injuries, and in addition have been the subject of claims and litigation for so long that there are fewer underwriting surprises compared to the newer, more complex coverages involved in the crisis lines. Even so, the Updated Report is at pains to confirm the general inadequacy of personal injury liability insurance beyond crisis areas. Note for example its discussion condemning high transaction costs, including those for all personal injury liability insurance. UPDATE, *supra* note 6, at 52-53. Note too the opening sentence of the closing paragraph of the Appendix to the Updated Report: "The overall pattern in the data is thus one of high and increasing cost ratios for underwriting losses and adjustment expenses, especially in [but not limited to] the crisis lines . . . ." *Id.*, app. at 22.

63 O'Connell, *A Proposal to Abolish Defendants' Payment for Pain and Suffering in Return for Payment of Claimants' Attorneys' Fees*, 1981 U. ILL. L. REV. 333, 342-44 [hereafter cited as *Abolish Payment for Pain*]; M. BERKOWITZ & J. BURTON, PERMANENT DISABILITY BENEFITS AND WORKERS' COMPENSATION (1987).

64 J. O'CONNELL, THE LAWSUIT LOTTERY 171-72 (1979).

65 UPDATE, *supra* note 6, at 53-55.

66 *Supra* note 24 and accompanying text.



A limitation on noneconomic damages . . . , if properly formulated, probably is the single most effective legislative reform of tort law. Not only does such a limitation significantly reduce the costs of the tort system, but it also serves to expedite settlements by eliminating an unknown which undermines the ability of the parties to reach agreement on compensable damages. Such a limitation also mitigates the unfairness of the tort system for many plaintiffs and defendants arising from the fact that widely different damages often are awarded for nearly identical injuries.<sup>67</sup>

This paragraph graphically illustrates the myopia of the Working Group's recommendations. Take the last sentence first. According to the Group, the way to mitigate the unfairness of discrepancy of results between claimants is to cut every claimant down to a low level, even those whom jurors believe ought to be paid more. Or take the statement that eliminating payment of pain and suffering would expedite settlements for economic ("compensable") damages. Elsewhere, the Working Group states that its recommended limits on pain and suffering will not hinder the collection of damages for economic loss.<sup>68</sup> But that is simply not so. Lessening the exposure of defendants to large verdicts for noneconomic losses lessens the incentives of defendants to pay for economic losses. If an insurer thinks it may be forced to pay a verdict that includes \$1,000,000 in noneconomic damages, it is much more likely to settle for a plaintiff's \$500,000 medical expenses and wage loss than if it knows pain and suffering damages are limited to, say \$200,000. Perhaps payment for pain and suffering is too high today. We cannot say as a matter of certainty. (That's the key problem of compensating in dollars for non-dollar losses.) But we should be under no illusion that putting a limit thereon does not affect other damages as well.

### III. A More Promising Cure

#### A. *True No-Fault Across the Board?*

Past reforms of tort law that have made the greatest difference have involved a trade: under workers' compensation and no-fault auto insurance, the injured parties may get less for loss, but at least they are assured of that less. Thus under workers' compensation and no-fault auto insurance, in return for giving up claims for pain and suffering, the injured parties are paid for much of their economic loss irrespective of fault of either payor or payee. This, in turn, eliminates the two variables that make personal injury tort law so unworkable — determining fault and the economic value of noneconomic loss.<sup>69</sup>

Admittedly the solution of workers' compensation and auto no-fault is not readily adaptable to other lines of insurance such as product liability, medical malpractice or other forms of liability. If one goes into an auto accident in reasonably good shape and comes out with a terrible

<sup>67</sup> UPDATE, *supra* note 6, at 79.

<sup>68</sup> 1986 REPORT, *supra* note 1, at 66-69.

<sup>69</sup> Concerning the experience of no-fault auto insurance laws, and the means whereby they can even more live up to their promise, see generally O'Connell & Joost, *Giving Motorists A Choice Between Fault and No-Fault Insurance*, 72 VA. L. REV. 61 (1986).

gash on one's forehead, or even with an arm severed, we know it was the automobile accident that caused the gash or the amputation. But instead assume one goes to a health care provider for treatment. The law cannot decree that the health care provider will automatically pay for any adverse condition becoming evident after the treatment. Some adverse conditions may be due not to the treatment but to the initial complaint. No matter what the doctor did perhaps the patient was going to get worse. So separating the adverse conditions due to the treatment from those due to the initial complaint is most vexing, on a fault or a no-fault basis.

So in turn mandating that every health care provider be liable for all adverse results occurring after medical service under a no-fault criterion forces any health care provider to face unknowable claims and costs. So too for product injuries. The law can hardly require that anybody who produced or sold or even possesses a product pay for any injuries to third persons resulting from that product without similarly creating unknowable new claims and costs.

#### B. *Incentives to Make — And Accept — Prompt Payment for Economic Losses*

But even so there are available means of beginning to achieve the effects of workers' compensation and auto no-fault by paying injury victims promptly for their economic loss, without endlessly litigating fault and the value of pain and suffering. Consider this proposal: A defendant in a personal injury suit is given powerful incentives to promptly offer to pay an injury victim's economic losses above his collateral sources, periodically as they accrue (plus an hourly fee for the plaintiff's lawyer). If the defendant does not do so, he loses defenses based on claimant's fault, and must pay a winning plaintiff's lawyer's contingent fee in addition to the award itself.<sup>70</sup> But if he does make such an offer, and the plaintiff refuses to accept it, the plaintiff must then prove his case of fault by both a heightened standard (1) of care (gross or wanton conduct) and (2) of proof (beyond a reasonable doubt, or at least by clear and convincing evidence), with both the losing plaintiff and his lawyer jointly liable for defendant's counsel fees.<sup>71</sup> That way still relatively expensive liability insurance will be reserved for paying losses not met by other more efficient insurance sources (such as health and disability coverages) in a manner similar to all other insurance devices (payable promptly and periodically for economic — not noneconomic — loss), except in cases of egregious conduct when a claimant is willing to take risks to get vindica-

70 For statutory language incorporating these ideas, as well as rationalizations for them, in an earlier version of these proposals, see O'Connell, *Abolish Payment for Pain*, *supra* note 63, at 352-53; O'Connell, *A Proposal to Abolish Contributory and Comparative Fault, With Compensatory Savings by Also Abolishing the Collateral Source Rule*, 1979 U. ILL. L.F. 591, 598-600. For an ambitious proposal incorporating some of these ideas, see Sugarman, *Serious Tort Reform*, 24 SAN DIEGO L. REV. 795, 819-40 (1987). For a further variant on combining an early offers' approach with expanding social and private loss insurance, see O'Connell & Guinivan, *supra* note 52.

71 For further development of this proposal focusing on products liability but applicable to other kinds of personal injury claims, see O'Connell, *Balanced Proposals for Product Liability Reform*, 48 OHIO ST. L.J. 317, 318 (1987). For a further variant on combining an "early offers" approach with expanding social and private loss insurance, see O'Connell & Guinivan, *supra* note 52.

tion of harms not deemed adequately recompensed by normal insurance means. An example of such egregious conduct would be an allegedly drunken surgeon who has amputated the wrong limb of a white collar worker, thereby causing loss far in excess of economic loss.<sup>72</sup>

This way, too, whatever deterrence the tort system achieves remains substantially in effect.<sup>73</sup> But in the typical case, tort law's incredible bulk and weight can be used against it in a kind of ju jitsu maneuver to achieve more rational insurance ends — by prompt, periodic payment of uncovered economic loss, not, as the Working Group would have it, by continued and expensive fighting under a still cumbersome fault criterion to pay some less and some more than normal insurance schemes pay in the event of misfortune.

In sum, the Working Group got it half right. The tort system is too cumbersome to function well as an insurance mechanism. But the solution is not to attempt to set the clock back to standards of fault of an earlier day (when the tort system was still intolerable, combining waste and want, if not as extensively and expensively as today) but to use the tort system as a means of reallocating — not just lessening — the funds it continues to use so badly with or without the Working Group's suggested reforms.

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<sup>72</sup> Of course, a blue-collar worker — or anyone else — also would have the right to pursue a tort claim if he or she wanted to risk it.

<sup>73</sup> See *supra* note 59 and accompanying text for more on deterrence. See also Moore & O'Connell, *Forclosing Medical Malpractice Claims by Prompt Tender of Economic Loss*, 44 LA. L. REV. 1267, 1285-86 (1984); O'Connell, *Offers That Can't Be Refused*, 77 NW. U.L. REV. 589, 618-20 (1982).