ISSN 1045-6333

HARVARD

JOHN M. OLIN CENTER FOR LAW, ECONOMICS, AND BUSINESS

IMPROVING MEDICAL MALPRACTICE LIABILITY BY ALLOWING INSURERS TO TAKE CHARGE

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Discussion Paper No. 556

08/2006

Harvard Law School
Cambridge, MA 02138

JEL Classifications: A10, I10, I11, I13, K10, K13

Improving Medical Malpractice Liability by Allowing Insurers to Take Charge

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Abstract

This paper proposes a solution to many of the basic problems with the current system of medical malpractice liability. By all accounts, despite consuming more than $20 billion annually, this system has proven ineffective and probably counterproductive as a means of deterrence and source of insurance. High litigation cost precludes or suppresses vigorous prosecution of most meritorious claims, while it motivates filing of unmeritorious claims for nuisance value payoffs. Patients are compelled to buy "tort insurance" that not only doubles the coverage for economic loss they already have and can cheaply supplement from commercial and governmental suppliers of first-party insurance, but also mandates coverage for non-pecuniary harm that no one wants if they have to pay higher premiums and taxes to get it. The solution is simply to change the law of insurance subrogation as it applies to insurers acquiring their insureds' tort claims. Currently the rule limits subrogation to the amount an insurer paid in covering its insured's loss. The proposed change would allow insurers to acquire their insureds' potential malpractice claims without limitation, including recovery of all damages, non-pecuniary as well as economic. In short, the paper proposes unlimited insurance subrogation (UIS) as a natural and efficient vehicle for patients to assign their entire potential malpractice claims to their first-party insurers. UIS will thereby improve both deterrence and insurance results of medical malpractice liability. By making first-party insurers plaintiffs and placing them on the same footing as their defense-side counterparts, liability insurers, UIS should increase the rate at and effectiveness with which meritorious claims are prosecuted and also reduce meritless litigation, as these large-scale, long-term repeat players will possess the needed means of mutual deterrence and motive for mutual cooperation. At the same time, as first-party insurers lower premiums (and taxes) in anticipation of subrogated claim recoveries, UIS will operate to convert expensive, risky, dilatory, and to a large extent unwanted tort insurance into a greater amount of more optimal first-party insurance. In addition to these direct benefits, UIS should encourage first-party and liability insurers to establish by contract a "private" system for more efficaciously resolving medical malpractice claims. The paper addresses possible costs of UIS, notably loss of patient cooperation in subrogation suits and jury sympathy for plaintiffs; none is found to pose a substantial problem.

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** Lee S. Kreindler Professor of Law, Harvard Law School. Professor Rosenberg thanks the Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethcs at Harvard Law School for research support. The authors appreciate comments from Edward Morrison and other participants in the Conference on Medical Malpractice Liability at the University of Chicago Law School, participants in the Kreindler Chair Lecture at Harvard Law School, and Dennis Connolly, Benjamin Falit, Joni Hersch, Louis Kaplow, Allan Morrison, Jeffery O'Connell, Steven Shavell, Jenna Steinhauer, and Kip Viscusi. The authors also acknowledge the foundational contributions to the field of medical malpractice liability by Paul C. Weiler. This paper builds on his pathbreaking research and thought.

Improving Medical Malpractice Liability by Allowing Insurers to Take Charge

Introduction

The medical system is in a critical state and the regime of tort law that polices medical malpractice is partially to blame.[1] Medical malpractice liability should, of course, serve the principal social objectives of the legal system. In addition to the general goal of increasing the availability of insurance for medical needs, the law specifically aims to deter the malpractice of medicine. But despite decades of reform efforts, medical malpractice liability functions not merely to underserve these basic objectives but rather to undermine them.

Of course, the same can be said of tort liability generally. But while the tort system is dilatory, expensive, and risky, medical malpractice litigation is worse on all counts and more. The comparative dysfunction of medical malpractice liability makes it a prime candidate for restructuring, and the vital good at stake, medical care, makes that restructuring imperative. This paper develops a proposal for harnessing market forces to ameliorate these problems.

The problems with medical malpractice liability are well known and documented. All-in-all, medical malpractice claims account for 10 percent, nearly twice their proportionate share, of the more than $200 billion tort-related costs incurred annually by liability insurers.[2] This sum, of course, does not include other types of substantial social expense and burden, most significantly the costs of precautions against malpractice and of administering courts. It should be emphasized, though, that, with the exception of the

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[1] For general overview of the problems with the U.S. healthcare system, see **Charlene Harrington & Carroll L. Estes, Health Policy: Crisis and Reform in the U.S. Health Care Delivery System** (4th ed. 2004). On the role and difficulties of supplying accident insurance to fund the provision of healthcare and cover related economic needs arising from illness and injury, see Kenneth S. Abraham & Lance Liebman, Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury, 93 **Colum. L. Rev.** 75 (1993). How much medical malpractice liability contributes to these problems is a matter of heated debate in political and policy quarters, with critics of the tort system on both sides. One faction contends that there are too many frivolous claims and maverick jury verdicts, while the other responds that the majority of filed claims have merit but comprise only a small fraction of meritorious claims that could be but are never file. For a summary of the opposing positions, see Alex Stein, Fixing Medical Torts by Repositioning Inalienability and Contract, Cardozo Legal Studies Research Paper No. 151, available at http://ssrn.com/abstract=889474. Our analysis and proposal in this paper do not require resolving these disputes. We offer a simple, comprehensive, largely market-based approach that should improve the functioning of the system regardless of what the evidence suggests is the magnitude or source of the problems. Notably, our proposal not only accommodates most of the reforms proposed by others for the medical malpractice system, but also the reforms being considered for the healthcare system in general.

[2] See **Tort Trials and Verdicts in Large Counties**, **1992** (U.S. Dept. of Justice).

fixed costs of the administering the courts, all the expenditures incident to operating the medial malpractice system are ultimately borne by patients in the premiums and taxes they pay for the commercial and governmental first-party insurance that funds their medical care both before and after a medical accident.[3]

In short, the evidence suggests that the costs of medical malpractice liability overwhelm its benefits. As a mode of supplying or supplementing medical accident insurance, spending over $20 billion annually for delayed, incomplete, and overpriced "tort insurance" covering only medical malpractice injury borders on the perverse. While the tort system overall requires 22 months to resolve claims,[4] medical malpractice cases take 30 percent longer to close.[5] Trial occurs significantly more often in malpractice cases than is usual for most tort claims.[6] Indeed, medical malpractice litigation is particularly intense, both because the cases involve high damages, contentious issues of fact, and complicated questions of medical protocol and practice, and because the stakes for doctors include their social and professional reputations. Indicative of the hard-fought nature of these cases, plaintiffs succeed at trial only 23 percent of the time, compared to a 48 percent success rate generally.[7] For insurance purposes,[8] this loss rate translates into high variability in recoveries; many cases end without recovery and although settlement with positive payout resolves a large fraction of other claims, these recoveries are steeply

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[3] See Michelle M. Mello & Troyen A. Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 **Tex. L. Rev.** 1595, 1620 (2002) (noting that the costs of medical errors and presumably the costs of medical malpractice liability, including the premiums doctors pay for liability insurance, are borne by private, federal, and state providers of medical, disability, income, and other insurance). Patients also pay taxes that help finance the judicial system.

[4] See **Tillinghast-Towers Perrin, U.S. Tort Costs 2003 Update: Trends and Findings in the Cost of the U.S. Tort System**.

[5] See **Tort Trials and Verdicts in Large Counties**, supra note 2 (reporting 36 month gestation period for medical malpractice claims, versus a mean of 30 months and a median of 24.7 months for tort claims similarly resolved generally); see also David M. Studdert et al., Claims, Errors, and Compensation Payments in Medical Malpractice Litigation, 354 **N. Engl. J. Med.** 2024, 2031 (2006) (reporting five years as average elapsed time between medical injury and close of malpractice litigation).

[6] See id. (reporting that 6.4 percent of medical malpractice claims are disposed of by jury trial against a mean of 2.3 percent of all tort claims disposed of in that manner).

[7] See id.; see also **Thomas H. Cohen, U.S. Dept. of Justice, Bureau of Justice Statistics, Medical Malpractice Trials and Verdicts in Large Counties, 2001** (2004), available at http://www.ojp.usdoj.gov/bjs/pub/pdf/mmtvlc01.pdf (noting that 70 to 80 percent of malpractice cases are won by defendants). A recent study considering both settlement and trial suggests that although plaintiffs prevail in only 21 percent of trial verdicts, they gain positive payoffs in 61 percent of claims resolved out of court. See Studdert et al., supra note 5, at 2026, 2031 (noting also that one in six claims involving medical error received no payment).

[8] We will refer to the compensatory justification for malpractice liability in terms of "insurance" because patients necessarily pay the cost or "premium" for potential recovery of tort damages through the price or tax charged to supply medical services. As such, viewing tort damages as "insurance" best measures the welfare effects of medical malpractice liability on patients before and after a medical accident.

discounted to account for the defendant's likelihood of prevailing at trial.[9] In the end, only 46 percent of the expenditures by liability insurers go to plaintiffs, with the rest paying lawyers' fees, litigation costs and expenses, and liability insurers' overhead.[10] Yet, all this expense is for naught, as there is no demonstrated systematic failure in the supply of first-party insurance that would necessitate special "tort insurance" coverage for medical malpractice. Instead, the same first-party commercial and governmental insurance that paid for the patient's initial medical treatment that gave rise to malpractice usually covers the medical and other needs that arise from malpractice. Moreover, tort insurance, which patients cannot contract with physicians to reduce or avoid, mandates coverage not only for tort damages that duplicate coverage for economic loss already available from first-party insurers at less expense and risk, but also for non-pecuniary harm (e.g., "pain and suffering") that evidence shows no one wants if they have to pay for it.

Indeed, the system of medical malpractice liability performs worst in the area where society may need it the most, namely in deterring substandard medical care. It is estimated that approximately 3 percent of those receiving medical treatment suffer iatrogenic injury and roughly a third of those adverse incidents result from negligent care.[11] This small but potent risk each year results in tens of thousands of deaths and social costs of between $17 to $29 billion in expenses for acute-care, long-term care for the disabled, lost income, and other economic needs.[12] But the current medical malpractice system is particularly inadequate at promoting deterrence. The complexity of medical malpractice cases is largely responsible for its failings.[13] Malpractice cases are governed by rigorous standards of negligence, causation, and proof and liability often turns on determinations of complicated disputes over medical issues, benefit-cost calculations, and questions of public policy that entail employing various highly sophisticated and expensive analytic tools and experts and spending large amounts for discovery and trial.[14] These difficulties are even greater when the inquiry into whether

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[9] See Philip G. Peters, What We Know About Malpractice Settlements available at http://ssrn.com/abstract=891120 (reanalyzing data from various studies to confirm strong correlation between probability of malpractice injury and the value as well as rate of settlement).

[10] See **Cohen**, supra note 7 (providing breakdown for tort cases from 2001). Studies have shown that similar figures hold for medical malpractice. See, e.g., Studdert, et. al, supra note 5, at 2031 (finding from a review of a sample of medical malpractice claims that "the total costs of litigating the claims" was "54 percent of the compensation paid to plaintiffs").

[11] **Institute of Medicine, To Err is Human: Building a Safer Health System** 1, 34-35 (2000). But see Rodney A. Hayward & Timothy P. Hofer, Estimating Hospital Deaths Due to Medical Errors: Preventability Is in the Eye of the Reviewer, 286 **JAMA** 415, 419 (2001) (arguing that these figures are exaggerated).

[12] See Mello & Brennan, supra note 3, at 1620.

[13] For a description of other impediments to using the current system as an effective means of deterrence, see id.

[14] See Roger B. Dworkin, The Process Paradigm: Rethinking Medical Malpractice, 41 **Wake Forest L. Rev.** 509(2006) (discussing the complex and expert nature of questions and proof in malpractice cases).

malpractice occurred focuses at the systemic, institutional, and professional level on the protocols and technologies for controlling risk rather than on a particular physician's decisions and conduct.[15] As a result, cost constraints limit the production of the information necessary to resolve these cases, which, combined with a lack of judicial and jury expertise regarding medical technology, practice, and policy, predispose the process to error.[16] Additionally, cost and risk distort investment in litigation, pricing out meritorious claims and defenses. Studies confirm that most meritorious claims are rendered unmarketable to plaintiff's attorneys and never get filed.[17] And for those meritorious claims that are filed, plaintiff's attorneys are apt to settle claims for less than their merit may warrant when confronted by the superior scale, risk bearing, and other litigation powers of a major liability insurer.[18] Simultaneously, the high litigation costs can be expected to generate unmeritorious malpractice claims.[19] Although these claims are likely to be dismissed or lose at trial, physicians as well as their liability insurers may still prefer settling them on a nuisance-value basis, the insurers seeking to lower their defense costs and the physicians seeking to avoid having their professional character and

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[15] See Mello & Brennan, supra note 3 (arguing for changing the focus to systematic features of managing malpractice risk). On the importance of and also on impediments to taking a systematic perspective in evaluating the reasonableness of medical care, see, for example, Michelle M. Mello, Using Statistical Evidence to Prove the Malpractice Standard of Care: Bridging Legal, Clinical, and Statistical Thinking, 37 **Wake Forest L. Rev.** 821 (2002).

[16] Cf. Pegram v. Herdrich, 530 U.S. 211 (1999).

[17] See **Paul C. Weiler et al., A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation** 42, 70 (1993) (finding that relatively few actual cases of medical malpractice result in claims); see also, e.g., Tom Baker, Reconsidering the Harvard Medical Practice Study Conclusions about the Validity of Medical Malpractice Claims, available at http://papers.ssrn.com/paper.taf?abstract_id=724781 (synthesizing data from various studies to confirm that a small fraction meritorious malpractice claims are filed); Thomas B. Metzloff, Researching Litigation: The Medical Malpractice Example, **Law & Contemp. Probs.**, Autumn 1988, at 199, 204.

[18] See Peters, supra note 9 (describing various factors that enhance the litigation and bargaining power of liability insurers relative to plaintiffs and their attorneys in medical malpractice cases).

[19] See **Weiler et al.**, supra note 17, at 42, 70 (reporting that based on Harvard Medical Practice Study of case data from New York that over eighty percent of the claims filed are in fact meritless); Troyen A. Brennan et al., Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation, 335 **New Eng. J. Med.** 1963, 1964, 1966 (1996) (reporting positive settlement payoffs in forty percent of the meritless cases filed); see also Michelle J. White, The Value of Liability in Medical Malpractice, 13 **Health Aff.** 75, 78 (1994) (reviewing data from several studies and concluding that 2.6 percent of negligent injuries result in claims, as compared to only 1 percent of non-negligent injuries and 0.1 percent of noninjuries); Frederick W. Cheney et al., Standard of Care and Anesthesia Liability, 261 **JAMA** 1599, 1599-1603 (finding that 42 percent of meritless claims received payment); cf. Studdert, supra note 5, at 2028, 2029, 2031 (finding fertile conditions for nuisance value litigation, including that defendants expend over five times as much as plaintiffs in the litigation spawned by meritless claims, that meritless claims constitute between 13 and 16 percent of filed claims, and that 28 percent of meritless claims received payments, averaging 60 percent of the amount paid on meritorious claims). But see Baker, supra note 17 (pointing to methodological problems with Harvard Medical Practice Study regarding meritless claims and reporting data from various more recent studies finding that system sorts out meritless claims and pays only 10 to 16 percent of them.)

judgments publicly defamed by the plaintiff's attorneys and second-guessed by a lay judge and jury. Even when physicians are exonerated by the legal system, they rarely walk away from the process unscathed because the charges of malpractice trail after them. Physicians' concern about being sued is both real and substantial, leading to such rational if albeit socially detrimental responses as engaging in "defensive medicine" and abandoning liability-prone jurisdictions, specialties, and patients.[20]

Our proposal improves medical malpractice liability by restructuring the system to allow insurers to take charge over the process of litigating and resolving claims. Only a simple change in a single rule relating to insurance subrogation is required to implement the proposal.[21] The rule in question governs the extent to which first-party insurers – governmental as well as commercial – can acquire their insureds' potential tort claims.[22] Subrogation usually involves the insurer enforcing a contract or equitable lean against the plaintiff-insured's recovery of damages by judgment or settlement, but can also involve the insurer suing the defendant directly.[23] Generally, current law restricts insurance subrogation to the amount of benefits the insurer has paid its insured.[24] In particular, this

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[20] On the perceptions of the risk and consequences of malpractice suit, see Randall R. Bovbjerg et al., Defensive Medicine and Tort Reform: New Evidence in an Old Bottle, 21 **J. Health Pol. Pol'y & L.** 267, 268 (1996) (finding substantial problem of defensive medicine). Others argue that whatever its incidence in the past, defensive medicine is much less prevalent today in the era of managed care that pays doctors on a capitation basis. See Patricia M. Danzon, Liability for Medical Malpractice, in **1B Handbook of Health Economics** 1368, 1370 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

[21] See generally **Robert E. Keeton & Alan I. Widiss, Insurance Law** §3.10(a)(1) at 220 (1988) (discussing the law and workings of subrogation); see also **Kenneth S. Abraham, Insurance Law and Regulation: Cases and Materials**, 244-246, 404-407 (4th ed. 2005); **John Alan Appleman, 11 Insurance Law and Practice** § 6501, at 431 (West rev. ed. 1981) (outlining the conditions for accrual and legal enforcement of an insurer's subrogation interest). For an overview of the subject with direct relevance to the analysis that underlies our proposal, see Jeffrey A. Greenblatt, Insurance and Subrogation: When the Pie Isn't Big Enough, Who Eats Last?, 64 **U.Chi.L.Rev.** 1337 (1997).

[22] First-party insurance directly covers health, fire, disability, life, and other risks of accidental harm, and therefore includes coverage for medical accidents or iatrogenic injuries, whether or not they stem from malpractice. See **Kenneth S. Abraham, Distributing Risk: Insurance, Legal Theory, and Public Policy** 175 (1986) (explaining first-party insurance and liability insurance). For simplicity, references to first-party insurers and insurance will include coverage supplied by governments, commercial carriers, charities, and other sources of funding and support related to meeting individuals' medical, income, and other economic needs relating to the risk of accident, medical or otherwise. Also for convenience, reference to premiums includes taxes and other means, direct and indirect, of funding the supply of first-party insurance.

[23] See **Tom Baker, Insurance Law and Policy** 391 (2003).

[24] See, e.g., id.; Elaine M. Rinaldi, Apportionment of Recovery Between Insured and Insurer in a Subrogation Case, 29 **Tort & Ins. L.J.** (1994). In short, insurance subrogation is viewed as serving two related purposes, first, to enable insurers to obtain indemnity or reimbursement of their outlays to insureds and, second, to prevent insured-plaintiffs from reaping double recovery when courts apply the rule barring the reduction of damages for collateral source payments, such as those made by first-party insurers. See Spencer L. Kimball & Don A. Daqvis, The Extension of Insurance Subrogation, 60 **Mich. L. Rev.** 841 (1962). Thus, ignoring litigation costs, if the insurer pays benefits of $100 to its insured and the insured then recovers $200 in damages on a tort claim, the insurer can take $100 of that recovery by way of subrogation. Symmetrically, if the insurer sues directly on behalf of the insured for the whole claim and recovers $200, it keeps $100 and pays the balance to the insured.

rule of limited subrogation has great practical effect in personal injury claims, since first-party insurance usually only covers economic loss.[25] Thus, it precludes insurers from acquiring control over the portion of personal injury claims seeking non-pecuniary and punitive damages, which comprise one-half to two-thirds of the average malpractice recovery.[26] Our proposal is to remove this limitation on subrogation as applied to medical malpractice. Put affirmatively, we advocate authorizing insurers to acquire the entire medical malpractice claim of their insureds without regard to how much they paid the insured or may recover in tort.[27]

Replacing limited insurance subrogation (LIS) with unlimited insurance subrogation (UIS) should improve the insurance and deterrence results from medical malpractice liability, increasing both the availability of first-party insurance and the quality of medical care and, therefore, the welfare of patients. UIS will improve deterrence by increasing the rate at and effectiveness with which meritorious claims are prosecuted. By placing first-party insurers on the same footing as their defense-side counterparts, liability insurers, UIS will eliminate asymmetries in litigation power that presently distort plaintiff-side litigation incentives. The parity of large scale and long-term interest between first-party and liability insurers should also reduce meritless litigation, as the insurers will possess both the means of mutual deterrence and the motive for mutual cooperation. UIS would also improve insurance results by converting risky,

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[25] See W. Kip Viscusi, Pain and Suffering: Damages in Search of a Sounder Rationale, 1 **Mich. L. & Pol'y Rev.** 141 (1996) (explaining on theoretical and empirical grounds the insureds' demand for first-party insurance coverage of economic but not non-pecuniary harm).

[26] See **W. Kip Viscusi, Reforming Products Liability** 102-04 (1991) (reporting that pain-and-suffering comprises more than 50 percent of damages in tort claims); see also **Neil Vidmar, Medical Malpractice and the Tort System in Illinois: A Report to the Illinois State Bar Association** 66 tbl.5.1 (2005) (finding that two-thirds of medical malpractice awards in Illinois are non-pecuniary); Joni Hersh, Jeffrey O'Connell & W. Kip Viscusi, An Empirical Assessment of Early Offer Reform for Medical Malpractice (draft, U. Chi. Medical Malpractice Conference, May 19, 2006), at 15-16 (reporting figures for pain and suffering in medical malpractice ranging from 25 to 54 percent).

[27] In effect, then, our proposal advocates allowing insureds to assign their full tort claims to insurers, and thus we use "subrogation" as a stand in for "claim assignment." There is a large literature on claim assignment that generally supports removing restrictions on the purchase and sale of tort claims. See e.g., Michael B. Abramowicz, On the Alienability of Legal Claims, 114 **Yale L.J.** 697 (2005); Peter Charles Choharis, A Comprehensive Market Strategy for Tort Reform, 12 **Yale J. Regulation** 435 (1995); Robert Cooter, Towards a Market in Unmatured Tort Claims, 75 **Va. L. Rev.** 383 (1989); Robert Cooter & Steven Sugarman, A Regulated Market in Unmatured Tort Claims: Tort Reform by Contract, in **New Directions in Liability Law** 174 (W. Olsen ed. 1988); Marc Shukaitis, A Market in Personal Injury Tort Claims, 16 **J. Legal Stud.** 320 (1987); see also Stein, supra note 1. Without rehashing the arguments in favor of tort claim markets in general, we conclude, as further developed below, that use of the market to effect the assignment or other transfer of potential medical malpractice claims—that is, use of a so-called ex ante claims market—may best promote the social objectives of deterrence and insurance in this context. Our focus on first-party insurers as the buyer or other transferee of potential malpractice claims is natural, for, as we explain, they normally start from a superior position relative to potential competitors with regard to access to information, organizational capabilities and control, and economic scale and incentives. The argument and proposal presented in this paper therefore contains no categorical limit on who might enter and compete in the ex ante market for malpractice claims against first-party insurers and what other market arrangements, including secondary markets, might be employed.

expensive, and largely unwanted tort insurance into a greater amount of more optimal first-party insurance. First-party insurers would treat the expected recovery of full tort damages as a stream of income, like that they derive from the subrogation of limited tort damages presently and from other investments, and use it to offset their expenses. Just as they now do under LIS, but to much greater benefit, the insurers under UIS would pass-through these savings to their insureds in the form of lower premiums. Thus, UIS will reduce the cost of first-party insurance, which will expand its availability and make all patients better off. [28] These pass-through benefits will also nullify the compulsory charge for the unwanted "tort insurance" coverage of non-pecuniary harms without diluting the deterrent effect of such damages. In addition to these direct benefits, we also foresee that

[28] For a detailed description of how insurers pass-through costs to their insureds, see infra Part I. We proceed on the realistic assumption that market competition and insurance regulation generally motivate first-party insurers to pass-through the expected subrogated tort recoveries in the form of lower insurance premiums, although we note that the matter is not beyond dispute and no systematic study of the question exists. In support of our position, it is noteworthy that roughly 75 percent of subrogation recoveries occur in automobile property damage and workers' compensation cases, and it would be surprising if insurers did not pass-through and lower premiums based on expected tort recoveries given the competitive market conditions in both areas. See Richard Carris & Bill Bartlett, Benchmarking Claims Performance, 41 **Risk Mgmt.** 30 (1994) (confirming premium reduction effect in these and other areas of insurance, but criticizing insurers for not fully asserting their subrogation interests to the optimal extent). Also, the prevailing consensus among courts is that insurers adjust premiums according to the allowable scope of subrogation. See, e.g., Cutting v. Jerome Foods, Inc., 993 F.2d 1293 (7th Cir. 1993); Powell v. Blue Cross & Blue Shield of Alabama, 581 So.2d 772 (Ala.1990); Cutting Hospital Service Corp. of Rhode Island v. Pennsylvania Ins. Co., 227 A.2d 105 (R.I. 1967); Garrity v. Rural Mutual Insurance Company, 77 Wis. 2d 537, 542 (1977). Similarly, most of the commentary affirms the pass-through, lower premium effect of subrogation. See, e.g., **Abraham,** supra note 21, at 154; Greenblatt, supra note 21, at 1354-55 & n.74, 75, 78 (1997) (reporting various communications with insurance industry actuaries who report that insurers do indeed take subrogation into account); see also **Harry L. Sutton Jr. & Allen J. Sorbo, Actuarial Issues in the Fee-For-Service/Prepaid Medical Group** 45 (Ctr. for Research in Ambulatory healthcare Admin 2d ed. 1993) (noting that "an adjustment to estimated total HMO expenses … should … project the impact of … subrogation") (cited in Greenblatt, supra, at n.74); F. Joseph Du Bray, A Response to the Anti-Subrogation argument: What Really Emerged from Pandora's Box, 41 **S.D. L. Rev.** 264 (1996). The evidence we have gathered from insurance specialists supports pass-through and premium reduction as well. See E-mail from Dennis Connolly, Managing Director, Marsh Financial Services (Dec. 28, 2001) (confirming that subrogation is prominent in property and workers' compensation and insureds follow closely the insurers' pursuit of subrogated recoveries because it directly affects their premiums) (on file with authors). Some unpublished research supports the hypothesis as well. See Robert Klinck, Beyond Rhetoric: An Empirical Analysis of the Effect of Subrogation on Insurance Premia (unpublished manuscript) (on file with the authors) (conducting an empirical comparison of automobile insurance premiums in states with different subrogation rules and finding that rates were lower in regimes with more subrogation and that the cause is insurers passing-through their subrogation gains); Britta W. Jacobson, Empirical Research on the Benefits of Unlimited Insurance Subrogation for Optimal Insurance (unpublished manuscript) (confirming pass-through, reduced-premium effects of subrogation based interviews with managers of first-party insurers and risk-managers for workers' compensation programs) (on file with authors). However, several courts deny the pass-through, premium reduction effect. See Allstate Insurance Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978); Franklin v. Healthsource of Arkansas, 942 S.W.2d 837, 840 (Ark. 1997); Hare v. State, 1999 WL 145308, at *7 (Miss. 1999); Maxwell v. Allstate Insurance Co., 728 P.2d 812, 815 (Nev. 1986). These decisions rely on the assertion in **Edwin W. Patterson, Essentials of Insurance Law** 151 - 152 (2d ed. 1957) that: "Subrogation is a windfall to the insurer. It plays no part in the rate schedules (or only a minor one)…" Accord Roger M. Baron, Subrogation: A Pandora's Box Awaiting Closure, 41 **S.D. L. Rev.** 237 (1996).

UIS will encourage first-party and liability insurers to implement by contract a "private" system for resolving medical malpractice claims. Operated in (and perhaps feeding back to reshape) the shadow of medical malpractice liability, contractual arrangements will provide a more efficacious means of achieving the social goals for medical malpractice liability.[29]

The balance of this paper proceeds in four parts. Part I explains how UIS would work and compares its scope and operation to LIS. We use stylized examples to illustrate the functioning of these subrogation alternatives. Part II elaborates the failings of the current system of medical malpractice liability and explains how UIS will comprehensively restructure the system to correct its basic defects. Part III next analyzes the expected advantages from using UIS along three dimensions—insurance, deterrence, and administrative efficiency. It then considers the indirect benefits that may result from giving insurers the opportunity to take charge and redesign the system by contract. Finally, in Part IV we discuss concerns about the effects of UIS, focusing primarily on possible problems involving patient cooperation, jury behavior, and litigation management. We conclude that these concerns do not undermine the efficacy and utility of our proposal.

I. Medical Malpractice Litigation and First-Party Insurance Subrogation

This Part first describes the relevant features of the current medical malpractice system. We then analyze the differences between a regime of no insurance subrogation and a regime of unlimited subrogation. Finally, we consider the choice between the current regime of LIS and our proposal of UIS in the medical malpractice context. In these comparisons, we employ a stylized, numerical example to illustrate the salient

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[29] One of us has previously sketched a general proposal for UIS in published and unpublished work. See David Rosenberg, The Uncertainties of Assigned Shares Tort Compensation: What We Don't Know Can Hurt Us, 6 **Risk Analysis** 363 (1986); David Rosenberg, Of End Games and Openings in Mass Tort Cases: Lessons from a Special Master, 69 **B.U. L. Rev.** 695, 729 30 (1989); David Rosenberg, Deregulating Insurance Subrogation: Towards an Ex Ante Market in Tort Claims, Harvard Law School Public Law Research Paper No. 43, John M. Olin Center for Law, Economics and Business, Harvard Law School, Discussion Paper Series No. 395 (2002), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=350940. To our knowledge, the only previous published proposal for unlimited subrogation is Jeffery O'Connell's. See Jeffery O'Connell, Bargaining for Waivers of Third-Party Tort Claims: An Answer to Product Liability Woes for Employers and the Employees and Suppliers, 1976 **Ins. L.J.** 530; Jeffery O'Connell, The Interlocking Death and Rebirth of Contract and Tort, 75 **Mich. L. Rev.** 659 (1977). For related analysis on how a LIS regime should handle cases where first-party coverage is incomplete but where the tortfeasor cannot pay the judgment in full, see Greenblatt, supra note 21; and Alan O. Sykes, Subrogation and Insolvency, 30 **J. Legal Stud.** 383 (2001). Beyond offering a new, theoretically sound and practically workable remedy for many of the problems with the current system of medical malpractice liability, this paper makes more general contributions to two other relevant literatures. First, with regard to the literature explaining and proposing various regulatory means of meeting the need to decouple the deterrence and insurance functions of tort liability, the paper develops a simple, comprehensive, market-based mechanism for achieving that result without sacrificing either goal. Second, the paper provides a case-study of the social welfare benefits of allowing ex ante claims markets, in particular how such markets, catalyzed by UIS, can ameliorate pressing problems plaguing the current system of medical malpractice liability by allowing insurers, by means of contract, to take charge not only of litigating claims, but also of the process itself.

points. Our focus is on describing the mechanics of the current medical malpractice system and subrogation; thus, we defer until Part II a more detailed description of how precisely our proposal restructures the medical malpractice system and until Parts III and IV a fuller consideration of the benefits and costs of our proposal.

A. Overview of the Medical Malpractice System

1. Rules

Medical malpractice is a subset of tort liability that is predicated on negligence.[30] Although two decades of reform have created significant variations in the specifics of the causes of action across jurisdictions, the basic rules structuring malpractice liability and damages remain largely in place and uniform. Most relevantly to our analysis, these rules allow damages recovered in medical malpractice suits to exceed the amount necessary to replace economic losses—such as the costs of medical services or lost income. The excess may consist of non-pecuniary harm, such as "pain and suffering," and punitive or exemplary damages. Crucially, plaintiffs receive any "excess" damages.

2. Parties

Although the dominant image of medical malpractice liability is that of a patient qua plaintiff suing a physician qua defendant for damages, in fact the patient-plaintiff and physician-defendant are not the only or even the primary "parties" involved in medical malpractice litigation.[31] One obvious additional party is the plaintiff's attorney. This attorney will agree to represent the plaintiff only if the attorney expects a profitable return on his or her investment of time and money in the litigation.[32] The attorney's return is

[30] Medical malpractice liability is generally determined by application of a negligence rule, involving a more or less precisely worked out benefit-cost analysis. See **Paul Weiler, Medical Malpractice on Trial** 114 (1991) (arguing against this general approach and in favor of a no-fault system). For proposals to reorient the system toward strict liability for institutional defendants, see Kenneth S. Abraham & Paul C. Weiler, Enterprise Medical Liability and the Evolution of the American Health Care System, 108 **Harv. L. Rev.** 381 (1994) (arguing that hospitals or managed care organizations should be held vicariously liable for their physicians' negligence); Mello & Brennan, supra note 3 (arguing for a form of strict hospital liability, albeit with limitations on damages). On the application of strict liability as the governing standard for malpractice claims, see **Weiler**, id. at 114-58.

[31] Though reference is generally made to physicians as targets of medical malpractice liability, we mean to include not only all categories of medical and healthcare personnel, but also hospitals, managed care organizations, governmental agencies, and other institutions having control over the provision of medical services that might be sued or implicated financially by suit for malpractice.

[32] Remarkably, most plaintiffs' attorneys in malpractice cases are not specialists in the field, and very often lack substantial experience in handling such cases. Recoveries reflect the inexperience of plaintiff's attorneys versus the relatively more experienced lawyers hired by liability insurers to defend doctors. See Peters, supra note 9 (describing studies of the adequacy of representation for plaintiffs in malpractice litigation).

usually a contingent fee based on a percentage of the recovery plus expenses.[33] Another party is the defense lawyer who is usually paid an hourly fee plus expenses. A less obviously prominent participant is the liability insurer, who in the current system is typically the most powerful party on either side of the case.[34] Liability insurers generally issue medical malpractice policies that cover both prospective liability and defense costs,[35] and grant the insurer broad discretion to hire the defense attorney, settle or not settle the claim, and otherwise control the strategy and management of the defense side of the case.

Hardly noticed in this picture of medical malpractice is the role of the first-party insurer. This insurer's participation begins before the time that the individual who is now the plaintiff receives the medical treatment that gives rise to the risk of medical malpractice. The first-party insurer provides the individual with coverage against the risk of economic loss and need arising from adverse medical conditions. Importantly, this coverage includes harm that arises from injury caused by malpractice. In the same ex ante time frame, in which the first-party insurer provides coverage to the patient-to-be, the liability insurer issues its coverage to the physician. Thus, both the patient-to-be and physician simultaneously pay their respective insurers premiums in exchange for their respective types of coverage. But note that since the first-party insurer pays for medical care received by the patient from the physician, the first-party insurer effectively pays the insurance premium for the physician that is built into the cost of care.

3. First-Party Insurance Subrogation in General.

The law currently authorizes first-party insurers to acquire a subrogation interest in the insured's potential medical malpractice claim but generally limits that interest to the amount of benefits that the first-party insurer actually provides to the insured to cover economic loss and need that arises from adverse medical conditions resulting from malpractice. That is, the first-party insurer can only recover through subrogation what it pays or promises to payout for malpractice-related loss. Consistent with this reimbursement cap, the first-party insurer can acquire a contractual or equitable lien against the proceeds of any medical malpractice recovery its insured obtains by settlement or judgment in the tort system. Moreover, in the absence of a suit by the insured, subrogation allows the first-party insurer to assert a claim against the offending

[33] Generally, expenses are taxed against the plaintiff's recovery after subtracting the lawyer's percentage. Expenses can be quite high in medical malpractice because these complex cases often include outlays for medical tests and the preparation and deposition of experts in addition to more standard litigation expenses.

[34] On the prevalence and role of liability insurance, see Mello & Brennan, supra note 3 (noting that physicians are nearly universally insured against medical malpractice liability).

[35] These types of coverage are, of course, subject to deductibles and any other sorts of controls that the parties include in insurance contracts to deal with problems of moral hazard that arise because the insurer will not be able to perfectly monitor the precautionary behavior of their insureds. On the moral hazard problem generally, see Steven Shavell, On Moral Hazard and Insurance, 93 **Q. J. Econ.** 541 (1979); and Richard Zeckhauser, Medical Insurance: A Case Study of the Tradeoff between Risk-Spreading and Appropriate Incentives, 2 **J. Econ. Theory** 10 (1970).

physician to recover any amount it has paid out.[36] First-party insurers treat the anticipated recovery from subrogation as a stream of income and use it to cover a portion of their costs of providing coverage; insurers will thus pass any increases in their income from subrogation through to their insureds in the form of lower premiums (or outright rebates).[37]

B. Subrogation in the Medical Malpractice Context

Thus, the current medical malpractice system usually has some degree of insurance subrogation whereby the first-party insurer receives part of a patient's tort recovery.[38] And because this subrogation interest is limited to the amount of benefits that the first-party insurer has paid out, we naturally refer to this regime as "limited subrogation" (LIS). Our proposal, in contrast, involves what we refer to as "unlimited subrogation" (UIS). The subrogation under our proposal is "unlimited" because it authorizes first-party insurers to sue for and recover all of the patient's tort damages—including damages not only to cover economic loss and needs, but also to represent non-pecuniary harm and serve punitive purposes—regardless of how much the insurer actually pays out to the insured or how much the insurer recovers in tort. At the opposite extreme from our proposal is a world in which the insurer is not allowed to have any subrogation, a "no subrogation" regime. It will help in understanding the mechanics of UIS to begin by comparing it to its opposite, the no subrogation regime. We then extend this comparison by contrasting the current LIS regime to UIS. Note, that the discussion in this section is general and that a more detailed description of our proposal and assessments of it are provided in Parts II through IV.

Begin by comparing UIS and no subrogation. (For simplicity, in this Part we assume that the only losses from medical malpractice are economic in nature.[39]) Given

[36] When the insurer alone sues and recovers more than what it has paid out, it must hold the overage in trust for the benefit of its insured.

[37] For a description of how insurers pass-through expected subrogation recovery in the form of lower premiums, see Greenblatt, supra note 21. See generally **Steven Shavell, Economic Analysis of Accident Law**, 235-36 (1987) (discussing how insurance subrogation lowers insurance costs). Because of competitive market forces (or, if that fails, because of government regulation), insurers will pass this expected recovery through to the insureds in the form of lower premiums. The available evidence suggests that the pass-through benefits of subrogation have a meaningful effect on rates. See supra note 28.

[38] Despite the long-standing and prevalent use of subrogation by workers' compensation programs, judicial enforcement of subrogation by accident and health insurers is a relatively recent and as yet incomplete development. See, e.g., Cunningham v. Metropolitan Life Insurance Company, 121 Wis.2d 437 (1985) (holding that health insurance provided indemnification for loss and therefore was not an investment that triggered the ban on subrogation applicable to life insurance); FMC Corp. v. Holliday, 498 U.S. 52 (1990) (holding that ERISA pre-empted state anti-subrogation statute as applied to self-funded health benefit plans).

[39] We relax this assumption in Parts II and III when discussing how a major benefit of UIS is that it eliminates unwanted tort insurance for non-pecuniary losses. Consequently, the discussion in this Part understates the benefits of UIS by focusing only on economic damages. Nevertheless, even with this restrictive assumption, the social welfare gains from our proposal are clear.

the choice between UIS and no subrogation, individuals rationally will prefer first-party insurance policies that include subrogation to those with no subrogation. The reason is because subrogation avoids duplicative insurance coverage and the corresponding cost of paying double premiums. In the world without subrogation, the risk of loss from medical malpractice would be covered and, in the event it materialized, paid by two separate sources of insurance: first-party insurance and tort damages. For this double-coverage, patients would not only pay the premium for the first-party insurance, but also would pay a "tort premium" as part of the price doctors charge for medical services. This tort premium in principle covers the premium charged by the physician's liability insurer.[40] UIS enhances the welfare of patients by eliminating double coverage and premiums; under UIS, patients will receive coverage only from first-party insurance and hence pay only one premium.[41] While doctors will continue to charge tort premiums in their price for medical services, patients will no longer pay those premiums because insurers will offset this tort premium by reducing their premium for first-party coverage based on the income they anticipate receiving from tort recoveries.

Consider the following stylized example to illustrate what happens to individual welfare in a regime of no subrogation.[42] Imagine an individual with wealth of $100,000

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[40] In principle, of course, first-party insurance could be restricted to "non-tort" risks, thereby eliminating the overlap by requiring patients to look solely to tort for coverage of tort-related economic loss. It is doubtful, however, that any patient would prefer tort damages to first-party insurance for needed economic loss coverage, given the delay, risk, and expense of relying on tort damages for insurance. We have found no evidence of any such knowing, voluntary reliance. In our research, for example, we have not discovered any insurance contracts expressly or judicially interpreted as excluding tort-related injuries from coverage, nor have we seen any governmental program imposing such restrictions.

[41] This conclusion is driven by the standard assumption that the insureds are risk-averse and, consequently, that their marginal utility of money is diminishing. As such, they rationally prefer to shift money by means of accident insurance from a no-accident state, in which the marginal utility of money is low, to an accident state where the reverse is true, but only up to the point of equalizing the marginal utility of money in both states. See generally **Shavell,** supra note 37, at 228 . In contrast to the risk-neutral individual, who would regard the even-odds bet of purchasing double insurance with indifference, the risk-averse individual, whose utility increases less from winning more money with a probability than it decreases from losing less money with certainty, would refuse such a bet. Given a 10 percent chance of losing $100, the risk neutral individual would experience no welfare difference between paying or not paying a $20 premium for coverage of the $100 times 10 percent accident risk plus an extra $100 times 10 percent "windfall" payoff; either way the individual comes out even from an ex ante perspective. Essentially, the $10 extra premium amounts to a lottery ticket that has a net payoff of $90 ($100 minus $10) with a 10 percent probability. Forgoing the bet, the individual gains and loses nothing, with certainty. Despite greater risk, taking the bet – 90 percent chance of no accident and "losing" the $10 premium outright plus a 10 percent chance of accident and "winning" $90 – leaves the risk-neutral individual in exactly the same position of no change in expected welfare. The reason why a risk-averse individual would reject such a bet is shown simply by weighting the marginal premium dollars charged for the excess, double coverage more heavily than the marginal "windfall" dollar recovered in the event of accident. If the ratio were 2:1, then ex ante the individual faces the prospect of losing $18 (90 percent times $10 premium times two) if no accident occurs and winning only $9 if an accident occurs.

[42] To represent the insured's diminishing marginal utility of money, we equate the welfare derived from a given amount of money with the square root of that amount. The same incremental increase in wealth results in a smaller incremental increase in utility as wealth rises. Thus, if wealth increases from 0 to 1 to 4 to 9 to 16, utility rises, but at a decreasing marginal rate, from 0 to 1 to 2 to 3 to 4.

who buys an insurance policy that covers the risks of economic loss from accident. For purposes of illustration, we further assume that the insurer calculates the premium based on a 1 percent chance that the insured loses his or her total wealth due to medical malpractice and charges an actuarially fair premium of $1,000.[43] Finally, we assume that the individual can sue an errant physician in tort for $100,000 in damages; thus, expecting to bear this tort liability, the doctor buys liability insurance, paying and passing through to patients the actuarially fair "tort" premium of $1,000. Consequently, the individual pays total premiums of $2,000 for the double coverage of the malpractice risk provided by first-party and tort insurance. This double coverage means that in the event of medical malpractice, the individual receives $200,000 because each source of compensation fully replaces the $100,000 loss as if it were the sole source of compensation. The following chart summarizes the welfare implications of these assumptions:

	%	Starting Wealth	Loss	First-Party Premium	Tort Premium	First-Party Recovery	Tort Recovery	Total Wealth	Welfare
No injury	99%	$100,000	$0	$1,000	$1,000	$0	$0	$98,000	298.33
Malpractice	1%	$100,000	$100,000	$1,000	$1,000	$100,000	$100,000	$198,000	444.97

In total, then, the patient's expected welfare is 299.80.[44]

Now compare this situation to UIS. UIS negates the double coverage and corresponding premium because the first-party insurer treats the anticipated recovery from tort damages—which here is assumed to be equal to its economic loss payments to the insured—as income. The first-party insurer then applies this expected stream of income to offset its costs of providing insurance and passes-through these cost-savings to insureds in the form of lower premiums. Under our assumptions, the pass-through will exactly offset the tort premium of $1,000, and, therefore, the first-party insurer charges no premium to cover the insured's medical malpractice risk. Under this system, injured patients will only recover from the first-party insurer and will recover nothing from tort because the first-party insurer subrogates the entire tort recovery of $100,000. The following chart summarizes the welfare outcomes in a world with UIS:

	%	Starting Wealth	Loss	First-Party Premium	Tort Premium	First-Party Recovery	Tort Recovery	Total Wealth	Welfare
No injury	99%	$100,000	$0	$0	$1,000	$0	$0	$99,000	314.64
Malpractice	1%	$100,000	$100,000	$0	$1,000	$100,000	$0	$99,000	314.64

[43] This figure is simply $100,000 times 1 percent.

[44] This figure is simply the total weighted average of the utilities across the different states of the world. In this case, it is 298.33 times 99 percent plus 444.97 times 1 percent. Note that this result assumes that every instance of malpractice is litigated and that every case is won and for the full amount without any litigation costs. As described in Parts II and III once one takes into account the fact that first-party insurers will be more likely to invest in litigation and will be more efficient litigators than plaintiff's attorneys in the current system, the advantages of UIS are magnified from those demonstrated here.

In total, then, the patient's expected welfare is 314.64. This figure is higher than the 299.80 in expected welfare that results from no subrogation. The reason for this difference is the risk-aversion of individuals, which means that receiving the expected value of a tort claim in cash upfront with certainty (here in the form of lower premiums) enhances the individual's welfare more than taking the chance of getting double recovery.

C. Limited Subrogation in the Medical Malpractice Context

The previous section shows that insured patients would rationally prefer UIS to a regime of no subrogation. In reality, though, the medical malpractice system currently operates under a third system: limited subrogation. Now we show that, for basically the same reasons, patients would rationally prefer UIS to LIS.

Consider first how LIS works presently. The typical rule is that the first-party insurer can recover in subrogation no more than it paid out to the patient to cover the insured loss. Any tort recovery above that amount accrues to the patient. Thus, the patient first pays premiums to the insurer in exchange for coverage, the insurer then pays the patient for any covered loss, and the patient (or insurer) finally files a tort suit. The proceeds of this suit are allocated first to pay the fee and costs of the plaintiff's attorney and the balance is then divided between the insurer and patient, with the insurer taking a proportionate share allocated according to the fraction its insurance payment represents of the total recovery and the patient taking the remainder. As a result of this expected tort recovery, the insurer reduces the premiums the patient pays.

Now consider the stylized example from above to compare LIS to UIS. Again, for simplicity and to avoid considering non-pecuniary damages at this point, we assume that only economic loss is at stake and that the limiting principle (serving as a proxy for the difference in scope between first-party and tort insurance) is that insurers can only subrogate one-half of any tort recovery.[45] Thus, individuals under LIS end up paying a $500 premium to the first-party insurer. The reason is that the first-party insurer only expects to recover $500 in tort, half of the expected liability of $1,000. Moreover, under LIS, individuals expect to recover only $50,000 in tort when there is medical malpractice because first-party insurers subrogate the other half. The following chart shows how welfare differs in various states of the world with limited subrogation:

	%	Starting Wealth	Mal-practice Loss	First-Party Premium	Tort Premium	First-Party Recovery	Tort Recovery	Total Wealth	Welfare
No injury	99%	$100,000	$0	$500	$1,000	$0	$0	$98,500	313.85
Malpractice	1%	$100,000	$100,000	$500	$1,000	$100,000	$50,000	$148,500	385.36

[45] In reality, of course, how much the first-party insurer can subrogate with limited subrogation generally depends on how much the first-party insurer has paid out to the patient. But the conceptual principles of limited subrogation can be illustrated regardless of why the limitation exists.

In total, then, the expected utility is 314.56.

Recall from above the welfare calculations for UIS, which yielded total expected utility of 314.64. Unsurprisingly, this number is higher than the expected utility for LIS. The reason is that limited subrogation only partially nullifies the double tort coverage and thus only partially confers the benefits of the pass-through of expected tort recovery on patients. Because the first-party insurer under UIS receives the full tort recovery, it expects twice as much recovery from tort. Thus, the first-party insurer can reduce the premium it charges to individuals in all states of the world by $1,000 rather than by just $500. As a result, risk-averse patients are better off with UIS than with LIS because under UIS the total amount of excess tort coverage is converted from a risky prospect into an immediate and certain payout of its expected value in cash. This conversion of risky tort recoveries to certain expected value payouts represents a key benefit of subrogation and illustrates the principle that, for the risk averse, the more subrogation the better.

However, we emphasize that the pass-through, premium-reduction effect is not the only benefit of UIS. UIS also restructures the process of medical malpractice litigation to better promote the social objectives of increasing the availability of insurance and the effectiveness of civil liability as a means of deterrence, as Parts II and III describe in detail. These gains result from and alone justify adoption of UIS separate from the pass-through effect.

II. UIS and Restructuring Medical Malpractice Liability

We focus in this Part on two of the most troubling flaws in the current medical malpractice liability system. First we describe their nature and consequences for achieving deterrence and insurance objectives. Then we explain how UIS will restructure the system to eliminate these defects and enhance both deterrence and insurance results.

A. Structural Flaws in the Current System

Both flaws arise from the coupling of insurance and deterrence functions in civil actions that results from use of the standard rule governing damage awards. This rule specifies that damage awards (i) go totally and only to the plaintiff, (ii) include all tortious loss, and (iii) depend on a prior determination of the defendant's liability.[46] At first blush, this rule seems a sensible way of linking the needs for funding compensation to serve insurance goals and for finding claim enforcers to serve deterrence goals. But in operation, it creates two fissures in the system that undermine its capacity to promote

[46] This problem of coupling deterrence and insurance functions has been attributed to the civil action rule of "unitary judgment" that renders the imposition of liability dependent upon the distribution of damages. See David Rosenberg, Decoupling Deterrence and Compensation Functions in Mass Tort Class Actions for Future Loss, 88 **Va. L. Rev.** 1871 (2002).

either goal effectively, let alone optimally.[47] The first is the divergence between the award of damages that are optimal for insurance purposes and those that are optimal for deterrence purposes. This problem means that neither the goals of insurance nor the goals of deterrence can be achieved without necessarily sacrificing the other. The second is the divergence between the plaintiff's attorney's incentives to invest in litigation to maximize his or her return and the optimal investment incentives that would maximize the expected judgment. While this problem typically is attributed to a conflict between the agent-lawyer pursuing self-interest at the expense of the principal-client's interest for the optimal investment, in reality, both parties rationally prefer the optimal investment, but cannot effectuate their mutual interest. What stands in the way is the rule governing damage awards, which, by design or effect, implements the prohibition against tort claim assignment. As a result, plaintiffs and their lawyers generally resort to contingent percentage fee arrangements that fracture their returns from litigation and, given the attorney's truncated interest, preclude an optimal investment strategy.

1. Functionally Divergent Damage Awards

Optimal insurance generally requires paying the individual's loss fully, neither more nor less, while optimal deterrence generally requires the tortfeasor to internalize the tortious loss fully, neither more nor less.[48] Civil liability cannot promote both of these objectives—optimal deterrence and optimal insurance—simultaneously for the simple reason that the amount of damages that would be optimal for one objective is not necessarily optimal for the other. Any system that, like the current one for medical malpractice liability, ties the amount of recovery the plaintiff receives to the amount of damages the defendant pays out will be unable to serve both goals.

The difference in the amount of damages that is needed to serve insurance and deterrence goals means that the amount of damages that would promote optimal insurance will cause defendants to internalize too much or too little damages to serve optimal deterrence purposes or, vice-versa, that the amount of damages that is needed to motivate defendants to bear the social costs of their tortious behavior will lead to too little or too much payout to serve optimal insurance purposes. To take an extreme but real example, consider a plaintiff-patient who suffers a severe medical injury and yet there was no negligence in the defendant-doctor's provision of medical services. If the focus is deterrence and negligence is the governing standard of liability, serving that goal precludes imposing any damages on the defendant-doctor because the provision of medical services was non-negligent. But this outcome prevents the system from providing any compensation to the plaintiff-patient who, regardless of whether the doctor was negligent, has suffered a medical injury and needs tort damages as a form of supplemental insurance coverage for the loss.[49] Likewise, different approaches to

[47] We hasten to note that these defects are neither endemic to nor special problems for medical malpractice liability. Both operate to undermine social objectives of civil liability in personal injury cases generally. The following discussion of these defects references the leading literature on each.

[48] See generally **Steven Shavell, Foundations of Economic Analysis of Law** (2004).

[49] For the sake of illustrating the divergence point, we are assuming some systematic failure in the supply of first-party insurance and assuming a need for civil liability to fill the gap. In truth, this situation is highly

determining liability lead to the same problems. For example, imagine that medical malpractice were to adopt a strict liability regime that would be appropriate for insurance purposes. In this case, the payment of strict liability damages to compensate losses could pose a "moral hazard" problem of patients feigning injury, taking inadequate care to avoid injury, or engaging in overly risky behavior, thereby undermining deterrence as well as insurance objectives.[50]

Similar problems arise under the "collateral source rule," which holds that the plaintiff should be able to recover the full amount of damages suffered regardless of the extent to which first-party insurance paid for or covers that loss.[51] These awards may overcompensate plaintiffs, but they may serve deterrence goals because the threat of such liability induces defendants to internalize the damages resulting from their negligent conduct. These awards might also serve deterrence goals by encouraging plaintiff's attorneys to invest in litigation of claims they might otherwise regard as uneconomical. Thus, any attempt to cut back on the amount of the award so as to better serve insurance goals by preventing overcompensation of plaintiffs could dilute deterrence by failing to impose on defendants the total sanctionable loss of their tortious activities.

2. Fractional Return on Litigation Investment

The fractional return to which we refer results from the contingent percentage fee arrangements under which most plaintiff's attorneys receive remuneration for their services in medical malpractice cases. The problem is that this arrangement degrades the expected value of the plaintiff's claim and thus, on average, diminishes the deterrence and insurance value of the litigation. These adverse effects stem from two sources; only the first has been generally recognized.

First, because the plaintiff's attorney is promised only a fraction of the full recovery, he or she may lack sufficient incentives to invest optimally to maximize the total recovery.[52] Instead, attorneys will have incentive to invest to maximize the return on their investment of time and money. The failure to invest optimally in maximizing total recovery undermines deterrence and insurance goals.

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improbable, as we have described above, due to the availability of both first-party commercial insurance and various forms of government-provided insurance. Indeed, given the high costs of medical care, medical malpractice is unlikely to occur absent some form of insurance paying for the treatment.

[50] See, e.g., Sykes, supra note 29, at 384. This problem with strict liability is of course not unique to medical malpractice. See, e.g., John Prather Brown, Toward an Economic Theory of Liability, 2 **J. Legal Stud.** 323 (1973) (discussing problems with strict liability in joint care situations).

[51] See generally 22 **Am. Jur. 2d Damages** § 392 (discussing collateral source rule).

[52] For prior analyses of this problem of fractionalized return, characterizing it in terms of a conflict of interest between the principal (client) and agent (attorney), see, for example, Kevin M. Clermont & John D. Currivan, Improving on the Contingent Fee, 63 **Cornell L. Rev.** 529 (1978); James D. Dana, Jr. & Katherine E. Spier, 9 **J. L. Econ. & Org.** 213 (1993); Bruce Hay, Contingent Fees and Agency Costs, 25 **J. Leg. Stud.** 503 (1996); and Murray Schwartz & Daniel Mitchell, An Economic Analysis of the Contingent Fee in Personal-Injury Litigation, 22 **Stan. L. Rev.** 1125 (1970).

A simple numerical example illustrates this problem. Suppose a plaintiff's attorney prosecutes a civil damage claim worth $60,000 under a contingent fee arrangement that promises the attorney 25% of any recovery. The investment at issue here is the attorney's time, valued on the market at $200 per hour. Suppose that confronting the defendant with expected liability of more than $38,000 would lead it take optimal precautions that would totally avoid the risk of tortious accident. Finally, assume that the chance of success at trial and related payouts vary in the following way with the time the attorney spends on the case, generating the following expected payouts:[53]

Investment in Hours	Probability of Success at Trial	Expected Judgment for Plaintiff		Expected Attorney's Fee	Attorney's Hourly Return
		Gross	Net		
10	5%	$3,000	$2250	$750	$75
30	60%	$36,000	$27,000	$9,000	$300
50	70%	$42,000	$31,500	$10,500	$210

Although an investment of 50 hours maximizes the expected judgment and net recovery, a rational, profit-maximizing plaintiff's attorney would not make that investment. Instead, the attorney would choose to invest only 30 hours because that would maximize the attorney's expected return per hour at $300. But since liability of $38,000 is required to get the defendant to take optimal precautions and since the plaintiff has suffered $60,000 in injury, from the social perspective, the attorney's fractional investment serves neither the goals of optimal deterrence nor of optimal insurance.

Second, the detrimental consequences of the plaintiff's attorney's disincentive to invest optimally are compounded by the fact that defendant's incentives to invest in litigation reflect the total return from an effective defense rather than only a fraction of that value.[54] That is, defendants have greater incentives to invest in developing their side of the case than plaintiffs do in developing their side. In an adversarial process, the existence of an asymmetry in litigation investment incentives exacts social costs by skewing the outcomes in favor of the party with the greater litigation power, undermining the social objectives of optimal tort deterrence and insurance.[55]

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[53] For purposes of illustration, we put aside other litigation investments and costs and consider the plaintiff's attorney's investment from a purely unilateral perspective, ignoring the bilateral reality of the defense investment and adjustments each side makes in light of the investment strategy it expects the other to pursue. We consider a rudimentary example of these bilateral effects next.

[54] See David Rosenberg, The Causal Connection in Mass Exposure Cases: A "Public Law" Vision of the Tort System, 97 **Harv. L. Rev.** 849, 904 (1984) (explaining the litigation investment advantage of defendants as owners of the total defense return over plaintiffs' attorneys working for a contingent percentage fee); see also David Rosenberg, Mass Tort Class Actions: What Defendants Have and Plaintiffs Don't, 37 **Harv. J. on Legis.** 393 (2000) (discussing why economies of scale and other aggregative efficiencies matter in the litigation process and demonstrating how defendants have an advantage in these areas).

[55] This asymmetry might help explain the previously noted finding that plaintiffs win in medical malpractice cases less often than they do in other tort cases.

This systemic biasing effect is illustrated by assuming that in the foregoing example the defendant has the same investment options as the plaintiff's attorney. Assuming that the plaintiff's attorney continues to invest 30 hours and ignoring any dynamic effects, the payoffs from the litigation now look as follows:

Investment in Hours	Probability of Success for Defense[56]	Expected Judgment	Net Marginal Return[57]
10	42%	$34,800	$1200 (=$36,000 - $34,800)
30	50%	$30,000	$6000 (=$36,000 - $30,000)
50	60%	$24,000	$12,000 (=$36,000 - $24,000)

Clearly then, the defendant will invest 50 hours, since that investment maximizes the net return in total avoided damages. Thus, the combination of a sub-optimal investment of 30 hours by the plaintiff's attorney and optimal investment of 50 hours by the defendant drives down the expected judgment from $36,000 to $24,000 and the plaintiff's net recovery from $27,000 to $18,000.[58] Note that under none of the investment scenarios would the expected judgment result in optimal deterrence.

B. Structural Changes Effected by UIS

The two basic structural defects outlined above bollix the workings and undermine the social utility of medical malpractice liability. Adoption of UIS restructures the medical malpractice system to eliminate both defects. It addresses these problems simultaneously by creating an efficient mode of claim assignment that allows the parties to change the rule governing damage awards. Under UIS the patients can effect the decoupling of liability determination from damage distribution through a simple transfer of potential medical malpractice claims to first-party insurers. This transfer at once aligns damage awards with deterrence objectives by motivating insurers to serve as law enforcers and with insurance objectives by converting tort insurance into more optimal first-party coverage. At the same time, the claim transfer consolidates the total return from litigation investment in one party, the first-party insurer, so that patients as well as

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[56] The example is constructed so that the plaintiff's attorney would invest 30 hours no matter what level of investment the defendant chooses. We therefore assume that if the defendant does not undertake a defense, the plaintiff's probability of success at trial from an investment of 30 hours is 60 percent.

[57] Net marginal return represents the marginal reduction in plaintiff's expected recovery (assumed and held constant at $36,000 from investment of 30 hours) from each additional input of litigation investment. Valuing the time input on the defense side at the same $200 per hour rate as that for the plaintiff's attorney, the net marginal return per unit of investment at 10 hours equals $120 per hour, at 30 hours equals $200 per hour, and at 50 hours equals $240 per hour. The last is clearly optimal for the defense.

[58] This figure is the difference in the plaintiff's recovery with a 60 percent chance of winning were the plaintiff's attorney to invest 30 hours unilaterally (as previously assumed) and the plaintiff's recovery with only a 40 percent chance of winning if the defense attorney invests 50 hours, subtracting the expected attorney's fees. The math is: (.6*$60,000 – .25*$36,000) – (.40*$60,000 – .25*$24,000).

insurers can reap the benefits from the optimal litigation investment that maximizes the expected judgment. Note again that no complicated processes are necessary to solve these problems; all that is required is a minor change in the governing law of subrogation to allow insurers to obtain a full rather than just a limited interest in their insured's claim.

1. Decoupling Liability Determination from Damage Distribution

UIS eliminates this problematic tie between the determination of liability and the distribution of damages by authorizing first-party insurers to prosecute the entire medical malpractice claim and to recover total damages, regardless of amount or type. It thus effectively decouples the determination of liability, including the resulting assessment of damages, from the award of damages. Under UIS, there is no necessary connection between the amount recovered by settlement or judgment on a medical malpractice claim and the amount the patient-plaintiff receives in insurance benefits. UIS replaces the lockstep relationship between the deterrence and insurance results of liability with a system that enables courts to pursue each objective separately and, as we show in Part III, more effectively. Notably, courts can attach priority to optimal deterrence objectives without concern that damage awards either must undermine the incentives of patients to take precautions or must disserve insurance needs.[59] Thus, UIS converts defective tort insurance into more optimal first-party insurance for the risk of medical accidents.

And because UIS pays the deterrence-driven damage awards to first-party insurers, it does not distort patient-plaintiff incentives, even though it passes through the expected value of these benefits to insureds in the form of reduced premiums. Since patients receive lower premiums automatically, the pass-through benefit does not affect their incentives to take precautions in, for example, comparison-shopping among competing medical services based on differences in malpractice risk and related prices. Thus, the role of price differences in signaling relatively risky healthcare providers, procedures, and specialties remain intact under UIS.

2. Consolidation of Return on Litigation Investment

UIS enables the first-party insurer to take complete, exclusive control over the prosecution of and, most relevantly here, the prospective recovery of total damages from a medical malpractice claim. Under UIS, the first-party insurer at once replaces the conflict-ridden conglomerate that presently comprises the plaintiff's side in a medical malpractice case. Moreover, this insurer will have comparable litigation scale and scope advantages to those presently possessed by the defendant's liability insurer. Thus, by consolidating the return from the litigation investment in the hands of the first-party

[59] On the normative argument for giving priority to optimal deterrence that avoids unreasonable risk rather than to optimal insurance that would cover such risk, see David Rosenberg, Mandatory-Litigation Class Action: The Only Option for Mass Torts, 115 **Harv. L. Rev.** 831 (2002); see also Rosenberg, The Causal Connection, supra note 54 at 877 (describing how optimal deterrence preventing injuries improves individual welfare such that individuals ex ante prefer regimes that promote optimal deterrence over those that provide optimal insurance of unreasonable risk); sources cited infra in note 96 (advocating reforms of the tort system that decouple its functions and allow it to focus on deterrence goals).

insurer, UIS solves both of the problems created by fractional return.

First, by consolidating the return, UIS motivates the first-party insurer to invest at the optimal level that promises to maximize the expected judgment value of the claim. Thus, using numbers from the previous example, the first-party insurer would have a 100 percent stake in the return on investment instead of a fractional 25 percent interest. Because of this 100 percent stake, the first-party insurer would find it worthwhile to undertake the 50 hours of work that would maximize the expected judgment value of the claim, which would lead to superior deterrence and insurance outcomes compared to those achieved from the 30 hours of investment that a plaintiff's attorney working on a contingent percentage fee would have been willing to make.

Second, UIS eliminates the asymmetry in investment incentives that prevails in the present system and that systematically biases the outcomes of the tort system in favor of defendant-doctors represented by liability insurers and thus undermines the pursuit of insurance and deterrence objectives. UIS confers opportunities for first-party insurers to exploit the investment advantages of litigation scale and scope previously available only to the liability insurer. To illustrate, suppose that, in the above example, by investing 50 hours, the plaintiff's side could raise the probability of success at trial from 40 percent to 65 percent, given defendant's counter investment of 50 hours. In contrast to the plaintiff's attorney constrained by a 25 percent return on investment, the first-party insurer would find it worthwhile to make the marginal investment of $4,000 in added time because that produces a marginal expected return of $15,000.[60] Importantly, this investment helps achieve both optimal deterrence and insurance goals, since now expected liability equals $39,000, which suffices to induce the doctor to take precautions to avoid the risk of malpractice, and which, as passed through by the first-party insurer in the form of lower premiums, translates into a larger amount of the more efficacious first-party variety of insurance coverage for insureds.

III. Social Benefits from Adopting UIS

Having explained how UIS would restructure medical malpractice liability, we now turn to elaborating the expected social benefits from the restructured system. We evaluate the benefits of UIS for promoting the effective management of medical accident risk along three dimensions: insurance, deterrence, and administrative efficiency. We first examine the direct benefits from the anticipated behavior of first-party insurers, projecting their rational response to the new opportunities that UIS creates for assuming control over medical malpractice claims. We then go on to consider the benefits flowing more indirectly from the adoption of UIS, the most propitious of which are likely to emerge from first-party and liability insurers together exploiting the new market conditions to establish improvements by contract, possibly including "privatization" of much of the medical malpractice system.

A. Direct Benefits

[60] The math here is 65 percent times $60,000 or $39,000 minus 40 percent times $60,000 or $24,000.

The prevailing justification for medical malpractice liability is that it compensates medically injured patients, with deterrence usually mentioned in passing or not at all.[61] Although this ordering of functions is the reverse of what we think it should be, it is evident that the current system fails to promote either goal effectively.[62] Here, we first show why UIS better achieves these two objectives than does the current system. We then go on to show that UIS improves administrative efficiency.

1. Insurance

Almost by definition, anyone who claims to be a victim of medical malpractice has first-party insurance coverage because suffering from malpractice is contingent upon receiving medical care in the first place and almost no one receives medical treatment unless insurance pays for it, one way or another. Commercial carriers provide much of this insurance, but a significant amount of coverage today is supplied through programs, often mandatory, that are administered or funded by federal and state governments. These programs range from ad hoc, emergency room services to categorical coverage provided by workers compensation, Social Security Disability Insurance, and VA hospitals to the general coverage supplied through Medicare and Medicaid.[63] We are not suggesting that this system of commercial and government insurance provides adequate, let alone optimal coverage. Rather, our point is merely that everyone has insurance coverage for medical care, including needs arising from medical accident, and that in paying for this insurance everyone necessarily bears the costs of medical malpractice liability in higher premiums and taxes.[64] Most importantly for our purposes here, these charges for commercial and governmental insurance include a component that essentially funds the use of medical malpractice liability as a supplementary form of "insurance" to cover economic injury arising from tortious provision of medical care. The pertinent question then is whether adoption of UIS would improve the provision of insurance coverage overall for patients relative to the current system of medical malpractice liability.[65]

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[61] See, e.g., McDougald v. Garber, 536 N.E.2d 372 (N.Y. 1989). For recent work asserting that the primacy of role of medical malpractice liability is compensation, see, for example, Dworkin, supra note 14. See generally Marc Feldman, The Intellectual Ordering of Contemporary Tort Law, 51 **Md. L. Rev.** 980, 1009 (1992) (arguing that the first priority of tort law is compensation).

[62] For an argument consistent with our view of the priority for deterrence, see, Mello & Brennan, supra note 3.

[63] Also included within our conception of "insurance" are medical services provided or funded by charitable organizations, such as the Red Cross. This conception reflects the reality of an individual being covered by a multiplicity of first-party insurers.

[64] Some might argue that this form of insurance is effectively free for low-income individuals who do not pay taxes or premiums and rely on social insurance for access to medical care. However, the fact that society bears the expense of providing tort-based medical malpractice insurance for low-income patients only means those low-income individuals have paid the opportunity cost for the prospect of recovering tort damages by forgoing welfare benefits from some other wealth or in-kind benefit transfer.

[65] On the deficiencies and costs of tort versus first-party insurance, see, for example, **Don Dewees et al., Exploring the Domain of Accident Law: Taking the Facts Seriously** (1996).

The answer is undoubtedly "yes." As a compulsory, non-waivable source of medical accident coverage, medical malpractice liability fails; indeed, it undermines optimal insurance goals for two basic reasons. [66] First, despite its enormous expense relative to other forms of governmentally supplied insurance, medical malpractice liability promises less than optimal, full economic loss coverage.[67] Even including potential payouts of non-pecuniary damages, the average expected recovery will likely fall short of replacing economic loss after deducting attorney's fees and litigation costs and discounting for the probability of losing at trial. Notwithstanding the high rate of settlement, medical malpractice liability involves a high variance in recovery, as viewed from the ex ante perspective, given that most meritorious claims are forgone, courts dismiss a substantial fraction of litigated claims, and of course the payoff is discounted for the chance of losing at trial. Certainly, no one confronting the possibility of a pressing need for medical care would rely on accident insurance that delayed its payouts for months or years; in light of these defects in tort insurance, it is therefore not surprising that cheaper, speedier, and less risky commercial and government first-party insurance represents the universal source of primary coverage. In short, on the most basic level, by charging patients over a dollar to deliver each dollar of deficient, delayed, unnecessary, and to a large degree unwanted medical malpractice coverage, the current system mocks the concept of optimal insurance.

Second, medical malpractice liability, like tort liability generally, awards damages unrelated to economic loss, such as damages for non-pecuniary harms. These damages are estimated to comprise one-half to two-thirds of the average damage award in medical malpractice, and, of course, patients pay the cost of receiving this type of "insurance" in the form of higher first-party premiums and taxes. But by forcing patients to pay for this non-economic medical malpractice tort recovery, the current system reduces patient welfare not just because the tort system is a less efficient provider of insurance but more simply because evidently individuals do not need or cannot afford such coverage. Overwhelming evidence shows that there is insufficient buyer demand for non-pecuniary coverage for either the market or government to supply it.[68] The absence of political as

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[66] See **Shavell,** supra note 37, at 186-99.

[67] See, e.g., 1 **American Law Institute, Enterprise Responsibility for Personal Injury: Reporters' Study** 30 (Philadelphia, 1991) (tort insurance more expensive than first-party insurance); Louis Kaplow & Steven Shavell, Fairness Versus Welfare, 114 **Harv. L. Rev.** 961, 1078 n.253 (2001) ("[C]ompensation through the tort system may cost on the order of one dollar for every dollar received by victims, whereas the cost per dollar of compensation from insurance companies is far less, often in the range of ten to twenty cents."); see also David A. Hyman & Charles Silver, The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?, 90 **Cornell L. Rev.** 893, 981 (2005) ("[T]he transaction costs of the tort system are high compared to first-party insurance coverage. For every dollar that reaches an injured patient as a result of a tort claim, another dollar or so is reportedly spent getting it there."); Studdert, supra note 9 ("In monetary terms, the [medical malpractice] system's overhead costs are exorbitant. The combination of defense costs and standard contingency fees … brought the total costs of litigating the claims in our sample to 54 percent of the compensation paid to plaintiffs.").

[68] There is evidence that insureds, if given the opportunity, willingly exchange the chance for winning non-pecuniary damages in tort for lower priced insurance. See e.g., Stephanie Owings-Edwards, Choice Automobile Insurance: The Experience of Kentucky, New Jersey, and Pennsylvania, 23 **J. Insurance Reg.**

well as market demand for non-pecuniary harm insurance reflects both the fact that suffering non-pecuniary harm frequently does not increase the marginal utility of money and that to supply such coverage would probably raise prices prohibitively.[69]

UIS solves both of these problems. In doing so it greatly enhances patients' welfare by freeing them from the current compulsory, defective insurance provided by

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25 (2004) (noting that 90 percent of New Jersey drivers opt-out of non-economic damages in exchange for lower priced insurance). The general absence of market demand for non-pecuniary harm coverage reveals individuals' preference against such coverage in tort. See **Shavell**, supra note 37, at 230-31 (1987); John E. Calfee & Paul H. Rubin, Some Implications of Damage Payments for Nonpecuniary Losses, 21 **J. Legal Stud.** 371, 371-75 (1992); Daniel A. Graham & Ellen R. Peirce, Contingent Damages for Products Liability, 13 **J. Legal Stud.** 441, 446-48 & n.11 (1984) (noting that the risk-averse individual would not choose to insure fully the personal value of irreplaceable losses). For a thorough analysis of the reasons and evidence for the failure of not only the market but also the government to supply non-pecuniary harm coverage, see Kip Viscusi, Pain and Suffering: Damages in Search of a Sounder Rationale, 1 **Mich. L. & Pol'y Rev.** 141 (1996).

[69] Some commentators, however, question whether the market accurately reflects insureds' preference for non-pecuniary harm insurance, asserting that the dearth of coverage stems from adverse selection problems due to the difficulties insurers face in classifying insureds by their relative risk of incurring non-pecuniary harm and charging them premiums accordingly for coverage. See, e.g., Steven P. Croley & Jon D. Hanson, The Nonpecuniary Costs of Accidents: Pain-and-Suffering Damages in Tort Law, 108 **Harv. L. Rev.** 1785, 1802-03, 1848-51 (1995); Alan Schwartz, Symposium on the Law and Economics of Bargaining: Commentary on "Towards a Market in Unmatured Tort Claims: A Long Way Yet to Go, 75 **Va. L. Rev.** 423 (1989). That argument, however, does not explain the absence of "political" demand for non-pecuniary harm coverage from government-supplied accident insurance, which presumably would not suffer from an adverse selection problem. It could be that individuals, ex ante, fail to appreciate the potential for non-pecuniary harm from accident, but the evidence suggests the contrary. Indeed, people routinely take account of this dimension of loss in choosing what and how much risk to undertake, evincing a rational ex ante preference not for insuring, but rather for cashing-out and reducing the risk of non-pecuniary harm. Significantly, in contrast to the evident lack of employee demand for non-pecuniary harm coverage from workers' compensation, employer sponsored health and accident insurance, and Social Security, there is substantial evidence that employees take account of the prospect of incurring non-pecuniary harm in their demands for wage premiums for bearing risk as well as in the amounts they are willing to pay for increasing safety. See **W. Kip Viscusi, Rational Risk Policy** (1998).

Moreover, there is good reason to doubt that the market defect explanation holds for commercial accident insurance. To meet any actual demand for non-pecuniary harm coverage, insurers can simply sell additional units of such coverage pegged to the existing, unproblematic coverage for pecuniary loss generally. See David Rosenberg, Individual Justice and Collectivizing Risk-Based Claims in Mass-Exposure Cases, 71 **N.Y.U. L. Rev.** 210, 226-27 (1996); Telephone Interview with Dennis Connolly, Managing Director, Marsh Financial Services (Aug. 13, 2001) (confirming the lack of demand for non-pecuniary harm insurance and, putting aside moral hazard problems, the practicality of supplying such insurance through additional units of coverage priced and paid for on the basis of related pecuniary harm coverage). For insureds less certain about the likelihood and extent of their need for non-pecuniary harm insurance, the market could also supply more refined coverage. For example, insurers could adopt a workers' compensation type schedule of injuries and offer insureds the choice of whether and how much non-pecuniary coverage to buy for each type of injury. To deal with the moral hazard problem, first-party insures could adopt tort-like rules and processes, such as those used to determine contributory or comparative negligence. Nothing in principle, and, with one exception, in practice would prevent the insurers from replicating the tort system in full in providing non-pecuniary coverage. The one exception is that in contrast to what courts do in supplying such coverage, the market could not force people to pay for it.

medical malpractice liability and replacing it with more optimal insurance from standard suppliers of first-party coverage. The manifold insurance benefits of UIS result directly from its restructuring of medical malpractice liability.

First, by decoupling the determination of liability from the distribution of damages, UIS converts deficient medical malpractice "insurance" coverage into more optimal first-party coverage. This conversion occurs because first-party insurers treat the anticipated recoveries of full medical malpractice damages as a stream of revenue that lowers the cost of supplying their coverage and pass these savings on to insureds in the form of lower premiums. Because their first-party premiums are lower, patients will thus benefit from an increase in the availability of first-party insurance, the most reliable, most comprehensive, most expeditious, and cheapest form of insurance coverage available. Assuming that individuals actually need more insurance than they currently have,[70] the lower price resulting from UIS means that insurance coverage will expand. Moreover, the decoupling effected by UIS eliminates the unnecessary duplication of functions that exists with the current system of double coverage and fits with the fact that patients do, as they must, rely first and foremost on first-party insurance even now.

Second, UIS eliminates the forced purchase of medical malpractice insurance for non-pecuniary harm. In passing through the expected recovery of non-pecuniary damages in the form of lower premiums for first-party insurance, first-party insurers negate the cost to patients of paying the medical malpractice tort premium for non-pecuniary harm coverage when those patients purchase medical services. To be clear, under UIS physicians will still charge patients or, more accurately, their first-party insurers a price for medical services that includes the expected costs of medical malpractice liability for full tort damages, non-pecuniary as well as economic. But patients will not actually bear the cost of the first-party premiums relating to the non-pecuniary component of that tort insurance charge. The reason is that this charge is fully offset by the recovery of non-pecuniary damages that the first-party insurer anticipates receiving from its subrogated tort recoveries and passes through to their insureds. Risk-averse individuals benefit because the UIS pass-through cashes out the physician's charge immediately with certainty. UIS improves their welfare relative to the current system, which compels patients to pay upfront for non-pecuniary tort coverage and that gives them only a lottery ticket chance of winning a tort suit and recovering damages if they suffer medical malpractice.[71]

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[70] See Sykes, supra note 29 (considering allocation of recovery where tortfeasor is insolvent and where plaintiff has not received full recovery from any insurance source).

[71] A simple example illustrates the point. Suppose an individual with wealth of $50,000 confronts a 10 percent chance of losing a leg, in which case the individual will suffer economic loss of $5,000 and non-pecuniary harm of 500 in lost welfare. Assuming the individual's marginal utility from money is not affected by suffering the non-pecuniary harm, compare the individual's total expected welfare under two regimes: Regime I insures only economic loss for a $500 premium; Regime II insures both economic and non-pecuniary loss for $25,500 (calculated as 10 percent times $50,000 economic loss plus 10 percent times $500 squared (representing the non-pecuniary loss of 500 in welfare)). The individual's total expected welfare of 717.49 under Regime I (which is 90 percent times 772.49 welfare from $49,500 plus 500 welfare from the leg in the no accident state plus 10 percent times 222.49 from $49,500 in the accident state) plainly exceeds the total expected welfare of 644.56 under Regime II (which is 90 percent times

Third, as described above, by allowing first-party insurers to consolidate the full return from investing in the prosecution of medical malpractice claims, UIS overcomes the fractional return defect in the system that leads to deficient investment by the plaintiff's attorney and that generates the asymmetric litigation advantage for defendants and their liability insurers in the current system. UIS's restructuring provides first-party insurers with the economic return needed to motivate them to make the optimal investment that will maximize the expected judgment from medical malpractice claims.[72] By maximizing this expected judgment, first-party insurers have greater expected revenues and will be able to pass-through larger amounts to patients, which again will lead to more and cheaper first-party insurance with its accompanying social benefits.

2. Deterrence

The deterrence objective is the major casualty of the current medical malpractice regime.[73] Indeed, a large fraction of malpractice events escape detection or go unreported. Physicians rarely provide information of their own or their colleagues' negligence, much less advise legal recourse to patients.[74] For their part, patients are often too preoccupied with their medical problems or worried about accusing and antagonizing their medical benefactors to consider bringing suit, and patients are often ill-informed about the options for legal recourse concerning medical malpractice. Moreover, as discussed above, high litigation cost, risk, and fractional investment incentives suppress the filing, let alone the vigorous prosecution, of meritorious claims. Magnifying this

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656.52 from $24,500 plus 500 welfare from the leg in the no accident state plus 10 percent times 523.93 from $274,500 in the accident state).

[72] It should also tighten any slack in incentives to pursue subrogation claims that presently exists under LIS.

[73] See, e.g., Studdert et al., supra note 5, at 286 ("[T]he evidence that the [malpractice] system deters medical negligence can be characterized as limited at best.").

[74] One attempt to solve this problem of physicians not reporting medical errors is the SorryWorks program that involves physicians reporting their mistakes and with their insurers sitting down with patients to explain what has occurred, to apologize, and to provide prompt compensation to cover the immediate expenses of the injured patients. The rationale is that prompt reporting and apology will reduce the number of lawsuits, thereby motivating greater disclosure and, presumably, precautions by physicians. See http://www.sorryworks.net; see also, e.g., Virgil Van Dusen & Alan Spies, Professional Apology: Dilemma or Opportunity?, 67(4) **Am. J. Pharmaceutical Education** 3 (2003). On the potential effectiveness of self-disclosure systems, see, for example, Charles Vincent et al., Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action, 343 **Lancet** 1609, 1612 (1994) (study of British patients and families finding 37 percent may not have brought malpractice suits had there been a full explanation and apology, more significant factors than monetary compensation). See also Jonathan R. Cohen, Advising Clients to Apologize, 72 **S. Cal. L. Rev.** 1009, 1011 n.7 (1999) (citing sources on this point). However, in conflating deterrence and compensation (and apology), such schemes risk failing the former objective. Optimal deterrence does not necessarily follow from an apology and payment of some money leading an injured patient to forgo suit: it depends on whether the doctor internalizes the costs of accident in sufficient degree to motivate the taking of reasonable precautions, not on whether a patient feels like forgoing suit from a genuine or merely palliated belief that the wrong has been righted. In any event, UIS fully accommodates programs such as SorryWorks if they are ultimately desirable
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problem is the superior litigation power wielded by liability insurers on the defense side. The resulting asymmetry in investment incentives, scale, and risk-bearing favoring defendants over plaintiffs and plaintiffs' attorneys will skew litigation outcomes on average in favor of defendants and thus will lead to underdeterrence.

High litigation cost also generates a force pushing toward overdeterrence. For despite defendants' litigation advantage, they apparently often prefer settling unmeritorious medical malpractice claims for their nuisance value rather than investing more to have the claims dismissed by courts or abandoned by plaintiffs. The threat of meritless suit combined with the public accusations, second-guessing, and potential for erroneous decisions by lay judges and jurors puts physicians in fear for their reputations as well as their finances.[75] The response of physicians is perverse if predicable, including flight from high liability jurisdictions, sub-specialties, and patients or even, in extreme cases, the profession itself; resort to "defensive medicine"; and the use of judgment-proofing strategies, such as "going bare" and shielding and concealing assets.[76] All of these responses lead to socially undesirable allocations of limited medical resources that likely impose the highest costs on those who need those services the most but can least afford them.[77]

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[75] The pervasiveness and seriousness of the fears physicians have of medical malpractice suit is suggested by studies that show physicians overestimate the risk of being sued for malpractice by 300 percent. See Ann G. Lawthers et al., Physician Perceptions of the Risk of Being Sued, 17 **J. Health Politics, Pol'y & L.** 463 (1992); see also Paul C. Weiler et. al., Proposal for Medical Liability Reform, 267 **JAMA** 2355, 2356 (1992).

[76] Numerous empirical studies have addressed these questions and have come to different conclusions about the magnitude of these effects. See, e.g., Randall Bovbjerg et al., Defensive Medicine and Tort Reform: New Evidence in an Old Bottle, 21 **J. Health Politics, Pol'y & L.** 267 (1996); Lisa Dubay et al., The Impact of Malpractice Fears on Cesarean Section Rates, 18 **J. Health Econ.** 491 (1999); William Encinosa & Fred Hellinger, Have State Caps of Malpractice Awards Increased the Supply of Phyisicans?, 24 **Health Affairs** 250 (2005) (finding that caps do increase physician supply); Darren Grant & M. McInnes, Malpractice Experience and the Incidence of Cesarean Delivery: A Physician-Level Longitudinal Analysis, 41 **Inquiry** 170 (2004); Daniel P. Kessler et al., The Impact of Malpractice Reforms on the Supply of Physician Services, 21 **JAMA** 293 (2005) (finding that physician labor supply increases in the presence of liability caps); Daniel P. Kessler & Mark B. McClellan, Do Doctors Practice Defensive Medicine?, 111 **Q. J. Econ.** 353 (1996); Michelle M. Mello, Effects of Professional Liability Crisis on Residents' Practice Decisions, 105 **Obstetrics & Gynecology** 1287 (2005); Mello & Brennan, supra note 3, at 1606-07 (expressing skepticism about the prevalence of defensive medicine); David M. Studdert, et al., Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, 293 **JAMA** 2609, 2612, 2615 (2005) (surveying "widespread" defensive medicine practices in high-risk specialties); see also Katherine Baicker & Amitbah Chandra (2006), The Effect of Malpractice Liability on the Delivery of Health Care, NBER Working Paper No. W10709 (2004), available at http://papers.ssrn.com/paper.taf?abstract_id=583707 (questioning the magnitude of the effect medical malpractice has on these choices but conceding it affects marginal choices); Jonathan Klick & Thomas Stratmann, Does Medical Malpractice Reform Help States Retain Physicians and Does it Matter? (2005), available at http://ssrn.com/abstract=870492 (noting that medical malpractice reforms are likely to retain doctors, but arguing that these reforms might also lead to worse health outcomes).

[77] Cf. David Matsa, Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps (draft, U. Chi. Medical Malpractice Conference, May 19, 2006) (describing how increasing medical malpractice costs leads to physician migration away from poorer rural areas).

The restructuring of medical malpractice liability by UIS corrects these deterrence defects not just by eliminating the need for the judiciary to be concerned about compensation goals, but also and primarily by enabling first-party insurers to acquire and consolidate the entire return from investing in litigation. Enhancing the litigation role and power of first-party insurers should increase the enforcement of meritorious claims over the current levels achieved by plaintiff's attorneys who lack comparable investment incentives from scale, risk spreading, and stakeholding as those that their adversary liability insurers typically are able to exploit. First-party insurers will also be better informed than patients or their families about the possibility that medical malpractice occurred and the legal standards for evaluating the potential claim. First-party insurers, moreover, will be less susceptible to intimidation by liability insurers and consequently less likely to accept settlements below what the merits of the claim would otherwise warrant. Additionally, replacing the current amalgam of parties comprising the plaintiff's side with the first-party insurer as the sole, single-minded "plaintiff" will not only avoid costly monitoring and coordination efforts, but will eliminate the potential for conflicting interests that can disrupt or derail prosecution of the claim.

Importantly, note that under UIS the price of medical care will continue to reflect differences in the risk of malpractice injury because doctors will still be liable for the resulting loss and their liability insurers will be adjusting premiums accordingly. The pass-through mechanism will not distort patients' choices in the market because they receive its benefits automatically, without regard to their need or choice of physician services. Thus, market forces should continue to channel first-party insurers and their insureds away from particularly risky physicians. Indeed, by improving the deterrent effect of the medical malpractice system, UIS enhances the ability of price signals to identify riskier physicians and will thus further reduce malpractice.

Although the deterrence benefits from UIS are most clear inasmuch as it will help to eliminate underdeterrence, allowing first-party insurers to take charge of their insureds' claims also promises to reduce undesirable overdeterrence from the filing of unmeritorious suits. Because first-party insurers will be large, repeat players in the medical malpractice system, they will have incentives to refrain from engaging in unmeritorious or abusive litigation since they know that liability insurers will be able to develop systematic responses to those tactics. These responses would likely include the liability insurer establishing a credible threat to litigate rather than settle nuisance value claims, and, if need be, to retaliate in kind. Although liability insurers can adopt these strategies in the current system, they may view the payoff as problematic since the task of building the required reputation for "hardball" litigation may be too costly when the adversary is a plaintiff's attorney, who, while a repeat player in general would not have a consistent, long-term relationship with the insurer. With the advent of UIS, though, the current sporadic encounters with plaintiff's attorneys will be replaced by long-term relationships with first-party insurers, who will have incentives to cooperate to avoid disrupting the smooth resolution of claims as well as the means of reprisal to deter liability insurers from engaging in nuisance value litigation.

3. Administrative Efficiency

In addition to the insurance and deterrence benefits described above, one further direct benefit of UIS is reduction of overall administrative and transaction costs. UIS will have these salutary effects primarily because it will lower the costs of identifying, evaluating, and acquiring malpractice claims and will suppress the litigation fraud and opportunism in which plaintiffs currently have incentives to engage. Cost savings will also arise because UIS will place more decisionmaking responsibility in the hands of private actors (and government insurers with analogous proprietary interests as well as first-hand experience and knowledge). They are likely to seek and find ways to develop more efficient processes that can lead to mutual gains for all parties involved, whereas the current system dominated by courts likely generates inadequate incentives on this front and has poor mechanisms for translating potential gains into policy changes. These cost savings are desirable both on their own terms because they free up money that can be better spent on achieving other social goals and because they contribute to better insurance and deterrence.

One example of the administrative benefits from UIS relates to how allowing first-party insurers to consolidate total control over the litigation avoids the costs of organizing, monitoring, and coordinating multiple parties on the plaintiff's side. Under the current regime, first-party insurers often expend substantial resources in tracking down and keeping tabs on potential and filed claims to prevent plaintiffs and their attorneys from ignoring or dodging a subrogation lien. Insurers also incur significant costs in recovering their share of settlements, which often fail to earmark the portion allocated to economic damages. One consequence of these costs is that insurers may avoid asserting their subrogation interests in many cases, which worsens the double insurance problems and wastefully spends scarce resources on overcompensating patients that could otherwise be used to provide better medical care.[78]

UIS will also lead to cost savings because the insurers on both sides of the litigation will have long-term interests and parity of litigation scale, stakes, capacities to routinize the process of resolving claims. For example, insurers likely would establish more cooperative arrangements and efficient bureaucratic procedures to streamline the exchange of information and negotiation of settlements. This type of collaboration should, over time, also reduce incentives for strategic bargaining as reciprocal displays of openness and straightforward negotiation build mutual trust and dependence. These results are just not the product of the parties having repeated opportunities to demonstrate a commitment to keeping informal agreements, maintaining confidentiality, and otherwise dealing in good faith. There is also the disciplining power of each side being in the position of credibly threatening to retaliate against the other for dealing in bad faith. In short, the insurers will have both the long-term self-interest to avoid and the available resources to deter unmeritorious and abusive litigation. Thus, although trials undoubtedly still will occur, under UIS, settlement should be more prevalent than it currently is and, importantly, the settlement process should generate outcomes that are achieved at lower cost and that more accurately reflect the merits of the underlying claims.

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[78] See 2 **American Law Inst., Reports' Study: Enterprise Responsibility of Personal** Injury 170 (1991) (citing costs of monitoring and settling as principal constraints on insurers enforcing subrogation interests).

B. Indirect Benefits

As described above, UIS promises direct benefits by improving medical malpractice along three dimensions: insurance, deterrence, and administrative costs. But, as also suggested above, some of the most important benefits from UIS are likely to result from indirect, market-driven collaborations between first-party and liability insurers. By authorizing first-party insurers to take large stakes in multiple litigations, UIS provides those insurers with a previously unavailable impetus to seek a common ground with liability insurers for mutually profitable reforms in the post-UIS regime of medical malpractice liability. Similar motivations should spur liability insurers to reciprocate first-party insurer efforts to find this common ground.[79]

The most important indirect, market-driven benefit is that insurers will have an incentive to "privatize" much of the malpractice liability system in an effort to reduce costs and to streamline determinations of liability. This private system, while opening up new possibilities for generating gains from trade, would still emerge and operate in the shadow of the post-UIS regime of medical malpractice liability. Thus, however comprehensive, the ensuing private reforms of substance as well as process would not alter the restructuring effected by UIS or the resulting reallocation of litigation power between the first-party and liability insurers. That is, because this privatization is the result of negotiation and occurs against the backdrop of the restructured UIS liability system, neither group of insurers would agree to changes that weaken their litigation position vis-à-vis the other. Thus, in short, the indirect benefits of UIS would not come at the expense of the direct benefits, but would only increase social welfare by providing patients with lower-priced and higher-quality medical services and insurance coverage.

Topping the privatization agenda would be reforming the substantive and procedural rules that currently govern the determination of liability and damages for medical malpractice liability. On one end of the spectrum, insurers could adopt minor changes such as giving professional insurance adjusters a greater role in evaluating and resolving routine claims. This approach could lead to the development of standard schedules of "fines" or other sanctions calibrated to varying degrees of medical malpractice that would provide a rough estimate of the damages in any one case but would provide administrative savings that more than outweigh the costs of making less accurate determinations of the damages in each case. On a broader scale, the standardization of damages could lead to insurers settling relatively similar cases en masse on an account book basis of debits and credits, perhaps resembling the process insurers currently employ to resolve the bulk of automobile claims.[80] By using standard

[79] Cf. **H. Laurence Ross, Settled Out of Court: The Social Process of Insurance Claims Adjustment** (1980) (discussing settlement processes generally and aggregate settlement practices in the automobile industry in particular). While the potential for these gains are inchoate in the current system, the fragmented nature of the plaintiff's side of the litigation creates collective action problems that prevent the parties from being able to negotiate with one another to achieve these benefits; thus, although regulation might be able to achieve some of these benefits for the collective good, by fostering cohesion of interest on the plaintiff's side, UIS allows private parties to achieve the gains without the need for potentially cumbersome as well as error-prone government intervention.

[80] See id. (discussing aggregation in the automobile insurance context).

schedules and averaging, all of these procedures would streamline the determination of damages in any individual case without sacrificing the deterrence effects of the sanctions internalized by liability insurers on an aggregate level.

More dramatic reforms of the current medical malpractice system are also possible. For example, insurers might agree to change the liability standards themselves to better serve deterrence and insurance goals. Thus, they might agree to deem physician compliance with relevant hospital or medical board protocols as constituting a complete or at least prima facie defense again claims of malpractice.[81] This approach would have the virtue of providing doctors with clearer guidance on what constitutes negligence and would give greater responsibility for preventing patient injuries to institutions and agencies that are well-positioned to monitor and control doctor behavior and to know what procedures and technologies are best suited to reducing the incidence of medical malpractice. These types of policies could either apply generally or perhaps could apply only in those cases where the first-party insurer (or all insurers jointly) pre-approved the protocols in question. This pre-approval could be either for the treatment of that particular patient or for a class of similarly situated patients, although the cost-savings would be less acute in the former case. A further extension would be for insurers to adopt group-based insurance schemes where hospitals as a whole are charged common insurance rates, which could both lower the costs to insurers of monitoring each doctor individually, shift responsibility for such monitoring onto hospitals that are well positioned to do that monitoring, and provide incentives for hospitals to control the risk of malpractice in ways that outside insurers are unable to do.[82]

Another set of reforms would be to change how evidence of medical malpractice is used. Because the insurers would seek and effectively employ more accurate and reliable assessments of malpractice claims, they likely would come to rely more heavily on highly refined professional criteria and correspondingly rigorous scientific methodology and evidence—such as that employed and developed by sophisticated statistical and epidemiological studies—than they do in the current system of lay adjudication. This reliance on professional criteria and scientific evidence and the desire for greater accuracy in malpractice determinations would in turn motivate further reforms, such as using expert adjudicators rather than the lay judge and juries of the current system. For example, insurers could convene panels of qualified physicians and

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[81] Cf. Randall Bovbjerg, The Medical Malpractice Standard of Care: HMOs and Customary Practice, 1975 **Duke L.J.** 1375, 1386; Mark A. Hall, The Defensive Effect of Medical Practice Policies in Malpractice Litigation, 54 **Law & Contemp. Probs.** 119 (Spring 2001); Edward B. Hirshfeld, From the Office of the General Counsel: Should Practice Parameters Be the Standard of Care in Malpractice Litigation?, 266 **JAMA** 2886 (1991); Michelle M. Mello, Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation, 149 **U. Penn. L. Rev.** 645, 647-49 (2001); see also James F. Blumstein, Medical Malpractice Standard-Setting: Developing Malpractice "Safe Harbors" as a New Role for QIOs?, Vanderbilt University Law School Public Law & Legal Theory Working Paper No. 06-08; Law & Econ. Working Paper No. 06-10 (arguing for the two-sided use of standards to reduce uncertainty and medical costs by allowing compliance with standards to serve as a defense and non-compliance to serve as evidence of malpractice). UIS would promote the consideration and adoption of any of these proposals.

[82] Cf. David Rosenberg, Joint and Several Liability for Toxic Torts, 15 J. Hazardous Mat. 219 (1987).

other experts to arbitrate or, if necessary, adjudicate questions of liability and sanctions for malpractice.

Of particular importance, privatizing the medical malpractice determinations could offer a much-valued means of protecting the reputations of physicians. Although obviously the risk of reputational harm may serve an important deterrent role, in many cases the reputational taint from accusations of malpractice may be disproportionate, premature, or unfounded. Thus, the concern is that the reputational impact of the current system of malpractice liability generates overdeterrence by imposing excessive reputational costs. This concern raises the question of whether the privatized system that UIS would facilitate could better achieve the competing needs of shielding physicians' reputations from unwarranted damage and of publicizing physicians' malpractice in appropriate cases. One way to better protect reputations as well as motivate disclosures and reporting of possible malpractice is to replace lay judges and juries with panels of experts who have a more sophisticated understanding of medical protocols and practice. But insurers might also adopt more explicit measures to preserve confidentiality and anonymity pending the resolution of disputed claims. Private arrangements between the insurers and other participants in the process could restrict disclosure of malpractice charges to the general public until they are finally determined.[83] These arrangements could also limit disclosure to governmental and professional regulators contingent on a prior preliminary, expert determination of probable cause or the like, with exceptions for cases involving allegations of criminal, serial, or a pattern of violations or similarly imminent and egregious misconduct. Obviously, these authorities could mandate disclosure, but in general the insurers are likely on their own to establish a scheme for protecting and impugning reputations consistent with optimal deterrence goals and thus, in general, outside regulation of the system probably will be unnecessary.

A final type of potential reform in the privatized system would be to devise means to deter unnecessary or strategic resort to litigation, which could further facilitate settlement or reliance on other lower cost, less error-prone mechanisms of dispute resolution that the insurers may devise. Although some disputes would inevitably boil over into the tort system, the private regime could render decisions that would be binding on the parties were their case to eventually wind up in court. The insurers could, for example, require the parties in a disputed case to stipulate to the admissibility and evidentiary significance of panel findings in any subsequent medical malpractice trial. This approach would limit the utility of relitigating issues in court and, in any event, would help to cabin the costs of disputes that ultimately require judicial resolution.

IV. Possible Costs of Adopting UIS

This Part considers whether the changeover to UIS entails possible "costs" relative to current system of medical malpractice. For purposes of this comparative

[83] And if reputational effects do play a particularly important deterrent role, when the insurers do choose to publicize wrongdoing, they could publicize it in a way so as to maximize those effects. That is, UIS could provide a platform both to ameliorate the problems of overdeterrence based on false claims and to improve optimal deterrence by better using the reputational lever against negligent doctors.

analysis, we assume that except for the direct effects of the restructuring worked by UIS (and those brought about indirectly by contractual arrangements between first-party and liability insurers), the relevant substantive and procedural features of the current system constitute a socially appropriate baseline such that significant deviations from it are deemed costs. As an example, we accept the present role of juries, despite the questions that have been raised about their propensity for making excessive damage awards and their lack of expertise in assessing liability, thereby ignoring the possibility that if UIS changed jury behavior the change might well be for the better. Our main focus is on two possible costs: first, whether patients will have sufficient incentives to cooperate in the prosecution of malpractice claims without the prospect of recovering tort damages, and, second, whether jury behavior would change if first-party insurers replaced individuals as plaintiffs. We also briefly consider problems that may arise when there are multiple, first-party insurers or, at the opposite extreme, when a single insurer represents both sides in the same case. We conclude that none of these concerns raises substantial doubt about the efficacy and utility of UIS.[84]

A. Patient Cooperation

Consider first the need to obtain patient cooperation to ensure the functioning of UIS. In order to recover from doctors in tort for their malpractice, insurers sometimes will need the cooperation of the injured patient in responding to discovery demands for medical tests and in offering testimony on damages, particularly for non-pecuniary harm. A question about patients' incentives to cooperate in this process under UIS arises because with the first-party insurer subrogating the entire recovery, patients would no longer have a direct financial stake in the litigation; in particular, they would no longer have the incentive to cooperate provided by the prospect of receiving a share of the recovery for non-pecuniary damages.

However, it is important not to overstate the extent of this problem. Patient cooperation is often not a significant factor in the successful prosecution of a medical malpractice claim. This will probably become a more significant norm of litigation as the focus of liability increasingly trains on institutional and systemic means of controlling the risk of malpractice. But even today, many conventional claims directed at physicians are effectively litigated even though the best witness on certain key issues of liability as well

[84] We note a further concern that first-party insurers might perversely maximize potential tort recoveries by inducing or steering their patient insureds to accept medical care from physicians prone to malpractice. Without denying that anything is possible, we view the chance of this occurring as highly unlikely. After all, this strategy could put first-party insurers on the hook for considerable economic costs. They would be paying out substantial sums with only a prospect of recovering any of it on a malpractice claim, let alone recovering more than the sums expended on first-party coverage and litigation. More fundamentally, there is no profit in the strategy. The expected malpractice recovery from channeling patients to risky doctors would be equal to the higher price, reflecting the physician's higher risk and higher liability premiums, that those doctors would charge for their services and that first-party insurers would payout on behalf of patients. And even if an insurer did engage in this behavior, principles of contributory negligence could bar any recovery. In any event, the liability insurers footing the bill would likely spot and report the strategy and would seek compensation for their losses and punitive damages (and probably criminal sanctions) that would deter such behavior or at least to prevent its recurrence. The first-party insurers would also face suits by victimized patients.

as damages—the patient—may have died or been too severely injured to testify or otherwise assist in preparing the case. In these cases (and in some degree generally), the basis for liability and the seriousness of the injury may be effectively conveyed through expert testimony. Even with non-pecuniary damages, one might question the need for patient testimony given the tendency of juries to extrapolate non-pecuniary damages as a multiple of assessed economic damages. And with regard to other questions that frequently arise in malpractice cases, such as the scope of a patient's informed consent and related issues of causation, judicial requirements for and reliance on expert testimony often render patient testimony largely superfluous.[85]

Even for those cases under UIS in which patient testimony would play a significant role, securing cooperation is usually possible without much difficulty. In many cases, the problem is that cooperation entails costs and burdens for the patient, which insurers can overcome simply by compensating patients for their time and expenses related to the litigation. Additionally, many patients will not need a financial payoff to motivate cooperation, as they will have ample non-pecuniary reasons for wanting to participate, such as punishing the defendant doctor or sending a "deterrence message" to other doctors.[86] And for less than fully cooperative insureds, insurers (liability as well as first-party) have developed effective means of dealing with them. Generally, insurers mandate cooperation expressly in their policies, making it a condition precedent to coverage and payment of benefits. Patients are therefore unlikely to withhold their cooperation in medical malpractice litigation because if they did they might not receive their contracted-for coverage or might be denied future coverage. And if all of this is insufficient to ensure cooperation, insurers can subpoena their insureds to compel testimony, submission to medical tests, and other needed assistance.

Yet, it is possible a case might arise in which the patient, whose testimony could substantially affect the expected judgment, is able to holdout and condition cooperation on receiving a share of the recovery. The concern is that in such a case, UIS might devolve to LIS or worse, as the first-party insurer confronts the choice to accept the liability insurer's settlement offer discounted either for the patient's non-cooperation or, on agreeing to the patient's price for cooperation, for making a fractional rather than optimal investment. If these were the first-party insurer's only alternatives, then the concern might be well founded. The first-party insurer, however, has another option, one that maximizes its profits relative to the other alternatives and that leads the liability insurer to settle without demanding either discount. UIS thus remains intact. In short, the first-party insurer's response is simply to promise the patient a share of the recovery that secures cooperation and to make the optimal litigation investment it would otherwise make under UIS that maximizes total expected recovery. This response is credible because the first-party insurer and patient can split the maximized total expected recovery

[85] See, e.g., Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

[86] Cf. Tamara Relis, "It's Not About the Money!": A Theory on Misconceptions of Plaintiffs' Litigation Aims, 68 U. Pitt. L. Rev., No. 2 (2007), available at http://ssrn.com/abstract=909522.

to make themselves better offer than they would be under the alternatives.[87] Anticipating inevitable exposure to the maximum total expected recovery, the liability insurer will not offer a discounted settlement in the first place; rather it will offer to settle without discount.[88] Therefore, UIS will function as effectively as it would have were the patient cooperating fully without pay.[89]

B. Jury Behavior

On the assumption that jury sympathy for injured plaintiffs tilts outcomes to some degree in favor of the plaintiff-side, UIS may be subject to the criticism that jurors will vote less often for and award less money to plaintiffs if they learn that the real party in interest is an insurance company. Again, however, it is important not to overstate the extent of this problem. It is unclear as an empirical matter that such juror sympathy exists.[90] After all, medical malpractice plaintiffs win in jury trials less than 30 percent of

[87] Of course, the first-party insurer may have prospectively lowered the insured's premiums based on its expectation of receiving the insured's cooperation and consequently full tort damages. But any portion of the payout the insurer cannot make up from its share of the recovery (if any), it would treat as a sunk cost. If the insurer incurs additional cost to establish credibility, for example, in actually having to carry out its threat, it can spread that cost over future cases in which the insurer reaps the greater benefit from having demonstrated to liability insurers that there is no profit in attempting to discount their settlement offers. And if the first-party insurer anticipates some systematic problem of patient non-cooperation and related discounted settlement offers, it will reduce its pass-through benefit to cover any net costs it expects to incur to establish the credibility of its response. Cf. Mitchell Polinsky & Daniel Rubinfeld, Aligning the Interests of Lawyers and Clients, 5 **Am. L. & Econ. Rev.** 165 (2003).

[88] The liability insurer might consider bribing the patient to be uncooperative. But such a bribery strategy promises no gain for the liability insurer because the patient will be able to extract up to the total "benefit" from the arrangement by credibly threatening to offer cooperation to the first-party insurer for an even better deal. Moreover, courts probably would refuse to enforce a non-cooperation agreement because it would conflict with the express terms of the first-party insurance policies and programs that require the patient to cooperate in the prosecution of the first-party insurer's subrogated claim. Courts voiding non-cooperation agreements and freeing both parties, liability insurer and patient, to defect at will from any arrangement they have made should effectively nullify their incentives to offer or accept a bribe for non-cooperation in the first place.

[89] So far we have considered the problem of patient recalcitrance on the assumption that it would not impede the ability of insurers, first-party and liability, to settle the claim based on a reasonable estimate of the expected judgment, including the counterfactual projection of how much the patient's cooperation would have affected the outcome of litigation. We surmise that most cases are of this sort. Nevertheless, a case could arise in which for some reason the insurers' ability to settle the claim depends on the patient's actual, voluntary, full cooperation. The best, profit-maximizing strategy for the first-party insurer to follow in such as case is to invest optimally to maximize the expected judgment and, in contrast to the case where the parties can settle, to promise and pay a share of the recovery to the patient for cooperation. To the extent cases like this requiring cooperation arise, UIS would thus continue to achieve its primary deterrence objectives, but would have diminished insurance benefits. And regardless, UIS would remain a better choice than LIS; UIS dominates LIS in producing optimal deterrence and superior if not optimal insurance results.

[90] For a study suggesting that juries might not be influenced by sympathy for plaintiffs and thus that this problem may be ephemeral, see Kevin M. Clermont & Theodore Eisenberg, Trial by Jury or Judge: Transcending Empiricism, 77 **Cornell L. Rev.** 1124, 1137 (1992), which found that judges were more likely than juries to rule for plaintiffs in medical malpractice claims tried in federal courts.

the time, although, to be sure, when juries do find for the plaintiff they award relatively high damages.[91] But high jury awards might be more influenced by jurors' desire to punish a doctor they have found liable than by the nature of the plaintiff, and UIS does not affect who the defendant is.

Even if the problem of altered jury behavior does exist, it may be obviated if the problem of ensuring patient cooperation is solved. If the patient is testifying and can present a sympathetic face and case to the jury, then the jury may not know about or may not consider the fact that a first-party insurer is actually receiving the recovery. Thus, to the degree the problem of jury reaction is about how juries perceive and respond to evidence, one can surmise that first-party insurers will deploy existing methods (or if need be develop new ones) to maintain the present level of jury sympathy.[92]

Another solution to the problem would simply be to provide more information to the jury about the role of the insurer in the litigation process. Courts could represent the first-party insurer as a "private attorney general" and emphasize the way in which providing full recovery serves desirable social goals of deterring errant medical practice and expanding the availability of needed insurance through lower premiums.[93] The jury might also be informed about the fact that insurers exist on both sides of the litigation.

C. Management Problems

UIS may also raise two management problems. The first is a problem of coordination that may arise when there are multiple subrogated insurers on the first-party side. But this situation already exists under LIS and is not exacerbated by UIS. Any seriously injured individual will likely tap coverage supplied by some combination of commercial carriers and various governmental insurance programs, such as workers' compensation, unemployment insurance, and Medicare. The situation is similar but far more prevalent for liability insurers, with multiple carriers actually or at least contingently supplying coverage at both primary and excess levels. The general solution for problems of coordination that may arise in either context is contract. Driven by market forces and mutual, long-term interest, the insurers resolve such difficulties by

[91] See **Tort Trials and Verdicts in Large Counties, 1992**, supra note 2.

[92] Despite all efforts at concealment and disguise, a jury in some case might discover and respond negatively to the role of the first-party insurer. While the liability insurer might seek to capitalize on this situation by discounting its settlement offer, the first-party insurer could respond similarly to the way it would in the case of an uncooperative patient. If need be, the first-party insurer could re-assign the claim to the injured patient, who would then become and be represented to the jury as the real party plaintiff. Because the first-party insurer would still profit most from investing optimally to maximize the expected judgment, the liability insurer would not discount its settlement offer.

[93] It is possible that such advice could motivate jurors to increase plaintiff verdicts to lower premiums for themselves. However, this strategy would be self-defeating as doctors increase prices to account for the greater potential liability, which would lead to higher premiums for insureds. Moreover, the extremely small benefit any one insured juror gets from a higher tort recovery in a given case would likely be insufficient to drive juror behavior. And in any case, judges can deal with the problem by issuing corrective instructions and reviewing jury awards.

agreement often before litigation commences or more frequently afterward on an ad hoc basis. These agreements do and will determine, among other key aspects of the joint litigation venture, which insurer should take the lead counsel role, the formula for allocating costs, and under what conditions an insurer can strike a separate settlement deal with the plaintiff. Problems of coordination arising under UIS should be amenable to the same contract solutions. Indeed, given the large-scale, repeat players involved and the prospect for their creating a long-term "privatized" system for resolving claims, coordination is likely to prove less of a problem than it does today. The parties may well develop innovative solutions, including the creation of primary or secondary markets for the sale of subrogated interests in potential or accrued claims to insurers or other entities specializing in medical malpractice litigation.[94]

The second potential management problem relates to the possibility that a single first-party insurer would have provided coverage to both the patient and doctor and thus would end up litigating as the real party in interest on both sides of a malpractice case. The concern is that the insurer might favor its own interests at the expense of one side or the other in derogation of the socially desirable outcome that a more adversarial relationship would produce. There is no evidence, however, of such conflict of interest arising in dual insurer situations that occur in the current system, most often involving automobile insurers. Moreover, it is not obvious that duality of interests would lead the insurer to shortchange one side or the other. Rather, a rational profit-maximizing insurer would make itself best off by treating both sides in the optimal manner, that is, by resolving the case according to the outcome that the optimal, return-maximizing investment on both sides would yield. In short, because it internalizes the total costs of medical malpractice, the dual insurer profits most by minimizing that sum. By doing so, it serves the social objectives of deterrence and insurance and thus enhances patient welfare. But all this notwithstanding, even if one believes that having the same insurer on both sides of the litigation poses a greater danger under UIS, the problem is solvable simply by mandating that the insurer maintain a separate and adversarial relationship between its plaintiff- and defense-side functions. Indeed, corporations currently often set up separate divisions that have conflicting interests and compete against as well as engage in internal transactions and joint ventures with one another. Administering medical malpractice litigation within a dual insurer would seem amenable to the similar arrangements to foster adversarial resolution of claims.[95]

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[94] If some case, however unlikely, involved irresolvable coordination problems among the first-party insurers, courts could resort to regulation, drawing upon the methods used to solve similar problems in multi-party cases, such as under the rules for consolidating and managing bankruptcy, complex, and federal multi-district litigations. The outcome that results from this court-based regulation would be no worse than that which results in the current system, which might also sometimes require regulation to disentangle otherwise irresolvable coordination problems among insurers, liability as well as first-party.

[95] Regulation may not be needed to produce this result since an insurer has ample reason to avoid internal conflicts of interest and to that end establish adversarial divisions on its own initiative. Because an insurer maximizes profits over the long-term by minimizing its total malpractice-related costs, it is likely to be in the better position than outside regulators to compare the costs and benefits of mixing or separating functions and thus typically will set-up a more optimal structure than regulation can provide.

Conclusion

The current medical malpractice system fails to serve the social goals of insurance and deterrence goals to which it is committed. Worse, it often subverts these goals. But UIS offers a simple and comprehensive solution to these problems. By making only a minor modification in the current rules governing subrogation, UIS would put first-party insurers in charge of the plaintiff's side of medical malpractice litigation, which would directly and immediately enhance the insurance and deterrence goals of the system. In addition to these direct benefits, UIS also creates a platform that encourages future voluntary changes by insurers. By generating strong first-party insurers on the plaintiff's side, the reform sets up a system where insurers on both sides of medical malpractice disputes can achieve mutual gains—and, more importantly, produce gains that accrue to society at large—through the use of private contracting to streamline and improve the process of resolving medical malpractice claims.

Indeed, whatever reforms one believes the medical malpractice system needs, adopting UIS seems likely to facilitate their adoption and use. Thus, the utility of our proposal for UIS is shown not just by its direct benefits, which would be substantial, but also by the way in which UIS harnesses the self-interest of the insurers, who would have substantial stakes in the medical malpractice system to focus their efforts on constantly innovating new and better mechanisms to eliminate unnecessary medical injury. Harnessing such market forces is a notable virtue of UIS that distinguishes our proposal from other proposals for market-based reforms and for decoupling liability and compensation functions of civil liability that require regulatory oversight with high costs to work effectively.[96] In contrast, allowing insurers to take charge avoids the need for regulation and its costs while promoting the goals of optimal deterrence and insurance far better than the current system.

[96] For market-based proposals, see, for example, Stein, supra note 1; Cooter,supra note 27; and Cooter & Sugarman,supra note 27. For decoupling proposals, see, for example, A Mitchell Polinsky, Decoupling Liability: Optimal Incentives for Care and Litigation, 22 **Rand J.** (1991), which argues that tort should be used only for deterrence purposes and that damages should escheat to the state; and Steven Shavell, The Fundamental Divergence Between the Private and the Social Motive to Use the Legal System, 26 **J. Legal Stud.** 575 (1997), which argues that taxes or subsidies should be used to align private and public litigation incentives in order to achieve optimal deterrence.