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"Unlimited Subrogation: Improving Medical Malpractice Liability by Allowing Insurers to Take Charge"

by

David Rosenberg

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Note: It is expected that you will have reviewed the speaker's paper before the Seminar.

Unlimited Subrogation: Improving Medical Malpractice Liability by Allowing Insurers to Take Charge

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Abstract

This article proposes unlimited insurance subrogation (UIS) to improve the insurance and deterrence results of medical malpractice liability. UIS provides a natural and efficient process for patients to assign their potential medical malpractice claims in full to their first-party insurers. The proposal entails a single simple change in the application of subrogation law to medical malpractice liability: remove the current legal restriction that limits subrogated claim-assignments to the amount in benefits an insurer pays its insured. UIS should improve insurance outcomes from the system because first-party insurers, anticipating subrogated recovery of total tort damages, non-pecuniary as well as economic, will lower premiums commensurately. This will convert the overly expensive, risky, dilatory, and with respect to non-pecuniary damages, unwanted "insurance" supplied by tort into more optimal first-party insurance. UIS should enhance the deterrence effects of tort liability as well. By making first-party insurers plaintiffs and placing them on the same footing as their defense-side counterparts, liability insurers, UIS should increase the effectiveness with which meritorious claims are prosecuted and also reduce meritless litigation, as these large-scale, long term repeat players will possess the motives for mutual cooperation and means for mutual deterrence. Beyond these direct benefits, UIS encourages further reforms by contract between the insurers that would take charge of the system. The article also evaluates the possible costs of UIS, specifically issues of patient cooperation, jury behavior, management difficulties, loss of tort insurance for non-pecuniary damages, and gaming the system. On analysis, these problems prove insubstantial because they are unlikely to arise or are readily solvable.

1. Introduction

Medical malpractice liability should further the optimal insurance and deterrence objectives of the legal system. The general consensus is that this regime of tort law, despite major reforms and great expense, disserves these basic goals. Critics disagree, however, over the nature and magnitude of the problem. Many see medical malpractice

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liability as characterized by frivolous lawsuits, misguided juries, duplicative compensation for injury, and intimidated physicians fleeing high-risk specialties and engaging in defensive medicine (Weiler 1993, Brennan 1996). Others dispute these claims as exaggerated if not wholly unsubstantiated and counter that rather than too much medical malpractice liability there is too little, claiming that meritorious claims are underenforced because of high litigation costs, superior litigation power of liability insurers, and physicians' concealment of their possible malpractice from patients (Baker 2005, Weiler 1993).

This paper proposes a comprehensive approach to improving medical malpractice liability. Only a single, simple change in the law governing subrogation by first-party insurers is required.[1] That change would authorize insurers to subrogate (acquire) their insureds' potential medical malpractice claims in full in return for a commensurate reduction in premiums.[2] Notably, our proposal for "unlimited insurance subrogation" (UIS) contrasts with most enacted or proffered tort-centered reforms of medical malpractice liability, which tend to take a substantive position on one side or the other in the debates over the causes and consequences of its failings and thus focus on adjusting specific rules of liability, damages, or proof. Instead, we offer a means of restructuring the framework of the entire system of medical malpractice liability that should prove effective regardless of the outcome of the current debates. Although our proposal itself entails no modification of the substantive or procedural rules of tort, the UIS framework would be sufficiently comprehensive and flexible to accommodate future reforms. Indeed, it would encourage and facilitate reworking of the system not just by courts and legislatures, but most significantly by the insurers – liability as well as first-party -- that UIS would motivate to take charge of enforcing medical malpractice liability.

Specifically, our proposal is to change the current rule that limits an insurer's subrogation interest--if subrogation is permitted at all--to the value of the insurance benefits actually paid or promised to the insured (Rinaldi 1994, Kimball & Davis 1962). Our proposal would remove this limitation as applied to medical malpractice liability. Put affirmatively, we advocate allowing insurers to subrogate the full potential medical malpractice claims of their insureds without regard to how much the insurer may recover by way of subrogation or how much it pays or promises the insured. Adopting UIS will have the greatest practical significance for subrogation involving personal injury claims.

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[1] 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 (Abraham 1986). For simplicity, references to first-party insurance includes coverage supplied by governments, commercial carriers, charities, and other sources of funding to meet individuals' medical, income, and other economic needs relating to the risk of accident. Also for convenience, reference to premiums includes taxes and other means of financing the supply of first-party insurance. Insurance subrogation, as used here, refers to a first-party insurer either enforcing a contract or equitable lien against the plaintiff-insured or suing the defendant directly to obtain some portion of the damages recovered or recoverable from a tort or other civil claim that arises from an insured loss (Keeton & Widiss 1998, Baker 2003).

[2] As used here, subrogation denotes not only first-party insurers acquiring an interest in their insureds' potential tort recoveries, but also their practice of treating expected subrogation recoveries as an income stream that offsets overhead and consequently lowers premiums. For discussion of the practice of insurers passing-through expected subrogated recoveries in the form of lower premiums, see *infra* pg. --.

Because first-party insurance covers only economic loss (Viscusi 1996), such as medical costs and lost income, current rules preclude insurers from subrogating non-economic damages,[3] which comprise one-half to two-thirds of the average tort recovery in those cases (Viscusi 1991, Vidmar 2005).

To see how our proposal would work with medical malpractice liability, first consider a legal regime that precludes subrogation altogether. Absent subrogation, the risk of economic loss from medical malpractice would be "insured" by two separate sources: first-party insurance and tort. In the event harm materialized, patients would receive compensation for their economic loss from both sources. For this double-coverage, patients would pay not only a premium charged by the first-party insurer, but also a "tort premium" charged and incorporated by physicians in the price of their medical services. In reality, the patient pays the two premiums at once to the first-party insurer who applies part to cover its costs of supplying economic loss coverage and part to cover the tort premium built into the price the insurer pays for the insured's medical care. Limited subrogation eliminates this system of double coverage and premiums by converting the economic loss component of tort insurance into first-party coverage. This conversion occurs because first-party insurers anticipate receiving a subrogated recovery of tort damages for economic loss and pass-through the expected value of that recovery to their insureds in the form of lower premiums (or, equivalently, as a cash rebate). Although doctors continue to charge tort premiums because they are still liable for economic loss they cause, the portion of that charge related to such loss is offset by this reduction in first-party premiums and thus the insured does not pay twice. Limited subrogation thereby improves the insurance results of medical malpractice liability relative to a no-subrogation regime.[4]

[3] By "non-economic damages," we include two classes of damages: non-pecuniary damages (e.g., pain and suffering damages; loss of consortium) and punitive damages.

[4] Double coverage and premiums for economic loss lead to problems of "moral hazard" and excess insurance, and thus limited subrogation is generally viewed as a necessary feature of an optimal insurance scheme (Sykes 2001). But at least two other solutions exist for the problem of double coverage and premiums, suggesting that the standard explanation for subrogation is incomplete. First, the market could solve the problem if first-party insurers excluded tort risks from coverage, relegating insureds to tort for insurance against these risks. But no commercial or government insurer to our knowledge excludes tort risks from coverage. This is for good reason: tort insurance is substantially more expensive, risky, and dilatory than first-party insurance. That limited subrogation has been used to solve the double insurance problem suggests insureds prefer first-party to tort insurance and that the unique virtue of subrogation is its capacity to convert suboptimal tort insurance into more optimal first-party coverage. The second solution, which a number of legislatures have adopted in the past 20 years to reform medical malpractice liability, is to eliminate the "collateral source" rule that allows plaintiffs to recover damages from defendants for losses already paid by first-party insurers. In these regimes, first-party insurance serves as the principal source of economic loss coverage. But this solution to the double coverage and premium problem undercuts the deterrence function of medical malpractice liability by reducing not only the amount of damages recoverable from the tortfeasor, but also, as we discuss below, the incentive of the plaintiff's attorney to invest in litigation. If one is convinced that the deterrence effects of medical malpractice liability are excessive, then eliminating the collateral source rule (and also precluding subrogation, indemnity, or similar claims by insurers against physicians) is a potent, if crude, way to reduce them. The comparative advantage of UIS, as we show, is that it promises to improve deterrence results – regardless of whether deterrence is excessive or deficient – and yield greater insurance benefits than limited subrogation, while also rendering the system of medical malpractice liability more rational and transparent, fostering future scrutiny and revision.

Our proposal for unlimited subrogation works in precisely the same way but instead of converting just the expected economic tort damages into lower premiums, it converts the total expected tort damages – non-economic as well as economic – into lower premiums. As we show, this produces even greater insurance benefits than limited subrogation, and in addition improves deterrence results and administrative efficiency.

A simple example illustrates the workings our proposal compared to subrogation currently.[5] Assume that a first-party insurer provides general coverage and that the insured risk includes a 1% chance of medical malpractice. In the event of malpractice, the insured would incur $5,000 of economic loss plus pain and suffering, for which tort would award an additional $5,000 of non-economic damages. Assume that absent subrogation the insurer charges the insured a premium of $1,000 for its economic loss coverage. The following table depicts the operation of three subrogation regimes: no subrogation, limited subrogation, and unlimited subrogation.

Table 1: Comparison of Alternative Subrogation Regimes

Subrogation Regime	Expected Subrogation Recovery	First-Party Insurance Premium	First-Party Insurance Payout	Net Tort Recovery to the Insured	Net Tort Recovery to the Insurer
No Subrogation	$0	$1000	$5,000	$10,000	$0
Limited Subrogation	$50	$950	$5,000	$5,00	$5,000
Unlimited Subrogation	$100	$900	$5,000	$0	$10,000

Allowing UIS to replace the currently permitted regimes of no insurance subrogation or limited insurance subrogation (LIS) should enhance patient welfare by further lowering the cost and increasing the availability of first-party insurance and by improving deterrence results to raise the quality of medical care. The insurance benefits of UIS become evident once it is recognized that tort liability and first-party insurers provide alternative and largely duplicative coverage for medical malpractice injuries and that patients pay for both types of coverage. There is strong evidence that tort is the inferior source of insurance because its coverage of economic loss entails greater expense, risk, and delay (Tort Trials 1992, Studdert 2006), and of non-pecuniary harm is unwanted by those who must pay for it.[6] Thus, by authorizing insurers to acquire their insureds' entire medical malpractice claims, UIS should surpass LIS in converting deficient and unwanted tort insurance into cheaper and more optimal first-party coverage

[5] For simplicity, the example ignores the tort premium and assumes tort recovery is certain and costless.
[6] The paucity of first-party insurance specifically covering pain and suffering is generally acknowledged. (Reporters' Study 1991; Croley & Hanson 1995). On the lack of insured demand for and commercial and government supply of non-pecuniary harm insurance, and for an explanation from insurance theory of why insureds rationally would eschew such coverage if they had to pay the premiums for it, see Shavell (1987), Calfee & Rubin (1992), Viscusi (1996). For further discussion of theory and evidence regarding non-pecuniary harm insurance, see *infra* p. –.

as, we assume, insurers reduce premiums in anticipation of greater subrogated recoveries.[7] UIS should also improve deterrence results. On one hand, UIS should increase the prosecution of meritorious claims by establishing on the plaintiff-side of medical malpractice litigation first-party insurers that have scale and investment incentives on par with liability insurers. On the other hand, UIS should reduce the incidence of meritless litigation by placing insurers, first-party and liability, in control of litigation and harnessing their long-term, repeat-player interests to establish efficient, cooperative relationships. We emphasize that these deterrence benefits of UIS do not depend on insurers passing-through the value of additional expected subrogated recovery to insureds. In addition to these direct benefits, UIS should also encourage the insurers to implement by contract a more efficacious, privatized system for enforcing medical malpractice liability.[8]

Our analysis proceeds in two basic parts followed by brief concluding remarks. Part II explains how UIS would restructure medical malpractice liability and elaborates the expected benefits. Then, using the current system as the baseline, Part III appraises the possible costs of UIS. In particular, we consider concerns about patient cooperation, jury behavior, litigation management, loss of tort insurance for non-pecuniary harm, and insurers gaming the system.[9]

2. Benefits of UIS

[7] For elaboration of the basis for this assumption, see *infra* p. – .

[8] In proposing to extend the existing LIS market in potential medical malpractice claims, this article joins the literature on markets for assigning or alienating tort claims (Abramowicz 2005; Choharis 1995; Cooter 1989; Cooter & Sugarman 1988, Shukaitis 1987). Abromowicz (2005) and Cooter (1989) focus, as we do on, pre-accident or ex ante tort-claims markets. Choharis (1995) and Cooter (1989) briefly consider restricted models of insurance subrogation, and reject their utility and that of subrogation generally without much discussion. Greenblatt (1997) and Sykes (2001) propose extending LIS somewhat to allow contracts enabling insurers to recover the amounts they pay out before insureds can recover any damages in cases where tort liability exceeds tortfeasor assets. One of us previously sketched a general proposal for UIS, see Rosenberg (1986), Rosenberg (1989), and Rosenberg (2002). To our knowledge, ours is the first fully developed proposal for UIS. The only earlier published proposals resembling UIS are O'Connell (1976) and O'Connell (1977), which outline a more restrictive model and argue its advantages, primarily compensatory, but do not develop the analysis on these points or consider the potential costs.

[9] This article provides a comprehensive, systematic, and in-depth analysis of the insurance, deterrence, and administrative efficiency implications of assigning tort claims ex ante, and in particular, of using UIS as a method for such assignment. It thus contributes to the literature on ex ante tort-claim markets, which discusses, but does not provide complete and developed analysis of these matters. In addition, this article presents a new, settlement-oriented solution for the victim-cooperation and jury-behavior problems that have prompted concern among commentators about the utility of ex ante claim assignment. It is also the first to consider use of unlimited insurance subrogation or any form of ex ante tort-claim assignment to address the problems with medical malpractice liability and, regarding insurance subrogation generally, to point out the incentives for and possible benefits from first-party and liability insurers contracting to "privatize" the tort system.

This Part explains how UIS solves the structural defects of the current medical malpractice liability system. It then elaborates the benefits of UIS measured by insurance, deterrence, and administrative efficiency goals. Finally, it describes the potential for UIS to lead to indirect benefits through private arrangements between insurers.

2.1. Structural Defects and UIS Correctives

We focus on two basic defects in the structure of the civil liability system. The first is the divergence between the incentive of a plaintiff's attorney to invest in litigation and the optimal investment incentive that would maximize the expected judgment value from litigation (Schwartz & Mitchell 1970, Clermont & Currivan 1978). The second is the divergence between damage awards optimal for insurance and deterrence (Shavell 2004). We first describe each defect and then explain how UIS would correct it.

2.1.1. Litigation Investment Incentives and UIS Consolidation of Return. The divergence in the litigation investment incentives of plaintiffs' attorneys from the optimal arises from the typical arrangement for their compensation: the contingent, percentage-of-recovery fee. Because this fee arrangement rewards attorneys with only a fraction of the recovery, they may lack incentives to assume a greater fractional share of the litigation costs even if the investment would maximize the total expected recovery.[10] This failure undermines deterrence and insurance goals. These consequences are compounded by the fact that defendants' incentives to invest in litigation reflect the total return from an effective defense rather than only a fraction of that value. That is, defendants – liability insurers, in medical malpractice litigation – have optimal incentives to invest in developing their side of the case while plaintiffs do not. 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, which distorts the results for both deterrence and insurance (Clermont & Currivan 1978).

By enabling first-party insurers to acquire complete control over the prosecution of and recovery from their insureds' medical malpractice claims, UIS solves the divergent investment problem by consolidating the total litigation return in a single entity. In addition, UIS eliminates the asymmetry in investment incentives that prevails in the present system that biases outcomes in favor of defendants. It does this by giving first-party insurers control over the entire plaintiff's side of litigation, allowing them to exploit the litigation scale and scope that liability insurers currently do.

2.1.2. Damage Awards and UIS Decoupling of Insurance and Deterrence Functions. Optimal insurance generally requires paying the insured's loss fully, neither more nor less, while optimal deterrence generally requires that the tortfeasor internalize the tortious

[10] For example, if a lawyer's investment of $1,000 worth of time would yield a 90% probability of winning $5,000 at trial for a total expected net recovery of $3,500, the plaintiff's attorney with a 25% percentage-of-recovery fee might nonetheless choose not to make this investment if he or she had the alternative of investing $250 worth of time for a 50% probability of winning $5,000 at trial for a total expected net recovery of $2250. Investing the additional $750 efficiently increases the total expected net return by $1250. But that marginal investment increases the attorney's return by only 25% or $312.50, leaving the lawyer to absorb a loss of $437.50.

loss fully, neither more nor less. Civil liability damage awards cannot promote both of these objectives simultaneously. The simple reason is that the amount of damages that is optimal for one objective is not necessarily optimal for the other. That is, the amount of damages necessary for optimal insurance can impose too much or too little damages on defendants for optimal deterrence purposes or, vice-versa, the amount of damages that is optimal for deterrence purposes can yield too much or too little payout to the plaintiff for optimal insurance purposes.

This problem of conflicting roles and effects of civil damage awards arises routinely in medical malpractice. For example, given that malpractice typically is judged under the negligence rule, it is likely that many claims will fail and be dismissed on a finding of non-negligence, denying patients any recovery. While this outcome may be required to achieve deterrence ends, it will prevent the tort system from providing tort insurance (assuming it were needed) to pay for accident losses, however severe they may be. Conversely, deterrence goals may require applying the "collateral source" rule to levy damages against a negligent physician equal to the total tortiously inflicted loss suffered by the patient, even though the economic component of that loss has been fully covered by first-party insurance and even though awarding the plaintiff the non-economic component of tort recovery exceeds the level of insurance coverage for which insureds would willingly pay.

UIS eliminates the problematic tie between the determination of liability and the distribution of damages by allowing first-party insurers to prosecute the entire medical malpractice claim and to recover total damages, regardless of amount or type. It thus decouples the determination of liability from the award of damages since under UIS there is no necessary connection between the amount recovered by the first-party insurer in tort on a medical malpractice claim and the amount that the patient receives in standard benefits from first-party insurance. This means that UIS replaces the lockstep relationship between the deterrence and insurance results of liability that exist currently with a system that enables courts to pursue each objective separately and more effectively. Notably, courts can attach priority to deterrence (Rosenberg 2002), without concern about meeting patients' need for insurance or awarding excessive damages that may lead to false and exaggerated claims and other moral hazard problems.

2.2. Improvements from UIS Restructuring

We elaborate 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 the enforcement of medical malpractice claims. We then consider the benefits flowing more indirectly from the adoption of UIS, the most important of which are likely to emerge from first-party and liability insurers establishing improvements by contract, possibly including "privatization" of much of the medical malpractice system.

2.2.1. Direct Benefits. a. Insurance. Almost by definition, anyone who suffers from medical malpractice has first-party insurance because incurring such an injury depends upon receiving medical care in the first place and receiving medical care is almost always contingent upon insurance paying for it.[11] Thus, the question is whether adopting UIS would improve the provision of insurance coverage for medical malpractice injury relative to the alternatives of no subrogation or limited subrogation.

UIS promises superior insurance results. Its restructuring of medical malpractice liability should generate beneficial insurance effects first by consolidating the full return from litigation investment in first-party insurers. The consolidation effect of UIS – motivating insurers to invest optimally to maximize the expected judgment and eliminating the asymmetry in litigation power favoring liability insurers – will yield higher expected tort recoveries from medical malpractice litigation. Jut as they now do under LIS, insurers will pass-through subrogated recoveries under UIS to insureds in the form of lower premiums, but to a much greater degree.[12] At the very least, UIS operates as a form of "anti-insurance" (Cooter & Porat 2002); lowering premiums leaves more money in the pockets of insureds, who being risk-averse should prefer the certain cash payout from UIS to the gamble offered by tort. But assuming realistically that there is chronic underinsurance for economic loss(Sykes 2001), lower premiums will improve insurance outcomes by allowing insureds to purchase more complete and broader coverage.

The decoupling effect of UIS magnifies these benefits by eliminating the unwanted tort insurance and premium for non-pecuniary harm.[13] To be clear, under UIS physicians still charge patients a price for medical services that includes the expected cost of liability for full tort damages – non-economic as well as economic. This charge preserves the deterrent effect from variable prices that can induce patients and their first-

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[11] Commercial carriers supply much of this insurance, but it also provided, and often mandated, by federal and state government programs, ranging from ad hoc, emergency room services to more categorical coverage such as workers' compensation, Social Security Disability Insurance, and VA hospitals, to general coverage under Medicare and Medicaid. Our point is not that this system is optimal, but rather that almost everyone has some type of insurance for medical care and that in paying for this insurance everyone pays the premiums and taxes that cover the costs of the medical malpractice liability system.

[12] We assume that market competition and insurance regulation motivate first-party insurers under UIS to treat expected subrogated tort recoveries as a stream of income that they can pass-through to insureds in the form of lower premiums. In support, we note the present practice of subrogation-based premium reductions under LIS (Greenblatt 1997). Approximately 75% of this pass-through practice occurs in connection with subrogated recoveries from automobile property damage and workers' compensation cases. (Carris & Bartlett 1994, Connolly 2006, Klinck 2002, Jacobson 2000). The pass-through practice under LIS is generally recognized by courts (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), and commentators (Abraham 2005; Greenblatt 1997; Sutton & Sorbo 1993; DuBray 1996). It should be noted that the pass-through practice is denied by some courts (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) and commentators (Baron 1996, Patterson 1957).

[13] Similarly, UIS nullifies the charge insureds incur for other types of non-economic damages, in particular, punitive damages.

party insurers to choose less-risky doctors. But patients will not actually bear the cost of paying for non-pecuniary and other non-economic tort damages because under UIS this charge will be offset by first-party insurers passing through to insureds the expected subrogated recovery of such damages in the form of reduced premiums.[14]

2.2.2. Deterrence. UIS also should improve the deterrence effects of medical malpractice liability. To start, regardless of whether the dominant problem today is over- and under-deterrence, UIS should lead to better results because it decouples the insurance and deterrence functions of damages. Decoupling frees courts and legislatures to focus medical malpractice liability on promoting optimal deterrence without concern for insurance objectives, which are fully served by first-party insurers.

But the most significant deterrence benefits should result from UIS concentrating the entire return from litigation investment in first-party insurers. If the current system under-deters medical malpractice, then enhancing the litigation role played by first-party insurers should increase the enforcement of meritorious claims over the levels currently achieved by plaintiff's attorneys who lack comparable investment incentives from scale, risk-spreading, and stakeholding. Moreover, because they will be called upon to pay the medical costs, first-party insurers likely will have more immediate access and better quality information than patients and plaintiff's attorneys have in the current system about the possible occurrence of malpractice and the appropriate legal course of action to take. First-party insurers also will be less susceptible to intimidation by liability insurers and thus will be less likely to accept settlements below what the merits of the claim warrant. In addition, replacing the current amalgam of parties comprising the plaintiff's side with the first-party insurer will minimize costly monitoring and coordination efforts and will eliminate the potential for conflicts that could disrupt or derail prosecution of the claim.

If instead the current system imposes excessive liability that deters not only malpractice but also desirable practice of medicine, UIS still promises to ameliorate the problem by reducing the filing of unmeritorious suits. Because first-party insurers will be large, repeat players in the new system, they will have incentives to refrain from engaging in unmeritorious or abusive litigation. Aside from the benefits of maintaining a

[14] A simple example illustrates this insurance benefit from UIS. Assume that an insured with wealth of $50,000 has the choice between buying first-party insurance with either limited or unlimited subrogation to cover a 1% chance of medical malpractice resulting in total loss of wealth plus non-pecuniary harm. Assume also that tort would payoff (ignoring litigation risks and costs) $50,000 in economic damages and $150,000 in non-pecuniary damages and therefore that the physician charges an additional $2,000 to cover this expected liability. Assume finally that non-pecuniary harm will not affect the insured's marginal utility of money. Representing the insured's diminishing utility of money by equating the welfare derived from any amount of money with the square root of that amount, it is straightforward to show the superiority of UIS over LIS. Under LIS, after paying first-party and tort insurance premiums totaling $2,500, the insured expects utility in the absence of malpractice of 216 (99% x 218 utility from $47,500) and in the event of malpractice of 4 (1% x 444 utility from $197,500) or 220 total. Under UIS the first-party insurer anticipates and passes through the expected subrogated recovery for medical malpractice of $2000, reducing premiums and rebating cash in that amount, thereby eliminating tort insurance and related premium entirely and raising the insured's total expected utility to 222 (100% x $50,000 - $500 first-party premium).

cooperative and predictable relationship, first-party insurers would also recognize that liability insurers are capable of developing systematic responses to those tactics, for example, by credibly committing to invest in litigation to deter nuisance suits. In the current system, liability insurers may view the payoff from such responses as problematic. Building the required reputation may be too costly when the adversary is a plaintiff's attorney who does not have a regular, long-term relationship with the liability insurer. But the advent of UIS will replace the current sporadic encounters with plaintiff's attorneys with long-term relationships with first-party insurers. Indeed, UIS should motivate both parties to avoid abusive tactics that would disrupt this relationship because they would pay the price not only in higher operating expenses, but also in facing an adversary who has the means to retaliate in kind as well as the ability to spread the cost of resisting nuisance value litigation across many cases.

2.2.3. Administrative Efficiency. In addition to the insurance and deterrence benefits described above, one further direct benefit of UIS is to reduce overall administrative and transaction costs. It is reasonable to expect that UIS will produce a broad range of efficiency gains by transferring control over the processing of claims from plaintiff's attorneys to first-party insurers, which possess greater expertise as well as incentives to effect systemic reforms. UIS should improve efficiencies not only by lowering the costs of identifying, evaluating, and acquiring malpractice claims, but also by eliminating much of the expense of organizing, monitoring, and coordinating multiple parties with conflicting interests that presently comprise the plaintiff's side in medical malpractice litigation. Notably, under UIS, first-party insurers will avoid the substantial burden of keeping tabs on potential and filed claims and overseeing settlement allocations to prevent plaintiffs and their attorneys from dodging subrogation.

UIS may also yield cost savings because the insurers on both sides have the long-term interests and parity of litigation capacities to establish more cooperative, streamlined arrangements for exchanging information and negotiating settlements. This collaborative experience would reduce incentives for strategic bargaining as reciprocal displays of openness and straightforward bargaining build mutual trust and dependence. In short, the insurers will have a mutuality of long-term self-interest to avoid, and parity of legal as well as economic power to deter, unnecessary, opportunistic, or unmeritorious litigation. Although trials undoubtedly still will occur, UIS should make settlement more prevalent and efficient than it currently is and thus should achieve outcomes at a lower cost than the current system and yet at the same time that will more accurately reflect the merits.

2.3. Indirect Benefits

Important benefits are likely to result more indirectly from 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 of medical malpractice liability. Similar motivations should spur liability insurers to reciprocate. In addition to the administrative cost savings noted

above, these arrangements should also lead to substantive reforms of medical malpractice liability.

The major, overarching consequence of the new framework created by UIS is the enhanced motivation it provides insurers to improve the insurance and deterrence results of medical malpractice liability through "privatization." UIS would give insurers the incentive to establish by contract a private, non-judicial system of substantive criteria and procedural mechanisms for defining, enforcing, and determining medical malpractice liability. This private regime would operate in the "shadow" of the public judicial system that has been restructured by UIS. Because neither set of insurers rationally would agree to changes that weaken its litigation position in the post-UIS medical malpractice liability system, these private reforms will not undermine, but rather will only serve to augment UIS insurance and deterrence benefits and ultimately patients' welfare.

Topping the privatization agenda would be reform of the rules that currently govern the determination of liability and damages. To start, insurers could adopt minor changes such as giving professional insurance adjusters a greater role in resolving routine claims. This approach could lead to the development of standard schedules of 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 in each case. On a broader scale, the standardization of damages could lead to insurers settling cases en masse on an account book basis of debits and credits, perhaps resembling the process insurers use currently to resolve the bulk of automobile claims (Ross 1980). By using standard schedules and averaging, all of these procedures would streamline the determination of damages in individual cases without sacrificing deterrence in aggregate.

More dramatic reforms are also possible. Thus, insurers might change the rules governing liability and damages, for example replacing the standard negligence rule with strict liability and adopting joint and several liability to focus sanctions on hospitals, managed care institutions, and government agencies. Training liability on such organizations would facilitate the use of group-based liability insurance that could lower premiums for doctors and costs for patients and enlist the contractual and market power of these "gatekeepers" to control the risk of medical malpractice. Further, insurers might specify medical protocols and liability outcomes such that non-compliance or compliance by the physician with these protocols would be presumed to some degree of conclusiveness to establish the basis for a finding of malpractice or for a defense against the charge. This approach could help provide doctors with clearer guidance on what constitutes malpractice. It would also give greater responsibility for preventing injuries to the institutions that determine protocol, which may be better positioned to know what protocols reduce malpractice most effectively and to know the best way to train and motivate physicians to comply with those protocols.

Other reforms might change the type and burden of proof for establishing malpractice. Because the insurers would presumably seek to employ evermore reliable assessments of malpractice claims, they could come to rely more heavily on refined

professional criteria and correspondingly rigorous scientific methodology and evidence—such as that employed and developed by sophisticated statistical and epidemiological studies—than the current system of lay adjudication does. This reliance on professional criteria and scientific evidence and the desire for greater accuracy in malpractice determinations could also motivate further reforms, such as using expert decisionmakers in place of lay jurors and judges to resolve claims. For example, insurers could convene panels of qualified physicians and other experts to arbitrate or, if necessary, adjudicate questions of liability and sanctions for medical malpractice.

Of particular importance, privatizing medical malpractice could offer a means of protecting the reputations of physicians. Although obviously the risk of reputational harm can serve an important deterrent role, in many cases this sanction may be disproportionate, premature, or unfounded, leading to overdeterrence. UIS might improve the situation by facilitating a better accommodation between the need to shield physicians' reputations from unwarranted damage and the desire to publicize malpractice when appropriate. One way to protect reputations and also potentially motivate disclosure of possible malpractice might be using expert adjudicators who have a more sophisticated understanding of medicine than lay judges and juries and thus are less likely to render mistaken judgments. Insurers might also agree to preserve confidentiality pending the resolution of disputed claims. These arrangements might limit disclosure to 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.

Assuming that the parties do not elect fully binding arbitration, therefore leaving open the possibility of some court cases, insurers could also adopt various measures to discourage unnecessary or strategic resort to litigation. For example, they could agree that decisions rendered by the private system would be binding to some degree on the parties were their case to eventually wind up in court. The insurers could, for example, require that parties in the private system stipulate as to the admissibility and evidentiary significance of expert panel findings in subsequent judicial proceedings. This approach would limit the utility of merely relitigating issues in court and, in any event, would help to cabin the costs of disputes that ultimately require judicial resolution.

3. Costs of UIS

This Part considers whether the change to UIS entails possible "costs" relative to the current system of medical malpractice. For purposes of this comparative analysis, we assume that, except for the restructuring worked by UIS, the substantive and procedural features of the current system are the appropriate baseline. This means that we treat significant deviations from this baseline as costs. For example, we accept the present role of juries, despite the questions that exist about their competence to decide medical issues, thereby ignoring the possibility that if UIS minimized the role of juries that this change might be for the better. Our focus is on five areas of possible concern: (1) patients' willingness to cooperate without the prospect of recovering damages; (2) jury reaction to substituting the first-party insurer for the individual patient as plaintiff; (3) management

of cases involving multiple first-party insurers or, the opposite, a single insurer representing both sides in a dispute; (4) loss of tort insurance for non-pecuniary harm; and (5) insurers gaming the UIS system to the detriment of patients. We conclude that none of these concerns raises substantial doubts about the wisdom of UIS.

3.1. Patient Cooperation

To recover from doctors in tort for their malpractice, insurers sometimes will need the cooperation of the injured patient. A question about patients' incentives to cooperate in this process under UIS arises because with the first-party insurer subrogating the entire recovery, patients no longer have a direct financial stake in the litigation to motivate them to cooperate as they do in the current system.

However, it is important not to overstate the extent of this difficulty. Patient cooperation is often not a significant factor in the successful prosecution of a medical malpractice claim. Many claims are effectively litigated even though the patient may have died or been too severely injured to participate in the litigation. In these cases and to some degree generally, the basis for liability and damages can be conveyed through expert testimony. Indeed, on key questions that frequently arise, 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 superfluous. Even with respect to pain and suffering, one might question the need for patient testimony given the tendency of juries to extrapolate the award for non-economic damages from the award for economic damages. And, if the anticipated insurer contracted reforms occur under UIS, the patient's role is likely to diminish further as the focus of liability shifts to statistical and systemic indicia of proof and institutional means of limiting malpractice risks.

In any case, securing patient cooperation under UIS usually would occur much as it does currently without any great difficulty. Many patients will not need a financial payoff to motivate cooperation, as they will have non-economic reasons for wanting to participate, such as punishing the defendant doctor or sending a "deterrence message" to others. For patients that do need a financial inducement, much of the time the issue is only that cooperation entails costs for the patient. Insurers can easily overcome this problem by compensating patients for their time and expenses related to the litigation. Insurers also have developed other means of dealing with less-than-fully-cooperative insureds. Insurance policies (first-party and liability) generally mandate cooperation and make it a condition precedent to payment of benefits and continued coverage. Patients are therefore unlikely to withhold their cooperation because doing so risks forfeiting needed compensation or triggering the denial of future coverage. Even if all of this is insufficient to ensure cooperation, insurers can subpoena insureds to compel testimony, submission to medical tests, and other necessary assistance.

Yet it is possible a case might arise in which a 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 however the first-party insurer responds to the patient's demand in such a case, it will confront and be forced to accept a

settlement offer by the liability insurer that is discounted to reflect either the patient's non-cooperation or the first-party insurer's fractional rather than optimal litigation investment. If rejecting or agreeing to the patient's demand were the only alternatives open to the first-party insurer, cases of non-cooperative patients thus could undermine the beneficial restructuring effected by UIS. But UIS authorization for claim assignment provides the first-party insurer with another option, one that maximizes its profits by inducing the liability insurer to make an undiscounted settlement offer. Essentially, the first party insurer can counter a discounted settlement offer with the threat (1) to pay the patient a share of the recovery that secures cooperation and (2) to make the optimal investment that would maximize total expected recovery, just as it would otherwise under UIS. This threat is credible because the first-party insurer and patient can split the maximized total expected recovery in a way that makes them both better off than they would be under the discounted-settlement alternatives.[15] Anticipating exposure to the maximum total expected recovery, the liability insurer will offer to settle the case without any discount.[16] Therefore, in the vast majority of cases that settle, UIS functions exactly as it would function were the patient cooperating fully.[17]

3.2. Jury Behavior

If jury sympathy for injured plaintiffs tilts outcomes in favor of plaintiffs, 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. But, here

[15] The first-party insurer would treat the reduction in the premium it has given to the now-recalcitrant insured as a sunk cost. If it anticipates incurring additional expense to establish credibility, the insurer can spread that cost over future cases where it reaps the benefit from having demonstrated to liability insurers that there is no profit in discounting their settlement offers. Although liability insurers can also spread the cost of paying the maximized total recovery in a given case, first-party insurers will prevail in the long run. The reason is that they can reduce the pass-through benefit to cover the costs of investing optimally to maximize total recovery and to pay-off patients to ensure cooperation (cf. Polinsky & Rubinfeld 2003). This is a profitable strategy for first-party insurers, whereas going to trial to face a cooperative patient rather than settling is not a profitable strategy for liability insurers.

[16] The liability insurer could bribe the patient to be uncooperative, but this strategy would have little chance of succeeding. Both the liability insurer's inducement as well as the patient's compliance would breach the standard contractual requirements for insured cooperation. For this breach, patients would face the sanction not only of forfeiting the balance of the policy coverage and payments, but also of having to repay benefits received. Moreover, because courts are unlikely to enforce such collusive agreements, it is doubtful that they would be made in the first place let alone performed given the prospect of both parties being free to defect. This threat of sanctions and defection, not to mention reputational harm, combined with norms of good faith and other social constraints on devious behavior, may explain why collusion is not considered a significant problem for subrogation arrangements today, despite their susceptibility to this form of gaming.

[17] So far we have considered the problem of patient recalcitrance on the assumption that it would not impede the ability of insurers to settle the claim based on a reasonable estimate of the maximum expected judgment that would result from the patient's full cooperation. 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. If this problem arose, the first-party insurer would continue to follow the strategy of investing optimally to maximize the total expected judgment, but in this case it would actually have to pay a share of the recovery to the patient for cooperation. Operating under this constraint, UIS would still achieve its primary deterrence objectives, but would not lower premiums as much as it would otherwise, although its insurance benefits would still exceed those of LIS.

too, it is important not to overstate the problem. Some empirical studies suggest that jury sympathy may not be major factor in determining liability (e.g., Clermont & Eisenberg 1992). Notably, plaintiffs win jury trials in medical malpractice cases less than 30 percent of the time, although to be sure, when juries find for plaintiffs they award relatively high damages (Tort Trials and Verdicts in Large Counties 1992). But this high payout rate may be explained not by sympathy for plaintiffs but rather by jurors' desire to punish culpable doctors, and UIS would not change the identify of the defendant. Moreover, to our knowledge, there is no evidence or even complaint that subrogation cases result in lower jury awards in the current system, although this may simply be because the subrogated insurer is less visible to the jury.

If UIS did threaten to alter jury behavior, first-party insurers likely could mollify jurors' reactions by presenting the testimony of a sympathetic, cooperative patient. More generally, to the degree the problem is one of how juries perceive and respond to evidence, one can surmise that first-party insurers will deploy existing methods or develop new ones to foster jury sympathy. In addition, courts can take corrective action by educating juries about the role of the first-party insurer in the litigation process. Courts could represent these insurers as performing the function of a "private attorney general" and emphasize the way in which providing full recovery serves desirable social goals. Or the jury might be informed about the fact that insurers are the real parties in interest on both sides of the litigation to help ensure that the jury is as objective as possible.

And if this problem turns out to be serious, first-party insurers have another option. Like the uncooperative-patient problem, the unsympathetic jury problem is generally worrisome only because it translates into discounted settlement offers by liability insurers that could undermine the restructuring benefits of UIS. Thus, in the vast majority of cases that could settle, the first party insurer can respond by credibly threatening to re-assign a sufficient share of the recovery to qualify the patient as the plaintiff-party in interest and who, as in pre-UIS trials, could be represented to the jury as such. And even if there is a residual group of cases that goes to trial and the first-party insurer must actually pay the patients in these cases, the deterrence benefits of UIS will continue to flow and the insurance results will still exceed those achieved by the current system because optimal investment leads to a higher recovery and hence bigger shares for both parties.

3.3. Management Issues

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. Many seriously injured individuals currently tap coverage supplied by some combination of commercial carriers and various governmental insurance programs, such as Medicare. Similarly, on the liability side, multiple carriers typically supply direct or contingent coverage at both primary and excess levels. Contract provides the general solution for these sorts of coordination problems that may arise when multiple subrogated or liability insurers are involved in litigation. Driven by market forces and mutual, long-term

interest, the insurers currently resolve management difficulties by agreeing, either before litigation commences or afterward on an ad hoc basis, on questions such as which insurer should take the lead counsel role, how to allocate costs, and the conditions for an insurer separately settling with an opposing party. Problems of coordination arising under UIS should be amenable to the same types of contractual solutions. Indeed, these types of coordination problems should prove less burdensome with UIS because the restructuring will encourage insurers to develop a long-term "privatized" system for resolving claims. Moreover, first-party insurers could develop innovative solutions that obviate the need for any coordination among them, such as creating primary or secondary markets for the sale of subrogated interests. And in the event an intractable difficulty arises in some case, courts can, as they now do, resolve the problem, drawing on methods used to solve similar coordination problems that inevitably will arise in multi-party cases.

The second potential management problem is the possibility that a single insurer will provide 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 more socially desirable outcome that an adversarial relationship would produce. There is no evidence, however, of such conflicts of interest arising in similar situations that exist in the current system, which often occur with automobile insurers that insure both drivers involved in an accident or insurers in workers compensation that prosecute subrogation claims against manufacturers of defective workplace machinery and also provide liability insurance to the manufacturers. In fact, one would not expect this duality of interests to cause the insurer to shortchange either side of the case since a rational, profit-maximizing insurer would make itself best off by treating both sides optimally. Specific to malpractice, because an insurer with such dual interests will internalize the total costs of medical malpractice, it profits by minimizing that sum, and by doing that it promotes both optimal insurance and deterrence, thereby enhances patient welfare. Any remaining problem with dual-coverage insurers under UIS can be addressed simply by mandating that insurers maintain a separate and adversarial relationship between their plaintiff- and defense-side operations. For example, corporations currently often set up separate divisions that have conflicting interests, and administering medical malpractice litigation within a dual insurer seems amenable to similar arrangements to foster the adversarial resolution of claims.

3.4. Loss of Tort Insurance for Pain and Suffering

UIS might prompt an objection that authorizing first party insurers to recover full tort damages will deprive patients of tort insurance for non-economic harm, in particular, for pain and suffering. However, even assuming, against the evidence, that insureds want such coverage (that is, that suffering non-economic harm increases their marginal utility of money in the accident state) and would willingly pay for such coverage, this objection has no relevance to our proposal as applied to commercially supplied insurance. This is because under our proposal UIS is simply a contractual option. Thus, the market for first-party insurance might offer insureds various subrogation packages, ranging from the status quo to UIS, which would provide and price the opportunity to forgo some amount

of tort insurance for pain and suffering. This market would for the first time reveal to patients how much the tort premium for non-economic harm coverage actually costs and benefits them.

In any case, because the market currently supplies trifling, if any, pain and suffering coverage there is good reason to believe that if given a choice between retaining this tort coverage and increasing first-party insurance coverage for economic loss, patients will generally prefer the latter and thus will opt for UIS (Owings-Edwards 2004).[18] For if insureds are currently unwilling to pay the market premium for first-party insurance against pain and suffering, it is doubtful they would voluntarily pay a much higher premium for more risky and dilatory tort coverage when they are given the opportunity to forgo it by UIS.[19] Moreover, on the realistic assumption that many insureds currently are underinsured for economic loss because of loading costs, deductibles, and other constraints on the supply of first-party coverage, it is reasonable to believe that insureds would accept the UIS offer of lower premiums to enable them to purchase greater coverage for economic loss.[20]

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[18] This is not to suggest lack of demand for compensation in exchange for bearing the risk of pain and suffering, but that demand is not for insurance; rather, it is for ex ante compensation, such as wage premiums employers pay for risky employments (Viscusi 1998), just the sort of ex ante compensation UIS promises. Some claim, however, that market demand for pain and suffering coverage is not negligible, pointing to sub-segments of markets for certain specialty lines of insurance, such as parents taking out whole-life insurance policies on their children, or workers who possess disability insurance that cover their economic losses buying accidental death and dismemberment coverage (ADD), which pays relatively small liquidated sums for loss of a limb, eye, and similar discrete traumatic bodily injuries (Croley & Hanson 1995). However, the most realistic understanding of such insured behavior is also the most plausible. The parents are likely duped by an insurance scam that portrays whole-life policies as a vehicle for tax-free college savings. And the ADD example is better explained as workers supplementing their disability coverage for income loss, which is generally capped at between 60–75% of pre-disability wages to discourage insureds from feigning the extent or duration of their disability. Insurers are willing to sell ADD as a supplement because the objectively verifiable severe injuries that are covered obviate these moral hazard problems (Croley & Hanson 1995).

[19] The lack of pain and suffering coverage is often attributed not to a lack of market demand, but rather to problems of adverse selection and moral hazard that hinder the provision of such insurance. In particular, the inherent subjectivity of the risk and injury involved is thought to prevent insurers from effectively risk-rating insureds' premiums and verifying their claims of harm (Croley & Hanson 1995). This argument, however, does not explain the absence of "political" demand for pain and suffering coverage from government-supplied accident insurance, such as workers' compensation, which does not suffer from problems of adverse selection. And although workers' compensation does confront moral hazard problems, so does tort. Tort employs rather expensive adjudicative processes to verify claims of pain and suffering. Yet, workers' compensation could do the same if workers were willing to pay the costs of such a system, which they evidentially are not. Similarly, it is doubtful that the market-defect explanation holds even for first-party commercial insurance, which could provide pain and suffering coverage simply by selling additional units of such coverage pegged to the existing coverage for economic loss generally or pegged to a workers' compensation-type schedule of traumatic injuries, from which insureds could select for augmented payouts (Rosenberg 1996; Connolly 2001). Moreover, the market could always deal with moral hazard by mimicking tort and adopting adjudicative rules and processes to verify claims of pain and suffering – if insureds were willing to pay the price.

[20] The foregoing argument also responds to the possible concern about UIS curtailing tort insurance for lost income. To be sure, moral hazard problems force governmental and commercial insurers to cover less than 100% of this loss, while tort, using adjudicative processes to deal with those problems, purports to provide full coverage. But it is far from clear that insureds, who apparently refuse to pay for government and

3.5. Gaming the System

Finally we consider whether UIS would open new, systematic, and significant opportunities for insurers to take advantage of insured doctors or patients. We conclude that UIS presents no such problems. Nor do we see UIS as magnifying the current opportunities insurers have to take advantage of their insureds. Indeed, UIS is likely to ameliorate the problems in this area that already exist. For example, because the value of insured cooperation will increase in many cases, UIS may help deter first-party insurers from denying or underpaying benefits in bad faith, a practice which persists in the current system despite reputational, tort, and administrative deterrents.

Given that endless possibilities for perversity are imaginable, we can make no claim to having proved that gaming is impossible. But analysis of the major UIS related effects on insurer incentives reveals no serious dangers. We have considered in particular whether first party insurers would steer patients to physicians prone to malpractice to boost subrogation revenues. We doubt that a reputable insurer would adopt this strategy, and, in any event, it is not one that a rational, profit-maximizing insurer would follow. The reason is that the increase in the expected malpractice recovery from channeling patients to risky doctors would be offset by those doctors charging first-party insurers a higher price to cover increased liability exposure. There are also many legal barriers to preempt this strategy. For example, both the injured patients and liability insurers could sue to recover compensatory and punitive damages for this malfeasance, principles of contributory negligence and assumption of risk would bar tort recovery for insurers who channel their patients to higher risk doctors, and the liability insurers footing the bill would likely detect the strategy and expose the first-party insurer to criminal investigation as well as scrutiny by insurance regulators.

Another potential form of gaming is that liability insurers might offer first-party insurers side-payments to drop or slacken the prosecution of malpractice claims. Again, while impossible to rule out, this strategy is unlikely to occur. To make the first-party insurer better off taking the bribe than prosecuting its subrogated malpractice claim, the liability insurer would have to pay a bribe that is at least equal to the expected subrogated recovery from the litigation under UIS. Obviously, there is no profit in making this

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commercial insurers to employ such processes as a means of alleviating moral hazard, are made better off by supplementing their income loss coverage through compulsory tort insurance. In fact, the supposition that tort insurance supplies full coverage is belied not only by the great costs and risks of tort liability, which have the effect of imposing a high deductible, but also by the fact that generally tort does not provide insurance for "future" (post-judgment or -settlement) income loss. In contrast to the periodic payment approach taken by first-party insurance, which replaces income loss for as long into the future as the disabling condition persists, tort normally resolves claims on a lump-sum, expected loss basis. Such a payout provides only the money to buy a commercial insurance policy that would cover future loss of income, not the insurance policy itself. UIS restructuring of medical malpractice liability would enhance the lump sum payout from tort and would automatically translate that recovery into real insurance by lowering first-party premiums, enabling insureds to obtain expanded coverage for income and other dimensions of economic loss.

payment, which in any event would represent a socially appropriate settlement of the claim.

Conclusion

While disagreement exists about the specific causes and consequences, the general consensus is that medical malpractice liability fails to promote the insurance and deterrence goals of the legal system. UIS offers a simple, comprehensive solution to these problems, regardless of the nature of the problem By making only a minor modification in the current rules governing subrogation, UIS would authorize first-party insurers to take control of the plaintiff's side of medical malpractice litigation, which would directly and immediately enhance the insurance and deterrence results of the system. In addition to these direct benefits, UIS also creates a platform that encourages future voluntary changes by contract between first-party and liability insurers.

Harnessing these market forces is a virtue of UIS that distinguishes our proposal from other enacted and proffered reforms of the medical malpractice system specifically and tort systems generally, which often require substantial regulatory oversight with concomitant costs to work effectively. In contrast, UIS allows insurers to take charge, avoiding the need for regulation and its costs while promoting the goals of optimal deterrence and insurance to a far greater extent than is currently possible. Of course, the privatization of medical malpractice liability does not preclude regulatory intervention. Indeed, UIS should foster judicial and legislative reform efforts by rendering the system more stable, transparent, and rational, especially through its singular focus on deterrence. Finally, we should also emphasize that there is nothing about UIS that limits its application to medical malpractice liability. UIS could also be deployed to deal with traffic accident litigation and more generally to the entire range of tort claims for personal injury.

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