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PRIVATE INSURANCE, SOCIAL INSURANCE, AND TORT REFORM: TOWARD A NEW VISION OF COMPENSATION FOR ILLNESS AND INJURY

*Kenneth S. Abraham and Lance Liebman**

The United States does not have a *system* for compensating the victims of illness and injury; it has a set of different institutions that provide compensation. We rely on both tort law and giant programs of public and private insurance to compensate the victims of illness and injury. These institutions perform related functions, but the relationships among them are far from coherent. Indeed, the institutions sometimes work at cross-purposes, compensating some victims excessively and others not at all.

The absence of a coherent system of compensation is reflected even in suggested reforms of existing institutions. Proposals to reform tort law[1] often do not recognize the role played by public and private

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1. Some reform advocates would do away with tort law and replace it with insurance. See, e.g., Peter W. Huber, Liability: The Legal Revolution and Its Consequences 193–206 (1988) (advocating replacement of tort by direct insurance, contract, and agency regulation of large-scale societal risks); Stephen D. Sugarman, Doing Away with Personal Injury Law: New Compensation Mechanisms for Victims, Consumers, and Business 127–48 (1989) (arguing for replacing tort system with social insurance system and new regulatory scheme to prevent accidents). Some would extend the reach of tort law. See, e.g., Glen O. Robinson, Probabilistic Causation and Compensation for Tortious Risk, 14 J. Legal Stud. 779, 781–83 (1985) (advocating tort liability for creation of risk of harm); David Rosenberg, The Causal Connection in Mass Exposure Cases: A "Public Law" Vision of the Tort System, 97 Harv. L. Rev. 849, 866–68, 881–87 (1984) (arguing for proportionality approach to proof of causation in mass tort litigation). Some would reorder tort law by transferring many of its compensation and deterrence functions to other institutions and strengthening the tort law that would remain. See, e.g., George L. Priest, The Current Insurance Crisis and Modern Tort Law, 96 Yale L.J. 1521, 1587–90 (1987) (calling for removal of insurance function of tort law, leaving deterrence function only); Richard B. Stewart, Crisis in Tort Law? The Institutional Perspective, 54 U. Chi. L. Rev. 184, 190–95, 198 (1987) (suggesting changes in allocation of functions among existing compensation institutions). Finally, some would create methods by which victims and injurers could elect alternatives to tort law. See, e.g., Jeffrey O'Connell, Neo-No-Fault: A Fair-Exchange Proposal for Tort Reform, *in* New Directions in Liability Law 186, 190–94 (Walter Olson ed., 1988) (advocating legislation allowing defendant to offer plaintiff mandatory settlement limited to value of economic loss).

insurance programs in compensating for health care expenses and lost income, even though insurance programs dwarf tort law as a system of reimbursement.[2] Similarly, those who offer proposals for altered private or public insurance protection—and many put changes in the nation's system of health insurance at the top of the domestic agenda[3]—usually ignore the connections between a family's insurance protection (whether provided by government, by an employer, or by first-party purchase) and the ill or injured victim's claims against a tortfeasor. Moreover, insurance reform proposals often ignore a fundamental insight of modern tort theory: when a system provides compensation for expenses not previously reimbursed, the entire cost of this new compensation is not an added social cost. The added cost of a new program may, in the broader social context, merely be shifted from victims or another program. The blindnesses of these proposals to their institutional "neighbors" are easy to explain. Because of academic and practice specialization, many of the persons most knowledgeable and creative about tort law know little about private and social insurance, while insurance and social-welfare experts often know little about tort law.

In contrast, other countries have articulated the principles that un-

2. Although more than forty states adopted tort reform legislation of some kind during the last decade, on the whole this legislation has merely tinkered with tort law doctrine and cannot be seen as fundamental change. The most common reforms include placing ceilings on the amount of pain and suffering damages recoverable, modifying the collateral source rule, and restricting the scope of joint and several liability. For a catalogue of the measures enacted, see Joseph Sanders & Craig Joyce, "Off to the Races": The 1980s Tort Crisis and the Law Reform Process, 27 Hous. L. Rev. 207, 217–23 (1990).

3. The prominence of the health care issue in the recent presidential election is particularly notable. Comprehensive health care proposals have been on the U.S. political agenda for fifty years. Currently discussed reforms range from the Republican proposal to create tax incentives for the purchase of health insurance and to support the creation of health insurance pools for small businesses, to proposals for Canadian-style "national" health insurance, see U.S. Gen. Accounting Office, Canadian Health Insurance: Lessons for the United States (1991) [hereinafter Canadian Health Insurance], to the Pepper Commission's recommendations for the institution of "universal" health and long-term care insurance for all Americans, see U.S. Bipartisan Comm'n on Comprehensive Health Care, 101st Cong., 2d Sess., Recommendations to the Congress: Access to Health Care and Long-Term Care for All Americans 1–3 (1990) [hereinafter Pepper Recommendations]. In between lie a variety of proposals for the provision of health insurance through employers or other groups, including "play or pay" proposals that would permit employers to provide such coverage ("play") or "pay" a tax to finance a publicly-operated insurance pool covering the residual population of uninsured persons. See Alain C. Enthoven, Managed Competition: An Agenda for Action, Health Aff., Summer 1988, at 25, 45; see also Alain C. Enthoven & Richard Kronick, A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy, 320 New Eng. J. Med. 29, 32 (1989) (advocating "pay or play" as part of a broader scheme to provide universal health insurance).

derlie their systems of injury and illness compensation.[4] Developing a clearer sense of the principles animating the institutional arrangements for compensation in the United States is an essential prerequisite to creating a more coherent system of protection and to assigning proper roles to tort law, private insurance and social insurance.[5]

The goal of this Article is to take the first step in this direction. The Article seeks to expose the existing relationships among tort law and the private and social insurance systems; to identify the gaps and overlaps in the existing network of compensation institutions; to analyze the obstacles to the achievement of a different regime; and to indicate the choices that must be made in constructing a coherent compensation system. Our angle of attack is more analytical than programmatic. Part I describes the "system" of compensation now in place in the United States. Part II analyzes relationships among different existing institutions, isolating points of tension and inconsistencies

4. For discussions of the health insurance systems of other industrialized countries, see generally Canadian Health Insurance, supra note 3 (1991); U.S. Gen. Accounting Office, Health Care Spending Control: The Experience of France, Germany, and Japan (1991). For a comparative discussion of disability and other protections, see P.R. Kaim-Caudle, Comparative Social Policy and Social Security: A Ten-Country Study 290–312 (1973). For a similar analysis of civil liability schemes, see Werner Pfennigstorf & Donald G. Gifford, A Comparative Study of Liability Law and Compensation Schemes in Ten Countries and the United States (1991).

5. Numerous scholars have explored the principles underlying existing institutions, contributing to the quest for a more principled and coherent system. Charles Reich saw that for contemporary citizens health, retirement, and disability benefits play the role that land performed in early modern times. See Charles A. Reich, The New Property, 73 Yale L.J. 733, 733 (1964). Others have extended the metaphor of estates in land to positions in the modern welfare state. See Lance Liebman, The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates, 89 Harv. L. Rev. 833, 864–67 (1976).

Today, some scholars press for a comprehensive benefit system, pursuing horizontal equity for those placed in need by harsh events. See Eli P. Bernzweig, By Accident Not Design: The Case for Comprehensive Injury Reparations 157–62 (1980) (proposing a statutory social insurance scheme premised on the notion of social responsibility to accident victims). Among the most inventive in suggesting devices for allowing individuals to protect themselves against economic loss is Jeffrey O'Connell. See Jeffrey O'Connell, Expanding No-Fault Beyond Auto Insurance: Some Proposals, 59 Va. L. Rev. 749, 773–75 (1973) (arguing for enterprise liability for injury resulting from typical risks inherent in the enterprise's activity). All of these studies look with interest at the comprehensive system in place in New Zealand. For a description of the New Zealand model, see Report of the Royal Commission of Inquiry, Compensation for Personal Injury in New Zealand 177–88 (1967); Geoffrey Palmer, Compensation for Incapacity: A Study of Law and Social Change in New Zealand and Australia 222–30 (1979).

Other scholars, however, are much more skeptical. They see diverse functions, especially deterrence, being performed by the current mix of programs and worry that a comprehensive social welfare alternative to current arrangements will generate large costs in reduced deterrence of those who could take precautions to avoid illness and injury. See, e.g., Michael J. Trebilcock, Incentive Issues in the Design of "No-Fault" Compensation Systems, 39 U. Toronto L.J. 19, 20 (1989).

of principle. Part III seeks to confront the problems ignored by most current proposals for compensation reform—the obstacles to expansion of the current compensation web. Part III also offers several models designed to guide thinking about the relationships among private insurance, social insurance, and tort.

I. The Existing Fabric of Protection

The United States has no "system" of compensation for the victims of illness and injury and has not adopted the principle that all such victims should receive full compensation. Consequently, we have a collection of different compensation programs, with gaps between and overlaps among them, leaving many victims undercompensated and some actually overcompensated. These different institutions employ different criteria for determining whether the victim of illness or injury receives benefits. Responsibility for compensation is based sometimes on fault, sometimes on cause, and sometimes on loss. For example, tort liability for accidental injury is generally imposed only upon proof of the defendant's fault; workers' compensation and similar no-fault systems pay compensation upon the occurrence of an illness or injury that can be ascribed to a particular cause, regardless of fault; and first-party private and social insurance cover particular occasions of loss, regardless of fault or cause.

A. *Fault-Based Compensation*

Although certain tort law doctrines impose true strict liability, most tort liability for illness or injury is predicated on some form of fault on the part of the defendant. Despite the considerable attention devoted to the subject, tort recovery is a modest compensation program in the context of the other systems of compensation available in the United States for the consequences of illness and injury. For example, in 1984, tort recoveries totaled $39 billion—something over $50 billion in current dollars.[6] But this sum comprised only one-tenth of the total paid by all systems. Moreover, this comparison ignores federal and state income maintenance programs.[7] If the sums paid by these programs are included, the quantitative significance of tort is even smaller. It would be foolhardy, therefore, to assess possible changes in tort law without considering the scope of these other programs and the obstacles that stand in the way of their expansion.

B. *Cause-Based Compensation*

In contrast to the tort system, which pays compensation after a de-

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6. See Jeffrey O'Connell & James Guinivan, An Irrational Combination: The Relative Expansion of Liability Insurance and Contraction of Loss Insurance, 49 Ohio St. L.J. 757, 759 (1988).

7. See id.

termination of fault, cause-based compensation programs pay as long as a loss arises out of or is caused by a particular activity or exposure. Workers' compensation is the most widespread of these programs, having been adopted in all fifty states.[8] It provides roughly $30 billion in benefits per year to workers who suffer illness or injury as a consequence of employment.[9] Benefits include full payment of medical costs and a percentage of lost wages up to a specified ceiling. In addition, workers' compensation makes lump-sum payments for designated injuries (for example, loss of a limb) under the infamous "meat chart," and pays survivors' benefits. Wage-loss and lump-sum payments comprise about 60% of the program's expenditures.

Unlike the loss-based insurance programs discussed below, which disburse only long-term benefits for total disability, workers' compensation pays benefits for both temporary total and permanent partial disability. About three-fourths of all workers' compensation cases involve payments for temporary total disability, but these comprise only 18% of all the money paid as benefits. In contrast, about one-fourth of the cases are permanent partial disability claims, which account for about 70% of all benefit payments.[10]

In addition to workers' compensation, a number of other cause-based compensation programs have been adopted in recent years. The most prominent of these are the auto no-fault plans, adopted in fourteen states, which pay over $2 billion annually.[11] Two states have also recently adopted cause-based programs to compensate the victims of birth-related neurological injury.[12] At the federal level, the Black Lung Benefits Program pays approximately $1.5 billion per year,[13] the National Vaccine Injury Compensation Program is projected to pay $80 million per year,[14] and Veterans' benefits for military service-related health care and disability total over $21 billion per year.[15]

Although these different cause-based programs have no particular relation to each other, and although Veterans' benefits are partly "welfare" rather than injury or illness compensation, it is nonetheless useful for comparative purposes to note that the total compensation that cause-based programs pay, approximately $55 billion, is roughly equal to the $50 billion paid by the tort system to its beneficiaries.

8. See 1 Arthur Larson, The Law of Workmen's Compensation § 5.30, at 39 (1992).

9. See Bureau of the Census, U.S. Dep't of Commerce, Statistical Abstract of the United States 368 (1991) [hereinafter Statistical Abstract].

10. See William J. Nelson, Jr., Workers' Compensation: 1980–84 Benchmark Revisions, Soc. Security Bull., July 1988, at 4, 9 (figures cited are for 1982).

11. See Josephine Y. King, No Fault Automobile Accident Law 7–14 (1987); O'Connell & Guinivan, supra note 6, at 767 n.2.

12. See Fla. Stat. Ann. §§ 766.301–766.316 (West Supp. 1992); Va. Code Ann. §§ 38.2-5000–38.2-5021 (Michie 1990 & Supp. 1992).

13. See Statistical Abstract, supra note 9, at 369.

14. See 42 U.S.C. § 300aa-15(j) (1988).

15. See Statistical Abstract, supra note 9, at 93, 360.

C. *Loss-Based Compensation*

Two basic forms of loss insurance provide compensation for the economic consequences of illness and injury: private insurance and social insurance. Together the sums paid by these two sources dwarf those paid by both the fault-based and cause-based systems of compensation.

1. *Private Insurance.* — The principal forms of private loss insurance provide coverage for health care expenses, income lost because of disability, and loss of life or limb. Each form of coverage is first-party insurance or victim's coverage, as distinguished from third-party or liability insurance which covers a party's liability as an injurer. Private first-party health, disability, and life insurance pay approximately $220 billion annually.[16]

a. *Health Insurance.* — Health care costs in the United States exceed $800 billion per year, and have been growing annually at a rate of 10%.[17] Basic private health insurance, including Blue Cross and Blue Shield and coverage provided by commercial carriers, covers various combinations of physician's services, hospitalization, rehabilitation, and nursing care. In addition, Major Medical insurance covers certain costs above the specified limits of coverage under primary policies. Together these sources of coverage pay roughly $185 billion in insurance benefits each year.[18]

Sizable as these benefits are in absolute terms, more than thirty million Americans have no private or socially provided health insurance,[19] and about one-quarter of those who are covered by health insurance of some sort have inadequate coverage. For example, in 1987,

16. See American Council of Life Ins., Life Insurance Fact Book Update 17 (1991) [hereinafter Fact Book] ($24.5 billion in life insurance benefits paid in 1990); Health Ins. Ass'n of Am., Source Book of Health Insurance Data 7 (1991) [hereinafter 1991 Source Book] ($185 billion in health insurance benefits paid in 1989); Health Ins. Ass'n of Am., 1988 Update: Source Book of Health Insurance Data 9 (1988) [hereinafter 1988 Update] ($5.6 billion in disability insurance benefits paid in 1986). Although classifying this coverage as "private" is a useful way to distinguish it from insurance provided through "on-budget" governmental expenditures, in some respects the classification is problematic. Most health and disability insurance, for example, is group coverage provided (or offered for purchase) as a fringe benefit of employment. The terms of coverage are regulated by a federal statute (Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001–1461 (1988)) as well as by state statutes and regulations. The fact that such heavily regulated coverage has become so common for middle-class wage earners and their families has important implications for the direction in which expansions might occur. See infra part III. Thus, it is also worth recognizing the tripartite distinction among individually purchased private insurance; heavily regulated, "private" employer-provided insurance; and governmentally operated "social" insurance.

17. See 1991 Source Book, supra note 16, at 7.

18. See id.

19. Congressional Research Serv., 100th Cong., 2d Sess., Health Insurance and the Uninsured: Background Data and Analysis 93 (Comm. Print 1988).

an estimated 15.3% of all insured families incurred health care costs greater than 5% of their income, and 3.7% of all insured families incurred costs greater than 25% of their income.[20] These costs included policyholder/beneficiary contributions in the form of deductibles and coinsurance payments and costs for services not covered under the policies or subject to lifetime benefit limitations.[21]

While these estimates provide a useful reference point, it is important to recognize that people who have no health insurance are not necessarily denied health care. Many of the uninsured are treated at public and nonprofit hospitals, which do not collect most of the charges billed to uninsured patients. Such hospitals then often include a portion of these unrecovered costs in the sums for which they are reimbursed by private health and social insurance.[22] In effect, insured patients provide partial insurance to uninsured patients; the "owners" of public and nonprofit hospitals then absorb the remaining cost of treating the uninsured. This system of "insuring" the uninsured, however, is far from ideal. Public and nonprofit hospitals have an incentive either not to treat or to under-treat the uninsured, and this incentive has its effects: people without health insurance receive less primary and preventive care than those who are insured.[23]

b. *Disability Insurance.* — Disability insurance protects the insured party against income lost as a result of physical or mental inability to perform his current or, in the case of some coverage, any occupation. This form of coverage usually insures against losses caused by total disability, although some policies also cover partial disability, often simply by providing short-term coverage for occupational disability and long-term coverage for general disability.

Disability insurance is the least prevalent form of private loss insurance. About 60 million people (roughly 55% of the workforce) are covered by private short-term disability insurance, defined as coverage against disability lasting for less than two years; but only about 24 mil-

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20. See id. at 3–4.

21. See id. In 1988, Congress attempted to address part of this problem by enacting "catastrophic" coverage for the elderly. See Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683. The costs were to be borne by a tax on relatively well-off older beneficiaries. But when the tax was imposed, taxpayers protested, and in 1989 the program was repealed. See Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, 103 Stat. 1979 (1989).

22. The extent of this cost-shifting is a matter of some debate, and it varies from state to state. See Jack A. Meyer, Financing Uncompensated Care with All-Payer Rate Regulation, *in* Uncompensated Hospital Care 167, 167–68 (Frank A. Sloan et al. eds., 1986).

23. See Joel Weissman & Arnold M. Epstein, Case Mix and Resource Utilization by Uninsured Hospital Patients in the Boston Metropolitan Area, 261 JAMA 3572, 3575–76 (1989) (analysis indicating shorter lengths of stay and fewer procedures for uninsured patients); Steffie Woolhandler & David U. Himmelstein, Reverse Targeting of Preventive Care Due to Lack of Health Insurance, 259 JAMA 2872, 2873–74 (1988) (lack of insurance is strongest predictor of failure of women to receive screening tests).

lion people (roughly 22% of the workforce) are covered by long-term disability insurance.[24] Private disability insurance pays only about $6 billion in benefits annually.[25]

c. *Life Insurance.* — General-purpose life insurance, whether whole-life or term, covers death resulting from any cause; special-purpose accidental death and dismemberment policies or endorsements to general-purpose policies (for example, providing "double indemnity") cover death or grievous bodily harm resulting from accidents. However, special-purpose policies and endorsements appear to provide so small a percentage of total life insurance payments that they are not even separately reported in the industry's own statistical summaries.[26]

The gross amounts of life insurance in force and paid in benefits annually are substantial. Life insurance payments to beneficiaries, as distinguished from payments to policyholders and annuitants as some form of return on savings, totalled $24.5 billion in 1990.[27] In the same year over $9 trillion in life insurance was in force, providing an average of $121,000 in life insurance per insured household in the United States.[28] Although the size of this average death benefit is more than nominal, much of the population probably has only modest coverage at most. On the one hand, roughly 80% of all policies, providing 64% of all coverage, insure persons with incomes of less than $50,000 per year.[29] But on the other hand, 47% of all policies provide 72% of all coverage.[30] It seems fairly clear, therefore, that slightly less than half of the population is protected by the vast majority of life insurance that is in force in the United States. The other half of the population is far less well protected.

2. *Social Insurance.* — Most governmentally provided "social" insurance against illness and injury in this country is loss-based; that is, benefits are payable upon the occurrence of a specified form of economic loss regardless of fault or cause.[31] Each American social insur-

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24. See 1988 Update, supra note 16, at 7 (statistics are for 1984 and 1986 respectively).

25. See id. at 9. By contrast, annual disability benefits paid by public programs and workers' compensation are ten times as large: over $60 billion in 1988. See Statistical Abstract, supra note 9, at 360.

26. See Fact Book, supra note 16.

27. See id. at 4.

28. See id.

29. See id. at 7 (1990 statistics).

30. See id.

31. There are, of course, other social insurance programs based mainly on economic need, but typically these do not provide compensation for losses expressly associated with illness or injury. Programs such as Aid to Families with Dependent Children and General Relief, while "categorical" (eligibility may require, for example, being a single parent and engaging in efforts to find work), fall into this category. See infra note 42 and accompanying text. Workers' compensation, which we regard as the paradigmatic example of cause-based protection, is sometimes described as social insurance in that government mandates and regulates such employer-paid insurance.

ance program was designed individually to meet particular needs. As a result, the programs taken as a whole do not reflect a clear vision of communal responsibility for an identifiable subset of the economic risks of modern life.

a. *Health Insurance.* — Medicare and Medicaid provide the lion's share of federally supported health care insurance.[32] In the aggregate, these two programs pay roughly $159 billion per year for health care provided to the elderly and the poor.[33] Other federal and state health care insurance and similar programs pay roughly $40 billion in benefits annually.[34]

Medicare provides reimbursement for hospital costs and physicians' services for individuals who are eligible for the Social Security old age and disability insurance programs, for nearly all elderly individuals not eligible for Social Security, and for persons with end stage renal disease.[35] The hospital-cost insurance program known as Part A is provided free of charge; under Part B, eligible individuals must pay premiums to obtain insurance for the costs of physicians' services. Medicaid is the federal program that matches the states' provision of health care assistance to low-income individuals regardless of age.[36] The amount of assistance provided varies considerably from state to state.

b. *Disability Insurance.* — Two large federal programs, Social Security Disability (SSD) and Supplemental Security Income (SSI), provide benefits to persons who are permanently and totally disabled.[37] Together these programs pay annual benefits of approximately $35 billion.[38]

Most workers who become permanently disabled are eligible for SSD benefits, which are monthly payments calculated in virtually the

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And unemployment insurance is in a sense triggered by limited forms of fault or cause as well as by loss, since those out of work after they quit or are fired for cause are ineligible. No easy conceptual taxonomy organizes these large programs, because they were invented at different times to respond to different problems, and to reflect different social judgments.

32. Medicare and Medicaid were created by Congress in 1965. See Health Insurance for the Aged Act, Pub. L. No. 89-97, 79 Stat. 290 (1965) (codified as amended at 42 U.S.C. § 1395 (1988)); Grants to States for Medical Assistance Programs Act, Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. § 1396 (1988)).

33. Medicare pays approximately $94 billion of this sum, and Medicaid pays the remaining $65 billion. See 1991 Source Book, supra note 16, at 38–39.

34. See id. at 40–41.

35. See 42 U.S.C. §§ 1395c, 1395o (1988).

36. See id. § 1396 (1988).

37. SSD was created by Congress in 1956. See Social Security Amendments of 1956, Pub. L. No. 84–880, 70 Stat. 807 (codified as amended at 42 U.S.C. § 401 (1988)). SSI was created sixteen years later. See Supplemental Security Income for the Aged, Blind and Disabled Act, Pub. L. No. 92-603, 86 Stat. 1465 (1972) (codified as amended at 42 U.S.C. §§ 1381–1383d (1988)).

38. In 1988, SSD paid benefits of approximately $24 billion; SSI paid approximately $11 billion. See Statistical Abstract, supra note 9, at 360.

same manner as Social Security retirement benefits. Eligibility requires that a claimant (1) have worked at covered employment for the requisite number of quarters; (2) suffer from an inability to work that is "medical" in nature; and (3) be permanently and totally disabled.[39] "Permanently" is defined as suffering from an affliction likely to last for one year or more, and "totally" as being unable to perform "any other kind of substantial gainful work which exists in the national economy."[40]

The second eligibility condition, that a claimant's inability to work be "medically determinable," excludes from coverage workers whose unemployment is caused by declines in capacity or willingness to work that cannot be explained medically. This requirement, which results in major dispute-resolution difficulties over such issues as eligibility for individuals affected by alcoholism and drug addiction, is central to the political and moral judgments that underlie the program. Congress has chosen to compensate some individuals for the unfortunate things that happen to them, but not to compensate others who are in economic need. In part, the distinction attempts to separate those whose own choices and decisions brought about their inability to work from those whose behavior is socially unobjectionable but who have been victimized by a medical event.

In fact, of course, the social judgment embodied in the program is imperfectly captured by the line between medical and nonmedical disabilities. Millions of people have shortcomings that result at least partially from injury, disease, or physical or mental decline and that restrict their employment opportunities. The real issue in determining whether they should qualify for benefits is not whether their disability can be diagnosed as medical. Rather, the thousands of cases that have been decided by written opinions show administrative and judicial decision-makers analyzing a complex series of factors, including the claimant's physical and mental abilities, age, sex, level of education and skills, as well as the structure of the relevant labor market.[41]

SSD is in a sense a supplement to the permanent total disability component of workers' compensation described earlier. Whereas workers' compensation covers only work-related disability, SSD is available whether or not a person's handicapping illness or injury was caused by employment. But SSD uses the same benefit formula as the Social Security retirement program, and therefore replaces only a small percentage of wages for all but the lowest-income workers. Thus most workers with a non-work-related disability will suffer a substantial income loss unless they have bought disability insurance on their own, their employers have provided it, or they have a cause of action in tort.

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39. See 42 U.S.C. §§ 423(c)–(d) (1988).

40. Id. §§ 423(d)(1)(A), (d)(2)(A) (1988).

41. See Jerry L. Mashaw, Bureaucratic Justice: Managing Social Security Disability Claims 108–21 (1983).

Another federal program paying benefits to the totally disabled that resembles insurance, SSI, makes means-tested payments to persons who are medically unfit for labor but either did not work enough to achieve Social Security eligibility or receive some Social Security payments but have so little income and assets as to be eligible for SSI supplementation. Included in this category are persons who are born with a disability, those disabled during childhood, and those disabled as adults before achieving sufficient participation in the labor force. Unlike Aid to Families with Dependent Children (AFDC)[42] or general relief arrangements, SSI benefits are not conditioned on a work search or acceptance of "improvement" services. Like SSD, however, SSI claimants must also satisfy the statutory disability standard of being "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment"[43] likely to result in death or to extend for twelve months.[44]

Finally, five states and Puerto Rico operate short-term disability programs that pay over $2 billion in benefits per year.[45] These programs impose taxes on employers or employees and create funds from which payments are made to persons who become totally disabled for a period of months.

II. Relationships Among Compensation Programs

The most striking feature of the "system" of compensation that we have just described is that it is not systematic at all. The United States lacks an intellectual structure to undergird its web of programs compensating the victims of illness and injury. In attempting to understand the different principles that underlie the current system and the directions that future development might take, two issues merit particular attention: (1) the goals of current compensation programs and (2) the methods by which they coordinate the benefits they pay. Analysis of each of these issues helps to uncover the relationships among American compensation programs and sets the stage for our discussion of the possibilities for expanding and restructuring the system in Part III.

42. See Aid to Families with Dependent Children Act, 42 U.S.C. §§ 601–687 (1988). Although AFDC is America's chief minimum income program, benefits are available only for families with children, and in no state do benefits place families at or above the so-called poverty line. $29 billion was spent on this program in 1988. See Statistical Abstract, supra note 9, at 358.

43. 42 U.S.C. § 1382c(a)(3)(A) (1988).

44. Some proposals call for a less rigorous standard of disability in SSI than that used in SSD, premised on the idea that a minimum income at the SSI level should be available to anyone who is not in good health and cannot in fact find work. See Sheila R. Zedlewski & Jack A. Meyer, Toward Ending Poverty Among the Elderly and Disabled Through SSI Reform 47–70 (1989).

45. In 1989, for example, these programs paid out $2.7 billion. See Soc. Security Bull., Spring 1992, at 124. The five states are California, New Jersey, New York, Hawaii, and Rhode Island. See id.

A. *The Goals of Existing Programs*

In Part I, we isolated the three bases upon which American compensation programs pay the victims of illness and injury: fault, cause, and loss. These programs can serve one or more of four principal goals: corrective justice, deterrence, forced insurance, and income redistribution. It is possible at least in theory to envision at one extreme a program concerned exclusively with corrective justice and deterrence—a system of civil liability for blameworthy behavior. At the other extreme would lie programs concerned exclusively with the redistribution of income to those suffering illness and injury. In between would lie programs of forced insurance, which, through various methods of pricing and risk classification, would combine elements of deterrence with elements of income redistribution.

While existing programs serve a mixture of these goals, typically one of the goals predominates. The dominant goal of each existing program can be discerned by examining the sources of funds used to pay claims, the nature of the events that are compensable, and the measure of compensation employed by the program.

1. *Fault-Based Systems.* — The tort system is the primary fault-based system for compensating victims of personal injury. Under the tort system, the injurer is the source of payment. Compensation is paid for full out-of-pocket loss and pain and suffering, except when the victim was also at fault, in which case damages are reduced (or denied entirely, in the few states which still adhere to contributory negligence) in proportion to the negligence attributable to the victim. Corrective justice and optimal deterrence are the conventionally understood goals of this arrangement. But in several respects the matter is more complicated than this simple analysis suggests. First, as many commentators have noted, the existence of liability insurance tends to undermine both the corrective justice and deterrence rationales for the imposition of tort liability.[46] An insured defendant does not personally correct the injustice done in causing injury to the plaintiff; rather, the defendant's liability insurer performs this correction. When the magnitude of the defendant's insurance premiums is not closely related to the magnitude of the defendant's liabilities, the defendant does not even perform this correction indirectly. Under these circumstances, the threat of tort liability may not only fail to achieve corrective justice, but may also fall short of promoting optimal deterrence, because a defendant can externalize the risk of liability through the purchase of liability insurance.[47]

Second, even aside from the impact of liability insurance, the imposition of liability in the long-latency toxic tort cases that have increas-

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46. See 1 American Law Inst., Reporters' Study, Enterprise Responsibility for Personal Injury 24–33 (1991) (noting this argument and its proponents).

47. See Kenneth S. Abraham, Distributing Risk: Insurance, Legal Theory, and Public Policy 64–83 (1986).

ingly become the focus of controversy within the tort system is unlikely to achieve the goals of corrective justice and optimal deterrence. In such cases the management and shareholders at the time a wrongful act is committed are unlikely to be those who, decades later, sustain the cost of any liability that is imposed for the consequences of the act of a defendant corporation. Consequently, the parties who are wrongdoers or benefit from wrongdoing do not correct the injustice suffered by the victims of long-latency torts. Rather, that injustice is corrected later by others, assuming that the party or parties held liable are solvent. On occasion, the price of shares in a business incorporates a discount for an already-identified probability that the business will be held liable for some past conduct. In such instances, those responsible for the conduct may well bear the cost of its predicted consequences. But when a particular risk of future harm has not yet been recognized nor potential liability for the risk accurately gauged, no such specific discount occurs. Thus, unless the risks associated with a particular pattern of conduct are recognized at the time the conduct takes place, the threat of tort liability for its consequences is unlikely to have the optimizing effect on risk at the core of the deterrence rationale.[48]

Third, in a large group of tort cases, the plaintiff and the defendant are not strangers, but stand in a direct or indirect contractual relationship with each other. Patients and their physicians fall into this category, as do product purchasers and sellers. Economic theory predicts that in efficiently operating markets these parties will contract for the mix of safety, liability, and compensation they prefer,[49] and so satisfy their desire for corrective justice and optimal deterrence. Yet, in prescribing a particular mix of liability and compensation and in making most forms of tort liability for personal injury nondisclaimable, tort law precludes such contractual arrangements. One perfectly plausible explanation for this blanket no-disclaimer rule is that, on balance, the markets for health care services and consumer products are not sufficiently efficient to permit contract to displace tort, and case-by-case inquiry regarding whether the requisite conditions for permitting displacement had existed would be prohibitively expensive. A complementary explanation is that the no-disclaimer rule has a paternalistic motive: to force potential victims to insure themselves against personal injury. If tort liability could be disclaimed, potential victims might not use the resulting price savings to insure themselves against the risk that they would be injured by the health care or the products they purchased. The no-disclaimer rule assures that victims are "insured"

48. See Donald N. Dewees, Economic Incentives for Controlling Industrial Disease: The Asbestos Case, 15 J. Legal Stud. 289, 317–19 (1986) (arguing that in asbestos context, the presence or absence of tort liability has little effect on a firm's incentives to reduce worker exposure).

49. See Ronald H. Coase, The Problem of Social Cost, 3 J.L. & Econ. 1, 6–8 (1960).

against losses caused by tortious action, with the likely consequence that potential injurers will charge potential victims at least part of the cost of this "insurance" through increased charges for health care or consumer products.

Finally, even when the threat of tort liability does have a deterrent effect on potential injurers, it may fail to create optimal incentives for potential victims to avoid injury and to reduce their losses after injury. The effects of the doctrine of comparative negligence on victim behavior are uncertain. Moreover, the recoverability of compensation in tort that is not subject to monetary deductibles or coinsurance creates *ex post* moral hazard: victims sure of recovery in tort are more likely to consume excessive medical care and not to return to work after injury than are victims without any prospect of recovery in tort.

In short, the conventional picture of the tort system as a corrective justice and deterrence regime is overly simple. Tort liability is also a forced-insurance arrangement, under which potential victims are required to insure themselves against the risk of suffering injury from the provision of health care or the sale of a product. In this respect, at least, tort law constitutes a disguised insurance program that resembles some of the programs that more explicitly perform this function. But unlike many of those programs, in our view, tort law is not a very sensible system of victims' insurance: it makes compensation available only when the injurer's fault can be demonstrated; it reduces compensation to the extent that the victim was at fault; its transactions costs are high; it covers pain and suffering in unlimited amounts even though many victims would wish limited or no such coverage *ex ante*; and in providing first-dollar coverage without explicit deductibles or coinsurance, it makes itself vulnerable to *ex post* moral hazard.[50]

2. *Cause-Based Systems.* — Certain of the cause-based programs perform the forced-insurance function much more effectively. In fact, each major non-means-tested cause-based program incorporates a forced-insurance feature. For example, workers' compensation, a cause-based system of nearly absolute liability for work-related personal injury, is obviously much less concerned with corrective justice than tort law and relatively more concerned with assuring compensation for those suffering such injury. Like the nondisclaimability of tort liability, the mandatory character of workers' compensation can be viewed as a reflection of this aim. At least part of the cost of the employer's liability is financed indirectly by employees, who in effect pay a mandatory premium (through wages that are lower than they would otherwise be) for the insurance protection they receive through workers' compensation. The other major cause-based system of compensation, auto no-fault, quite transparently incorporates a forced-insurance

50. See George L. Priest, The Current Insurance Crisis and Modern Tort Law, 96 Yale L.J. 1521, 1550–63 (1987) (discussing failure of tort law as an insurance mechanism).

feature, since it requires potential victims themselves to purchase insurance protection.[51]

Because workers' compensation and auto no-fault are cause-based systems, however, they retain some capacity to promote deterrence. And because they employ less than perfectly-refined risk classification, they also embody some income redistribution from potential to actual victims of work- and auto-related injury and illness. In effect, these are intermediate, mixed programs whose main goal appears to be forced insurance, but that incorporate deterrence and income redistribution as subsidiary goals.

3. *Loss-Based Systems.* — The structure and financing of the non-means-tested loss-based insurance programs reveal that forced insurance is also one of their major goals. Over 80% of private health and disability insurance is purchased on a group basis, generally as a fringe-benefit of employment.[52] In most states, the provision of this coverage is not legally mandatory,[53] but health insurance and short-term disability coverage have become such ordinary benefits of employment by medium-size and large firms that their existence reflects a social precommitment to insurance in these settings, reinforced by the income tax subsidy provided such benefits. Many employment-based private loss insurance programs, however, also use reasonably refined risk classification and managed-care features that are likely to have at least mild deterrence effects.[54]

Similarly, because the two major non-means-tested social insurance programs, SSD and Medicare, are both partially financed by potential beneficiaries and are mandatory, they contain a strong forced-insurance component. They respectively help to assure that virtually all disabled citizens have minimum insurance against loss of income resulting from disability and that the elderly have minimum insurance against the cost of hospitalization. Given the demands that would be placed on the public fisc in the absence of this component of SSD and Medicare, the method of financing these two programs can be regarded in part as a nonprogressive[55] tax that avoids the income redistribution to the dis-

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51. In contrast, the federal Black Lung Benefits Program, financed largely by the coal industry, is less a forced insurance scheme *among* victims than a redistributive program *for* them. See Black Lung Benefits Act, 30 U.S.C. §§ 901–945 (1988).

52. See Health Ins. Ass'n of Am., Source Book of Health Insurance Data 5 (1989) (health insurance); Health Ins. Ass'n of Am., Source Book of Health Insurance Data 16 (1984–85) [hereinafter 1984–85 Source Book] (disability insurance).

53. But see Haw. Rev. Stat. §§ 392, 393 (1988) (requiring employers to provide temporary disability and health care benefits for employees). Steps toward mandatory health insurance have been taken in Massachusetts, Oregon, and Vermont.

54. Of course, efforts at cost containment can raise profound questions of fairness. See, e.g., McGann v. H&H Music, 946 F.2d 401, 404–08 (5th Cir. 1991) (holding that an employer many impose a low dollar limit on medical reimbursement for AIDS treatment after an employee has tested HIV-positive), cert. denied, 60 U.S.L.W. 3582 (U.S. Nov. 9, 1992) (No. 91-1283).

55. This characterization is a bit oversimplified. SSD can be regarded as somewhat

abled and the elderly that might otherwise occur. But SSD is financed by a wage tax that is paid half by employers and half by employees,[56] and Medicare is financed partly by the same type of wage tax and partly from general federal revenues.[57] This component of SSD and Medicare financing makes them more purposefully redistributional.

Income redistribution, however, clearly is the major function of the two principal means-tested loss-based insurance programs: Medicaid, which provides health care assistance to the poor, and SSI, which provides income support to the disabled who are not eligible for SSD. Both programs are noncontributory, and both insure only those with very low or no income.[58] But this is income redistribution on a fairly limited basis. Many of the working poor are ineligible for SSI because they have been forced to insure themselves under SSD; and the same individuals are ineligible for Medicaid in many states even if they have no other health insurance, as is likely to be the case.

All of these loss-based programs, like the cause-based ones discussed above, contrast sharply with the tort system in one salient respect. To varying degrees, these programs employ techniques designed to manage or contain the incentives of insured victims to consume a greater than optimal quantity of medical care or disability protection. These techniques for dealing with *ex post* moral hazard—deductibles, coinsurance, managed care, ceilings on coverage, waiting periods—vary from program to program, but each is directed at the kind of post-accident "victim deterrence" that is notably missing from the tort system, which in effect fully "insures" the victims it compensates.

4. *A Comparison of the Systems and Their Goals.* — Arraying the bases upon which American compensation programs make payment and the programs' varied goals along two different axes reveals the following structure:

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progressive because the benefit formula is skewed toward low-wage workers. Medicare can be regarded as somewhat regressive because richer people live longer and consume greater amounts of expensive medical care.

56. See Bernzweig, supra note 5, at 33.

57. See Marilyn E. Manser, Historical and Political Issues in Social Security Financing, *in* Social Security Financing 21, 35 (Felicity Skidmore ed., 1981).

58. See supra notes 35–36, 42–44 and accompanying text.

	FAULT	CAUSE	LOSS
CORRECTIVE JUSTICE/ DETERRENCE	Tort among strangers	Traditional strict liability	
FORCED INSURANCE	Medical malpractice Products liability	Workers' compensation Auto no-fault Birth-Injury funds Vaccine Fund	SSD Medicare Private insurance
INCOME REDISTRIBUTION		Black Lung Benefits Program	Medicaid SSI

In light of the preceding discussion of the mixed goals of these programs, we have obviously oversimplified by suggesting in the matrix that each program serves only one goal. But the matrix is nonetheless revealing. The empty cells at the top right and bottom left demonstrate that certain goals cannot easily predominate within certain kinds of programs. For example, a loss-based compensation system could not achieve precise and focused corrective justice and deterrence unless premiums (or taxes) financing the system were calibrated to responsibility for the losses covered by the system and paid by potential injurers, who might in some cases be potential victims themselves. For instance, oil companies, automobile manufacturers, and smokers would have to be charged higher taxes to finance a national health insurance program than pillow manufacturers and nonsmokers. In effect, financing would have to be cause-based even while the right to compensation was loss-based. Such an approach is theoretically possible, but it would pose enormous administrative difficulties. For this reason, it is unsurprising to see that no existing compensation system falls in the top right cell of the matrix, although private loss-insurance programs seek modestly to achieve deterrence by charging risk-classified premiums and employing other cost-containment measures.

Similarly, it would be extremely difficult to use a fault-based system to achieve wealth redistribution from those with high incomes to those with low incomes.[59] If poor people do not suffer a disproportionately

59. In fact, it probably is true that in certain respects the wealthy are treated better by the tort system than the poor. For example, in all likelihood the wealthy have disproportionately greater access to the tort system than the poor for two reasons. The first is cultural—the wealthy may be more likely than the poor to feel comfortable with and be willing to use the legal system for redress. The second is a function of the recoverability of full damages for wages lost as a proximate result of tortious action. Because the wealthy are likely to suffer more lost wages from any given injury than the poor, attorueys are more likely to be willing to represent them on a contingent-fee basis. Moreover, whenever liability is imposed on a party in a direct or indirect contractual relationship with the plaintiff, full recovery of lost wages in tort has a regressive income

high (or low) share of the injuries resulting from malpractice or defective products, then an expansive (or restrictive) right to recover in tort for such injuries will not benefit the poor disproportionately. And even if tort law could be shaped so as to benefit poor plaintiffs disproportionately, one would have to take into account the impact of imposing liability on particular categories of defendants and the resulting effect on their employees and customers before one could be certain that a particular rule had a net redistributional effect. Consequently, there is no form of tort liability for personal injury whose main goal is income redistribution, and the bottom left cell of the matrix is empty.

What the matrix does not reveal, however, is why the remaining cells are filled the way they are. Some of the possible explanations make sense, but some require closer analysis. For example, because both fault- and cause-based systems of compensation have the potential to promote deterrence, a nondeterrence explanation for the allocation of some compensation functions to the tort system and others to cause-based systems is desirable. The differences between the capacity of these systems to achieve corrective justice is one possibility. As we noted earlier,[60] however, although the fault system takes the *form* of a corrective justice system, the widespread incidence of liability insurance limits the degree of correction that flows directly from the defendant to the plaintiff. Moreover, some cause-based systems preserve an attenuated sort of corrective justice by employing a financing mechanism that charges the parties associated with injury-causing activities the cost of compensating for these injuries. On the other hand, some cause-based systems—most notably auto no-fault—have no capacity to promote even this attenuated form of corrective justice, because they are financed through premiums paid by potential victims, not by potential injurers. Thus, it may be that the *appearance* of corrective justice influences the choice between fault- and cause-based systems.

Overall, however, the allocation of functions between fault- and cause-based systems may be determined as much by practical considerations as by reasons of principle or appearance. First, the kinds of personal injuries that have been carved out of the tort system and transferred to cause-based systems often are those believed (sometimes correctly and sometimes not) to be technically susceptible to treatment on a causal basis. Work- and auto-related injuries, vaccine side effects, black lung disease, and birth-related neurological defects are thought to be both easily discernible and in the main distinguishable from other

redistributional effect, since all purchasers pay the same "premium" for tort liability "insurance" as part of the price of a product or service, regardless of the magnitude of the income they can expect to lose if they are the victim of tortious action for which a seller is responsible. See Priest, supra note 50, at 1559. Placing a ceiling on the amount of lost wages recoverable in tort (whatever else one thinks of the idea) would tend to reduce this income-regressive effect.

60. See supra notes 46–47 and accompanying text.

kinds of injuries or diseases with other causes.[61] The development of broad-based medical, products, or environmental injury compensation systems based on causal responsibility has not yet been possible, however, precisely because of the difficulty of defining a conceptually sound and easily applied compensable event in these fields—a difficulty that has long been recognized.[62]

Second, as a matter of practical politics, it is almost always easier to adopt a cause-based system if its cost is no greater than the cost of the component of the tort system it replaces.[63] Thus one characteristic of cause-based systems that recommends them is that they generally pay beneficiaries their economic losses only, and often only partial economic losses at that. The tort system, in contrast, purports to pay both economic and noneconomic losses in full. But when the number of injuries resulting from fault is small in comparison to the number caused without fault by the activity in question, even restricting payment to economic losses alone may not be sufficient. Because compensating the economic losses of all eligible claimants might cost more than the component of the tort system a proposed cause-based system would replace, employing cause-based systems runs into political obstacles.

Similarly, the decision to retain fault-based and cause-based systems at all when they overlap with loss-based systems is easy enough to explain, but not always as easy to justify in principle. Even when it would be feasible to employ broader-based loss insurance systems ex-

61. Part of the explanation for the current troubles facing workers' compensation, however, may well lie in the new difficulty of drawing the work-/nonwork-relatedness distinction. When workers' compensation was created to deal mainly with injury, it was clear that a broken leg on the job was work-related. But with the advent of disease claims that may or may not be work-related (for example, asbestosis, stress, heart attacks), the work exposure allegedly responsible for the loss may have occurred decades earlier, cigarette smoking by the employee may have magnified the probability of loss by ten, and other factors may have intervened to render the work-relatedness determination highly difficult and more costly to make.

62. See, e.g., Clark C. Havighurst & Lawrence R. Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 Milbank Memorial Fund Q. 125 (1973) (proposing no-fault medical adversity insurance); James Henderson, The Boundary Problems of Enterprise Liability, 41 Md. L. Rev. 659, 662–76 (1982) (calling for concrete lists of events triggering liability, yet admitting that "techniques for avoiding errors of inclusion and exclusion have obvious limits").

63. This insight can be traced back in the academic literature at least as far as Walter J. Blum & Harry Kalven, Jr., Ceilings, Costs, and Compulsion in Auto Compensation Legislation, 1973 Utah L. Rev. 341, 342–43. Of course, this political fact of life may rest as much on oversimplification as on accurate cost accounting. Some apparently "new" costs may merely be shifted from one source to another rather than newly incurred. The point holds not only for cause-based but also for loss-based programs. Expanded health insurance costs more if more people get care, but if they are getting it already, then the political debate about "increased" costs may merely misread or misreport which current costs are being replaced. The point holds for cost "cutting" as well. Medicaid can be "cut" by pushing the working poor into hospital charity and then letting the cost of charity be passed to Blue Cross.

clusively, we have retained tort liability, workers' compensation, and auto no-fault, for example, because of our unwillingness to surrender entirely the possibility of achieving corrective justice and deterrence in the classes of cases that these systems cover. But these systems' capacity to achieve corrective justice and deterrence is inherently limited. Some of the well over $100 billion per year spent by these systems—especially a portion of their transactions costs—might be better spent compensating the losses of those who suffer illness and injury but are ineligible for recovery in tort or from any cause-based system and are not covered by private or social loss insurance. Proponents of fundamental reform of the tort system commonly make this suggestion,[64] though sometimes without a sufficient appreciation for the difficulties of expanding our various systems of loss insurance. Conversely, the proponents of health and disability insurance reform[65] usually talk of reform without referring at all to the relation between these fields and the tort, workers' compensation, and other no-fault systems. To get a sense of the possibilities, in the next section we examine how these relationships actually operate and then turn in Part III to several visions of the future.

B. *Coordination of Benefits*

The different programs for compensating the victims of injury and illness analyzed thus far relate to each other not only conceptually; in actual operation the coverage provided by the different programs sometimes overlaps. Examining the methods these programs employ—or fail to employ—in coordinating coverage in the event of such duplication is yet another way of understanding the American compensation "system."

Focusing first on the relationship between the tort system and the different cause-based compensation programs, it is apparent that in many instances there is no duplication. For example, workers' compensation is almost always an exclusive remedy against a claimant's employer; a claimant under the Florida and Virginia birth-injury programs generally has no cause of action in tort;[66] and an auto no-fault policyholder whose claim falls below the statutory tort "threshold" may not bring an action alleging negligence by the driver who injured her. In these instances a shift from the emphasis on corrective justice that is

64. See, e.g., Huber, supra note 1 (arguing that incentives to assess and avoid risk are best promoted through *ex ante* private contract and private insurance); Sugarman, supra note 1 (arguing for the replacement of personal injury law with a generous system of social insurance).

65. See, e.g., Enthoven, supra note 3 (proposing a system of managed competition); Enthoven & Kronick, supra note 3 (same).

66. See Fla. Stat. Ann. §§ 766.301–766.306 (West Supp. 1992); Va. Code Ann. §§ 38.2-5000–38.2-5021 (Michie 1990 & Supp. 1992).

the hallmark of tort law toward forced insurance—a characteristic goal of cause-based programs—has been decisively made.

In other situations, however, neither tort law nor a cause-based program is the exclusive vehicle of recovery. Under such circumstances, each system has essentially three options: (1) to allow duplicate (or overlapping) compensation; (2) to allocate primary coverage responsibility to the tort system; or (3) to allocate primary coverage responsibility to a cause-based system. Although cause-based systems occasionally employ the first approach, for the most part they adopt either the second or third. For example, workers' compensation takes the second approach. When an employee who has been paid workers' compensation brings a suit against a third party (for example, the maker of a product that caused the employee's injuries), the employer or its insurer has a right to indemnification out of any tort recovery received by the employee from the third party. The ostensible effect of this arrangement is that the product maker, not the employer, bears the full cost of the loss. Although in the long run the purchase price of the product may be adjusted to take account of this effect, the message clearly reflected in this arrangement is that the goals of tort law are of greater importance than the goals of workers' compensation. In auto no-fault, by contrast, the third option is employed. Here, the tortfeasor is relieved of a portion of his or her liability, because auto no-fault benefits typically are offset against any tort recovery obtained by a no-fault policyholder. The message of this approach is that the goals of the no-fault program take precedence over the goals of the tort system. While there may be political explanations for this inconsistency, we can see no persuasive basis for it in principle.

Loss-based systems also tend to interact quite inconsistently with both fault- and cause-based systems. For example, until recently the principle of coordination that applied when loss-based and other systems overlapped was similar to the principle by which tort and workers' compensation recoveries currently are coordinated. In tort law, the collateral source rule allowed the plaintiff to recover from the defendant sums already paid to the plaintiff by loss-based systems of compensation. Loss-based systems could be reimbursed out of these recoveries pursuant to contractual or statutory rights of subrogation.[67] As a result, at least in theory, loss-based systems did not compensate for losses paid by the tort system.[68] Similarly, as between cause- and loss-based compensation systems, the former shouldered ultimate coverage responsibility. For example, Social Security Disability benefits were, and still are, reduced by sums paid or payable by workers' com-

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67. The exception was and is life insurance, which in general is not subject to rights of subrogation or reimbursement.

68. In practice, however, double compensation of certain losses probably occurred because insurers did not exercise their rights of subrogation or reimbursement out of policyholders' tort recoveries. See 2 American Law Inst., supra note 46, at 170–71.

pensation.[69] In short, loss-based insurance did not compensate for losses paid by fault- or caused-based compensation programs.

Thus, coverage priority ran from fault-, to cause-, and finally to loss-based compensation systems. The importance of corrective justice and deterrence seemed to explain these priorities. When both fault- and loss-based compensation were available, corrective justice and deterrence suggested that the tortfeasor or its liability insurer should bear primary responsibility for compensating the victim. When both cause- and loss-based compensation were available, concern for the promotion of deterrence through cost-internalization required allocating primary coverage responsibility to the cause-based system. In both situations, loss-based systems served as secondary sources of compensation and the other systems were primary sources.

This overall consistency has recently been shattered, however, by changes in the collateral source rule in tort law and by the development of analogous changes within some of the newer cause-based systems. The collateral source rule was partially or completely abolished by legislation in more than a dozen jurisdictions during the last decade.[70] As a consequence, in these jurisdictions most loss-based systems of private and social insurance bear primary responsibility for losses that would otherwise be compensable in tort. To complicate matters further, even where this new scheme is applicable, it is subject to an exception for Medicare and Medicaid benefits. State rules governing coordination between these benefits and other sources of compensation are preempted by provisions in the federal statutes creating Medicare and Medicaid, under which the programs bear only secondary or tertiary coverage responsibility.[71] Similarly, several of the new cause-based compensation schemes that have been carved out of the tort system reverse the traditional coverage priorities described above. For example, in many states, auto no-fault benefits are payable only to the extent that workers' compensation and loss-based sources of compensation are not available;[72] and the Florida and Virginia birth-related neurological defect funds pay medical expenses only to the extent that such benefits are not payable by health insurance.[73]

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69. See 42 U.S.C. § 424a (1988).

70. For a catalogue of these and other tort reforms of the past decade, see Sanders & Joyce, supra note 2, at 255–58.

71. See 42 U.S.C. § 1396b(o) (1988); see also Rubin v. Sullivan, 720 F. Supp. 840, 844–46 (D. Haw. 1989) (holding that Hawaii no-fault insurance statute exempting Medicaid recipients from coverage was preempted by federal statute); Abrams v. Heckler, 582 F. Supp. 1155, 1163–65 (S.D.N.Y. 1984) (upholding federal regulation prohibiting Medicare payments where state law's no-fault insurance benefits are secondary to Medicare).

72. This allocation is subject to the exception for Medicare and Medicaid described supra note 71 and accompanying text.

73. See Fla. Stat. Ann. § 766.31(a) (West Supp. 1992); Va. Code Ann. § 38.2-5009(1) (1990).

One motive for these changes has almost certainly been the desire to reduce the costs of the system that is made a secondary source of compensation for the loss in question. Whatever else might be said in favor of this motive, at the level of principle it is nearly empty, since the change merely shifts costs from one system to another without reducing them overall. Indeed, to the extent that the older fault-over-cause-over-loss approach to coverage priorities could be justified on deterrence grounds, the recent reversal of priorities is likely to increase marginally rather than decrease costs overall, because of the loss of deterrence resulting from the reversal.

A very different justification for these changes, however, may well have an arguable basis in principle. Under the traditional collateral source rule, loss-based compensation rights were seen as assets of the tort plaintiff—assets from which the defendant should not benefit and which therefore were not offset against the plaintiff's recovery in tort. For the same reason, payments from loss-based systems did not reduce cause-based recoveries. It might now be argued that the recent reversals of these traditional coverage priorities reflect the fact that cause- and loss-based sources of compensation have proliferated. Employer-provided health and disability insurance and Social Security Disability benefits, for example, are so widespread that they no longer need be considered uniquely individual assets. Rather, according to this argument, the implicit assumption underlying the new priorities is that nearly everyone has such insurance. Since no one has made a conscious decision to purchase these forms of insurance instead of consuming other goods, rules denying the parties responsible for payment under fault- or cause-based systems the benefit of the existence of loss-based compensation have become unnecessary. The fact that the new rules do not apply to life insurance—which remains largely a personal consumption item purchased in varying amounts by different individuals—supports this thesis.

The assumption upon which this interpretation is based, however, is inaccurate. Although private and social loss insurance is much more widespread than it was even several decades ago, such coverage is not as pervasive as the assumption suggests. As we noted in Part I,[74] thirty million people have no health insurance, approximately 78% of the workforce has no private insurance against long-term disability, and the maximum Social Security Disability benefit covers only a portion of the income lost from permanent total disability. Medicaid and SSI are also incomplete programs of coverage. Thus, while there has been a trend towards greater protection, substantial gaps in the fabric of private and social insurance remain. Moreover, the reversal of coverage priorities that makes loss insurance primary has been incomplete in two ways. First, while some states have revised the traditional collateral source

74. See supra notes 19, 24, 41–42 and accompanying text.

rule, others have not. Even in those states that have revised the rule, the shift in priorities has been limited by the federal preemption in the Medicare and Medicaid statutes. Second, workers' compensation has retained the traditional priorities, while several but not all of the newer cause-based systems have reversed them.

All this makes the effort to discern any principle or principles in the American system of compensating for illness and injury extremely difficult. The system is a patchwork of different programs that are loosely and inconsistently coordinated. That condition is perhaps only natural for a set of programs that did not grow up as a system and that are only now being perceived as potentially systematic. For those whose proposals for reform anticipate the development of a genuine "system" of compensation, the challenge is to understand the obstacles that stand in the path of such development and to devise ways of overcoming them.

III. Toward a Coherent System of Compensation

If the different American compensation programs are to be woven into a coherent and coordinated system, then greater attention will have to be paid both to the scope of the individual programs and to the relationships among them. We shall offer three different models of more expansive, more coherent systems. These include: (1) a tort system oriented mainly to achieving corrective justice and deterrence combined with greater private and social insurance protection—a model we call "broader categorical subsistence"; (2) a scheme embodying a similarly limited tort system but more systematic private and social insurance protection, which we call "full subsistence"; and (3) a scheme with a very limited tort system and private and social insurance against virtually all the economic losses suffered by individuals as a result of illness and injury, which we call "full welfare."

Our aim is not to recommend one approach over others, although it is obvious that, because any actual expansion will likely be incremental, a "broader categorical subsistence" approach is in reality more likely to be adopted than the other two more expansive approaches. Rather, we want to analyze the obstacles that would impede a commitment to any one of these intellectually valid approaches, and sketch the contours of each approach, outlining the three different models toward which the current system might evolve.

A. *Obstacles to Expansion*

Expanding the current patchwork of compensation programs would generate considerable, but not insurmountable problems. In what follows we discuss separately the difficulties that would be encountered in expanding health and disability insurance, for the two forms of coverage face different challenges.

1. *Health Insurance.* — The insurance system has shown itself quite capable of providing adequate health insurance to the vast majority of the American middle class, although without more adequate cost controls it is uncertain whether that system will be able to continue in its present form. Largely for reasons of cost, the system has not provided health insurance to the working poor. The Pepper Commission estimated that the additional federal cost (in 1990 dollars) of providing adequate health insurance and long-term care to the entire population would be $66 billion per year, about two-thirds of which would be net new spending.[75] In one sense, this may be a low estimate, since without more effective cost controls, the addition of this much demand is likely to push health care costs even higher, with corresponding subsequent increases in the cost of the new programs. But it seems highly likely that any major health insurance initiative will not only focus on the financing of additional care, but include far-reaching cost-containment measures as well. These measures might counteract cost increases that could otherwise be anticipated.

Moreover, in several other ways the Pepper Commission's estimate of the cost of providing universal health care coverage may be misleadingly high. First, certain overhead cost savings could be expected from a universal health care program even if it retained reliance on the private market to supply the lion's share of coverage. For example, if legislation prescribed several different model forms of coverage that the private market would be permitted to offer, the costs of determining eligibility, complying with insurers' different documentation requirements, and processing claims would decline.[76]

Second, it is possible that with the advent of universal health insurance, reducing the scope of tort liability would find more political favor than at present, and that the savings from this reform could be used to help finance the health insurance system. For example, a significant portion of the tort system's dollars are spent processing and litigating auto-accident claims—yet auto liability ranks low in its capacity to achieve either corrective justice or deterrence. Similarly, a portion of tort dollars is spent on the kind of long-latency disease claims that we argued earlier also have a limited capacity to achieve corrective justice or deterrence.[77] If automobile and long-latency tort liability were reformed, the resulting savings could help offset the cost of universal health insurance. Indeed, although major stand-alone tort reform is

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75. See Pepper Recommendations, supra note 3, at 21. Of the $23 billion of this sum that would be devoted to health insurance, about $12 billion would be net new spending, since $11 billion would be offset by savings to employers and the states. See U.S. Bipartisan Comm'n on Comprehensive Health Care, A Call For Action 67 (1990) (Final Report) [hereinafter A Call for Action].

76. One recent study suggests that there could be considerable savings from such a move. See Canadian Health Insurance, supra note 3, at 62–70.

77. See supra note 48 and accompanying text.

politically improbable at present, legislation enacting health insurance reform is a promising vehicle for accomplishing a trade-off between health insurance expansion and the reduction of tort liability.[78]

Third, the American health insurance system is only at the beginning of an era in which preventive care, designed to minimize the incidence of illness and injury, and "managed care" measures, directed at deterring excessive and unnecessary treatment, are being employed. Moreover, in the case of any partial substitution of health insurance for tort liability, preventive and managed care might well accomplish certain forms of deterrence at which tort law and many cause-based systems have been less successful because they tend to pay compensation without using explicit deductibles, coinsurance, or other cost-minimizing devices. The cost sacrifice that results from reduced deterrence of injurers may thus be at least partially offset by the cost savings generated by devices that focus on post-accident victim deterrence, albeit by reducing actual compensation somewhat.

Finally, a considerable portion of the cost of a universal health care program would not constitute "new," but rather shifted costs. Admittedly, some portion of the Pepper Commission's estimated costs of such a program would appear to be entirely new; that is, they would be costs that previously were not incurred, because some patients receiving care under the new program would not have received such care in the past. But the remainder of the cost of the program would be for care that has been provided in some other way in the past—free of charge by a public hospital, private hospital, or physician and either charged off as a bad debt or recovered from an insurer as overhead reimbursement. Under the new system, the cost of this previously provided care would be a saving to insureds, providers, and insurers that should be offset against the gross cost of the new program in order to calculate its net cost.[79]

In addition, there is a strong argument that in calculating the net cost of a universal health insurance program, two other kinds of savings should also be offset against even the entirely new cost of such a program: (1) the savings in future health care costs resulting from increased preventive care under the program; and (2) the increased social productivity that additional health care would generate. Although the maguitude of these potential savings is not easy to estimate, the savings would undoubtedly have a measurable effect on the net cost of universal health insurance.

In short, in an era of economic and budgetary hard times, the $66 billion price tag on universal health and long-term care insurance poses a daunting obstacle to the adoption of such a system. But that is a

78. The Pepper Commission itself estimated that approximately $1.5 billion could be saved through imposition of a cap on liabilities. See A Call For Action, supra note 75, at 66.

79. The Commission estimated this savings at $9.5 billion in 1990 dollars. See id.

gross-cost estimate, against which it is reasonable to offset unquantifiable but probably substantial savings that would result from the enactment of such a program.

2. *Disability Insurance.* — In contrast to health insurance, which is provided on a widespread basis to the middle class, the failure of the American compensation system to provide adequate long-term disability insurance even to the American middle class has no immediately obvious explanation. Why does private disability insurance play so small a role in the American system of compensation for the consequences of illness and injury? Of course, one possible answer is that the potential beneficiaries of such compensation simply do not want it. We believe that this explanation is both inaccurate and simplistic, however, for it ignores the factors that inhibit the development of a robust market in disability insurance on both the supply and the demand sides of this market.

a. *The Nature of the Problem.* — The history of private disability insurance is mainly the story of a series of lessons learned by the insurance industry and of the progressive sophistication of the instruments used to provide disability insurance coverage in response. Two periods are particularly noteworthy. First, after the Great Depression, it became clear that there was a strong linkage between economic conditions and the frequency and severity of claims.[80] Second, the extension of SSD to virtually all Social Security participants after 1956, the growth of some state disability protection programs, and the indexing of SSD benefits in 1972 essentially have made the lower-income market an unlikely source of private disability insurance policyholders.[81] Insurers have recognized that disability insurance is a specialty line, requiring a fund of experience and an operation designed to confront and neutralize the factors that render the line volatile. Disability insur-

80. Prior to World War I, disability insurance was available but uncommon. Between 1918 and 1929, however, the industry grew significantly and coverage was more widely purchased. See Charles E. Soule, Disability Income Insurance: The Unique Risk 4 (1989). When the depression of 1929 struck, disability insurers experienced for the first time the special problems with which they continue to struggle today. As unemployment increased, both the number of disability insurance claims and the average period of disability grew with it. In addition, the policyholder's will to work influenced his or her likelihood and rate of recovery. At this point, many of the insurers then writing disability coverage recognized that this line of insurance is much more volatile and requires very different underwriting and claims management skills than does life insurance. They tended to withdraw from the market, leaving it largely to specialty carriers, who revised their policies in an attempt to guard against the claims incentives they had created. This state of affairs continued for roughly the next 25 years. After several decades of stability, however, many companies entered the market during the 1960s. In addition, recognizing that the professional and the self-employed markets were potentially highly profitable, insurers increased maximum benefit levels available under disability insurance policies. By the early 1970s, benefits of $3500 per month were common. See id. at 10.

81. See id. at 11–13.

ance is not regarded as a ready source of easy profit. On the contrary, because insurers are wary about disability insurance, it is not widely marketed on an individual basis, and competition in the line does not appear to be intense.

If the history of disability insurance were all there were to explain this state of affairs, it would be reasonable to wonder why the insurance industry's entrepreneurial incentives had not created a more active market by now. With its hard-won sophistication, the industry would be able to place appropriate limits on its exposure through underwriting prudence and carefully drafted policy provisions, tap the reservoir of demand for disability protection, and write vastly expanded amounts of coverage. Unfortunately, more than mere caution born of the history of this line of insurance stands in the way of such an expansion. Two separate obstacles afflicting the supply side of the market place severe and probably inescapable limits on the potential scope of the private disability insurance market.

First, the threat of adverse selection limits the supply of disability insurance.[82] The consequence of adverse selection, of course, is higher premium charges for standard and low-risk policyholders. In the absence of adverse selection, premiums for these individuals would be lower; more would apply for coverage, and those who insure notwithstanding the higher rates would purchase more coverage than under the present regime. The magnitude of the impact of adverse selection on disability premiums is difficult to estimate, but the problem un-

82. All voluntary insurance is afflicted to some extent by adverse selection, the disproportionate tendency of those who are more likely to suffer losses to seek insurance against those losses. Disability insurance is especially susceptible to adverse selection, however, because the application-screening and risk-classification processes that can be used to neutralize this problem tend to be least effective in the disability insurance context. The effectiveness of each method depends on the insurer's ability to determine the probability that an applicant will suffer a disability. If insurers can identify high-risk applicants, either their applications can be declined or they can be charged appropriately higher premiums than standard risks.

Information about these probabilities is likely to be less available in disability insurance, however, than in many other lines. One reason is that morbidity data is neither as available nor as reliable as, for example, mortality data. During the past twenty years more reliable information has been developed on both the frequency of disability claims and the rate of recovery. But the persistent lack of reliable data has contributed to adverse selection problems, which in turn have limited the market for coverage and prevented the accumulation of reliable data. The problem has thus to some extent been self-perpetuating. See id. at 16. A second reason the problem of adverse selection is especially severe in disability insurance derives from the nature of the insured event itself. Disability is not merely an objective phenomenon like injury or death; it also is a subjective product of illness, injury, or disease. Insurers can of course estimate the probability that an individual will be injured or become sick. But the probability that the injury or sickness will disable any given individual depends in part on his or her personality and character, both of which are likely to be more difficult to assess. Both the underwriting and risk-classification decisions in disability insurance are therefore unusually subjective and may fail to neutralize adverse selection.

doubtedly is partly responsible for the inactivity of the market.[83]

Second, the problem of moral hazard so afflicts the entire market that there are effective limits on the form and amount of disability insurance that insurers can safely sell. Moral hazard is the tendency of an insured party to exercise less care to minimize losses than he would exercise if he were uninsured.[84] In disability insurance, moral hazard is present both *ex ante* and *ex post*. That is, the insured individual is more likely than the uninsured individual to become disabled, to recover from a disability more slowly, and never to recover from a disability.[85] Disability insurers try to combat the different forms of moral hazard that afflict disability insurance by providing the insured with incentives to remain healthy and to recover as quickly as possible from any disability that is suffered. For example, disability insurance usually is written to cover no more than roughly 60% of the potential after-tax income loss that would be caused by a disability, and insurers attempt to coordinate coverage so that this ceiling is not exceeded even when the insured is entitled to disability payments from other sources, such as SSD or workers' compensation. Even this ceiling, however, may not be sufficient to combat moral hazard completely.[86] And the obvious conse-

83. For technical discussions of the nature and magnitude of the effect of adverse selection in insurance markets, see Michael Rothschild & Joseph Stiglitz, Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information, 90 Q.J. Econ. 629, 634–38 (1976); Charles Wilson, A Model of Insurance Markets with Incomplete Information, 16 J. Econ. Theory 167, 187–202 (1977).

84. See Abraham, supra note 47, at 14–16.

85. Moral hazard troubles most forms of insurance, but like adverse selection, it is especially severe in disability insurance. Admittedly, the most blatant form of *ex ante* moral hazard—intentionally suffering a loss—is likely to be minimal because of the insured party's self-interest in avoiding injury or disease, although perhaps for some people the prospect of even disabled leisure may be more attractive than working in good health. But undoubtedly the greater *ex ante* moral hazard in disability insurance is the possibility of "false positives"—claims of disability when none exists. Some of these may border on fraud; others are likely to be the product of economic conditions that reduce the job prospects of the marginally able and in effect push them into the disabled category. Because the very concept of disability and its corresponding definition in disability policies is partially subjective in the ways we noted above, see supra notes 40–41 and accompanying text, such ineligible claims are difficult to detect, and some are paid. Moreover, the cost of detection and the percentage of contested claims are comparatively high.

False positive disability insurance claims are a potential problem not only *ex ante*, but also *ex post*. Even after a genuine disability, the prospect of continued subsidized leisure is likely to be more attractive for some people than returning to work; and because of economic conditions, claimants who become marginally able to work may remain "disabled" because they cannot find a job.

86. The existence of a variety of government benefits, for example, sometimes makes the calculation of this ceiling difficult for private insurers. Of course they could operate their payment schedule so as to pay only in addition to what any government program pays and only a total that is, for example, 80% of pre-disability earnings. But government program rules sometimes prohibit offsets and reductions (this is a complicated issue in various programs, with interesting recent law), and even when

quence of this device is that those who are genuinely disabled may be unable to maintain their previous standard of living because their losses are only partially insured.

Finally, psychological factors may affect the market for disability insurance. Potential policyholders may misperceive the risk of suffering a disability, and this inadequate knowledge of or concern about the prospect of disability may thereby limit the demand for disability insurance.[87] We would not be at all comfortable relying exclusively on this

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permitted, it may be expensive and intrusive for the insurer to discover a policyholder's other sources of income (for example, from part-time or unreported work). Thus, there are real world situations in which continued disability actually pays more than returning to work (especially on an after-tax and after-work-expenses basis), making moral hazard a continued threat.

87. There are two reasons why, in theory, potential purchasers of private disability insurance may be "underconsuming" this product. First, psychological studies of decision-making under uncertainty suggest that people typically underestimate the risk of low-probahility, unpleasant events. See Daniel Kahneman & Amos Tversky, Prospect Theory: An Analysis of Decision Under Risk, 47 Econometrica 263, 275, 282–83 (1979). For a theoretical application of this literature to disability insurance purchases, see Samuel A. Rea, Jr., Disability Insurance and Public Policy 28–35 (1981). Below a certain threshold level of probability, such risks are ignored. If total disability is perceived as a low-probability event, then this perception may partly explain the comparatively limited individual demand for disability insurance. Second, potential purchasers may assume that the forms of insurance that already cover them against certain kinds of disability—workers' compensation and social security—provide hroader or more generous coverage than in fact they do.

Some corroboration of this "underconsumption" theory can be found in the actual pattern of disability insurance purchases. Counting paid sick leave as short-term disability insurance, more than twice as many people are covered by short-term than by long-term disability insurance. See 1984–85 Source Book, supra note 52, at 16. Long-term total disability obviously is a much lower prohability event than short-term disability, and many people may simply ignore this risk, even though it is potentially more devastating. A perfectly rational insurance consumer might be hetter advised to bear a greater portion of the short-term disability risk herself and insure more of the long-term risk.

How much influence these two possible risk misperceptions may have on the demand for coverage is hard to say, in part because there is no objectively correct insurance level against which to compare the levels actually purchased. The very notion that the demand for disability insurance is "low" is therefore problematic. There is no objective way to determine the "proper" amount of insurance for any individual. Insurance consumption decisions are affected by the price of the product, funds available for purchase, and the degree of risk aversion associated with the risk to he insured. An effort to determine whether aggregate demand for disability insurance is adequate in any ultimate sense therefore would not be sensible.

Nonetheless some insight into the nature of the demand for disability insurance can be gained by comparing the risk of suffering a disability, the risk of dying, and the amount of disability and life insurance purchased nationwide. At any given age the risk of being disabled for more than six months is about equal to the risk of dying within a year. See Soc'y of Actuaries, Part 6 Study Notes: Group Long-Term Disability Coverages 2 (1976). Yet the nation spends considerably more on life insurance than on long-term disability insurance. See Statistical Abstract, supra note 9, at 360, 519–20. Moreover, only a small portion of the total expenditure on disability insurance is for voluntary private (individual or group) coverage; the bulk is for social insurance that is

psychological factor to explain the small role played by private, voluntarily-purchased disability insurance in the United States. This explanation, however, may help to round out the picture of a market in which the supply of coverage is seriously limited by the need to combat adverse selection and moral hazard, and in which demand is unduly low because of misperception of the risk of suffering an uninsured disability. In any event, the prospect for the development of a more robust voluntary private market for disability insurance is extremely weak.

b. *Filling the Gap.* — In light of the foregoing analysis, disability insurance poses a challenge very different from the health insurance problem. In the health insurance context, the key question is *how* to fill the gap in coverage that afflicts a minority of the population. In the disability insurance context, however, the threshold question is *whether* the gap affecting the majority of the population should be filled. Given the impact of adverse selection on the voluntary market for disability insurance, mandated private coverage or expanded provision by the government are probably the only feasible approaches. Yet this could entail considerable cost.

Estimating the cost of a mandatory universal total disability insurance system is difficult for both conceptual and practical reasons. Social consensus as to what events are appropriate reasons for not being at work is continually evolving. The current controversy over "family leave" is an excellent example.[88] Estimating the costs of long-term disability compensation, moreover, requires decisions about which reductions in earning ability—some of which are predictable results of aging, for example—should count as "disabilities" for purposes of measurement.

Even setting aside these important conceptual questions and using definitions of disability adopted by existing studies of the issue,[89] estimating costs poses practical problems. Nonetheless, an estimate of the order of magnitude of the costs involved is possible. We calculate that public and private insurance benefits for disability under six months

either publicly funded and mandatory (SSD) or privately financed and effectively mandatory (workers' compensation). In contrast, most life insurance is voluntarily and privately purchased in the commercial market. Of course, the comparison is not entirely fair since disability is merely a risk, while death at some point is certain. But many people do not buy "permanent" life insurance; they purchase term insurance or forms of whole life insurance that has coverage that terminates or can be transferred into accumulated cash-value. Consequently, although the comparison is not entirely fair, it is revealing. Given the apparent contrast in demand for insurance against the roughly equivalent statistical risks of annual long-term disability and death within a year, the risk misperception hypothesis is at least plausible.

88. The Family Leave Act, S.5, 102d Cong., 1st Sess. (1991), was vetoed by President Bush. The veto was overridden in the Senate but not the House. See Kenneth J. Cooper, House Fails to Override Bush Veto of Family Leave, Wash. Post, Oct. 1, 1992, at A7.

89. See Daniel N. Price, Cash Benefits for Short-Term Sickness: Thirty-Five Years of Data, 1948–83, 49 Soc. Security Bull., May 1986, at 5.

duration probably now total about $20 billion of the roughly $55 billion in income lost each year from such disability, leaving a shortfall of about $35 billion.[90] Estimating the shortfall for disability exceeding six months is more difficult, because there are no comparable figures regarding total income lost from such disability. Assuming that the ratio of benefits paid to total income lost is roughly the same for short-term and long-term disability,[91] then the approximately $60 billion in current public and private long-term disability benefits paid falls short of providing full compensation by about $100 billion per year. Putting these very rough estimates of the compensation shortfalls in disability protection together, the total compensation shortfall is in the neighborhood of $130 billion.[92] An efficient system of compensation, however, would not provide full payment for all these losses. A 30 to 40% deductible or coinsurance feature for disability insurance would be sensible, in order to combat moral hazard and create appropriate incentives against overconsumption of benefits. Taking these features into account, the additional cost of a system that adequately compensated the disabled for the economic consequences of both short- and long-term disability would probably be in the range of $100 billion per year.

As in the case of health insurance, a portion of this additional cost of universal disability insurance would probably not be "new," but rather, shifted cost. Those who now lose wages because of uninsured disability bear this cost themselves; a universal disability insurance program would remove these costs from the uninsured and channel them through the new program. In contrast to the health insurance example, however, a higher portion of the cost of universal disability insurance would in fact be truly new cost. Under universal disability insurance, both *ex ante* and *ex post* moral hazard would be likely to increase the frequency and extent of disability; and there would be fewer offsetting savings from such measures as preventive and managed care because these measures are far less developed in the disability field than in the health insurance field.

3. *The Public-Private Issue.* — It is commonplace to regard reliance on the private market for the provision of even mandatory insurance (for example, auto liability insurance) as preferable to governmentally provided coverage. Competition among private insurers is thought to

90. For the 1983 estimates on which this very crude projection is based, see id.

91. This assumption itself may be somewhat suspect, since major federal benefit programs (most notably SSD) compensate some long-term disability but little or no sbort-term disability. See supra note 40 and accompanying text.

92. Rough confirmation that at least the order of magnitude of this estimate is accurate is provided by a recent study conducted by the RAND Institute for Civil Justice. That study found a wage-loss compensation shortfall for the victims of nonfatal accidents (tbat is, the estimate excluded wages lost because of fatal accidents and all illness, but included income loss from both short- and long-term disability) of approximately $51 billion per year. See Deborah R. Hensler et al., Compensation for Accidental Injuries in the United States 85 (1991).

preserve the virtues of efficiency and autonomous choice that are widely valued in our society. Aside from the obstacles to expanding health and disability insurance, the question whether such expansion should rely on the private market or occur through the development of social insurance therefore must also be addressed.

In our view, the choice between the private and social insurance alternatives is both more problematic and, in certain respects, less important than the prevailing view suggests. First, at least in some respects, a universal social insurance system could capture economies of scale and uniformity that the private market now lacks. For example, the administrative costs of our decentralized private health insurance system may account for more than half the difference in cost between the Canadian and American systems.[93] Such savings could go a long way toward offsetting the decreased efficiency that could result from the absence of a competitive insurance environment. Clearly this issue is far from settled; our point is simply that the private insurance market is subject to its own inefficiencies and that these must be compared to the inefficiencies of social insurance in choosing between the two.

Second, the differences between private and social insurance are less important when both approaches have mixed goals, combining limited deterrence and modest income redistribution with the predominant goal of forced insurance. Whether the evolution is from the direction of the tort system, in which the deterrence goal predominates, or from traditional social insurance, in which income redistribution is primary, the expanded programs of health and disability insurance that we describe in the next section would lie midway between these extremes. Whether private or governmentally operated, universal health insurance would employ preventive and managed care measures, risk classification, deductibles, and coinsurance features to deter unnecessary cost; perhaps universal disability insurance would develop analogous devices that are only modestly used at present. At the same time, charges to those capable of paying for coverage ("premiums" if the programs were private, "taxes" if they were not) could be set with an eye toward financing the provision of coverage for those incapable of paying for it, either through private insurance pools, governmentally provided coverage, or some combination of the two. In short, many of the concerns we have been analyzing could be effectively addressed by either alternative.

B. *Models of Expansion*

The United States does not have a complete explanation for the scope and character of the liability and insurance programs that cur-

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93. See Steffie Woolhandler & David U. Himmelstein, The Deteriorating Administrative Efficiency of the U.S. Health Care System, 324 New Eng. J. Med. 1253 (1991).

rently compensate the victims of illness and injury.[94] Available explanations—including forced insurance and income redistribution—would suggest expanding current programs. Indeed, one of the best arguments for expanding the system is that current programs can only be explained by principles that suggest expansion. European countries and Japan provide such expanded protection.[95] The United States has developed some, arguably even most, of the technology and devices necessary to provide it.

Partly out of default, the tort system is now performing certain aspects of the task of compensating the victims of illness and injury. Yet for reasons elaborated above, tort law is a highly unsatisfactory system of compensation.[96] Random victims are protected at giant overhead costs. Large sums go to lawyers rather than to compensating victims or funding additional accident reduction. Thus it seems sensible to consider adjusting private and social insurance programs to perform the compensation function that is needed, while pursuing the legitimate goals of tort law—corrective justice and deterrence—in different ways. Adapting existing programs to attain new goals is hardly unknown; workers' compensation and auto no-fault are the product of just this sort of approach, the first now more than seventy-five years old and even the second quite mature intellectually. Other recently adopted cause-based systems have begun to follow suit.[97]

Any expansion of individual insurance programs should be combined with the institution of a coherent system to govern interaction among the programs. Three models of expanded compensation for illness and injury are plausible: broader categorical subsistence protection, full subsistence protection, and full welfare protection. Each of these loss-based models also carries with it implications for existing and potential fault- and cause-based systems. Hence, we focus our analysis not only on the scope of individual new or expanded programs, but also on the relationships among the different components of the three models.

The compensation system currently in force in this country can be most accurately described as a collection of categorical subsistence programs. Compensation is categorical in the sense that it is provided to a victim of illness or injury only if the victim fits within the category covered by a particular program. And with the exception of the tort system, which at least in theory compensates all the losses victims have

94. For an argument that there is a rationale for the patchwork of social insurance programs that evolved from the Social Security Act of 1935—programs that form a part, but only a part, of the entire picture, see Theodore R. Marmor et al., America's Misunderstood Welfare State (1990).

95. See supra note 4.

96. See supra notes 46–50 and accompanying text.

97. See the Black Lung Benefits Program, 30 U.S.C. §§ 901–945 (1988), and Veterans' Benefits, 38 U.S.C. §§ 101–5228 (1988).

suffered, virtually all compensation programs provide what amounts to subsistence-level protection against the economic consequences of illness and injury. Small losses tend to be generously compensated, but catastrophic losses receive only partial compensation.

The major gaps in this categorical subsistence protection result from both of its features. Because the protection is categorical, a major portion of the population—the working poor—does not have health insurance. Moreover, individuals with even comparatively generous health insurance are likely not to be fully insured against catastrophic losses because of monetary ceilings on and exclusions from coverage. Because most sources of disability insurance assure beneficiaries of only subsistence, rarely is full income replaced in the event of disability.

Fault- and cause-based compensation schemes exhibit a kind of ambivalence toward these gaps. On the one hand, these compensation schemes have expanded, in part to fill the gaps in the system of loss insurance. As we argued in Part II,[98] in certain ways tort law has moved beyond assuring corrective justice and deterrence in order to provide compensation that would otherwise be unavailable or incompletely available to the victims of severe injury and disease. Partly in reaction to these expansions of the fault system, cause-based compensation programs have been developed to deal with particular classes of illness or injury as these expansions of the fault system have become objectionable. For example, a rise in obstetrical malpractice claims brought about the enactment of birth-related neurological defect compensation funds in two states,[99] and the threatened disappearance of childhood vaccines prompted the enactment of a federal vaccine side-effect compensation program.[100] On the other hand, the recent reversals of coverage priorities (through modification of the collateral source rule) that render loss-based insurance the primary source of coverage over fault- and cause-based compensation serve to contract the scope of the latter systems.

Thus, fault and causal systems appear to expand when loss insurance is incompletely available and to contract when such insurance is available. The extent of the expansion and contraction, however, varies from state to state and with the type of fault- or cause-based compensation involved. The challenge posed for our first model for change is how to bring greater principle and consistency into this system. The challenge posed for any efforts that would go beyond this model is how to huild on the principle and consistency toward which the first model would move.

1. *Model I: Broader Categorical Subsistence.* — Our first model would restrict the expansion of tort law so that corrective justice and deter-

98. See supra notes 46–50 and accompanying text.

99. See supra note 12.

100. See supra note 14.

rence remain its predominant goals, and would regularize the expansion of the current categorical subsistence approach. The model would eliminate ad hoc expansions and contractions of fault- and cause-based compensation and set priorities for expansion. We believe that provision of subsistence-level health care protection to the working poor should be a high priority. This would extend protection to the individuals who comprise the bulk of the thirty million people without health insurance.[101] Assuring basic health care insurance at affordable rates to everyone in the United States would thus be a principal task of Model I.

Potential expansions of disability insurance programs might assume any of four forms: protection against partial disability; protection for the dependents of the disabled; protection for those whose disability is partly the product of advancing age; and protection against temporary disability.

a. *Partial Disability.* — By imposing the requirement of total disability, SSD and most private disability insurance programs do not provide compensation for partial disabilities—those that prevent a person from engaging in a prior occupation but do not completely eliminate that person's ability to work. This requirement makes eligibility a yes-no question, with a claimant being found completely ineligible or fully eligible. A substantial percentage of all applicants are near the borderline of eligibility: something is wrong with them, perhaps they could work with difficulty or pain, and while it is reasonable for society to exempt them from further employment, others with similar difficulties continue to work.

The requirement of total disability is a major cause of the dissatisfaction with the outcomes of the vast adjudication system that labors to make SSD eligibility decisions. Because an individual's application requires such a subjective determination, and because so many of the cases are near the yes-no line, every student of the system concludes that outcomes depend on which decisionmaker sees a case, where in the country an application is filed, and what words a physician may have chosen to describe a condition.[102]

A partial disability insurance system might alleviate some of the difficulties associated with the SSD total-disability approach. Certainly, the importance of decisions involving claimants on the borderline between total and partial disability would diminish under such a system. However, a partial disability insurance system would face the daunting administrative task of determining degrees of disability. In addition, the cost of such a system is uncertain. As we noted above, the bulk of

101. See Congressional Research Serv., supra note 19, at 94.

102. For analyses of issues concerning the Social Security Disability program, see Edward D. Berkowitz, Disabled Policy: America's Programs for the Handicapped 79–104 (1987); Mashaw, supra note 41, at 21–46; Deborah A. Stone, The Disabled State 3–14 (1984); Liebman, supra note 5, at 836–55 (1976).

workers' compensation payments are made to compensate permanent partial disabilities. It is likely that a program to compensate for non-work-related permanent partial disabilities would be correspondingly expensive, at least in part because of the various moral hazards associated with disability insurance of any sort.

b. *Compensation for Minor Dependents of the Disabled.* — In a sense, existing disability insurance programs already provide compensation to all the minor dependents of the disabled by replacing a portion of the income lost by those who had supported the dependents in the past. It would be a relatively simple matter to adapt the current Social Security Survivors program to replace more of the lost earnings of deceased providers.[103] It would be much more difficult, however, to expand it into, or to add, a program providing replacement income for children when a parent remains alive but disabled in some way that reduces the support available to the child. Providing adequate support for the child in such a situation would almost certainly require transferring funds to the parent directly. Yet at that point it would be hard to see the program as anything other than a minimum income for the young (or, in European parlance, a "children's allowance"), but without a rationale for the provision of such an allowance only to children of the disabled rather than to all children in need.

c. *Disability Resulting from Advancing Age.* — The magnitude of the problem of disability resulting from advanced age has been a major force behind the decisions in both the United States and Europe to

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103. In marked contrast to other developed nations, the United States has no program that provides a minimum income to each child. The most important program providing income to dependents that currently exists in the United States is represented by the "S" in OASDHI (Social Security). See 42 U.S.C. §§ 401–433 (1988). It makes income-support payments to "survivors" of a deceased person who had achieved eligibility. See id. § 402. The payments are based on the earnings of the late worker (normally a parent or a spouse), and are made until a minor survivor reaches age 18. See id. § 402(d). The program pays over $35 billion in benefits each year. See Statistical Abstract, supra note 9, at 360.

Because survivor benefits, like OASDHI payments to the aged and the disabled, are determined by a progressive formula (replacing a large percentage of smaller incomes and a smaller percentage of larger incomes) and because there are no benefits for wages above the maximum ($51,000 in 1990), this program is relatively adequate wage-loss replacement for spouses and children of those with low incomes and a much less complete replacement for dependents of those earning more. For discussion of this program and of policy issues concerning benefit levels and taxes, see Martha Derthick, Policymaking for Social Security (1979); Theodore R. Marmor & Jerry L. Mashaw, Social Security: Beyond the Rhetoric of Crisis (1988); Alicia H. Munnell, The Future of Social Security (1977). Concerning the benefits provided through the Social Security system to surviving children, see Stephen D. Sugarman, Children's Benefits in Social Security, 65 Cornell L. Rev. 836 (1980). Because of its relevance to issues of gender fairness, there has been more literature about "derivative" Social Security benefits for surviving spouses. See, e.g., Grace G. Blumberg, Adult Derivative Benefits in Social Security, 32 Stan. L. Rev. 233, 233–92 (1980); Peter W. Martin, Social Security Benefits for Spouses, 63 Cornell L. Rev. 789, 789–840 (1978).

limit public disability benefits to only the most compelling claimants.[104] As a general matter, it is immensely difficult to apply the concept of a disabling illness or injury to individuals who are declining in capacity and energy, especially when the workplace is changing because of new technology and the capacities of younger workers. Some individuals beyond age fifty also have difficulty adapting to new types of work and being selected for vacant positions. Any compensation initiative directed at this phenomenon would have to separate those to whom something compensable has occurred from those who are merely tired or not as able as they were formerly.[105] A disability insurance program directed at those suffering disabling illness and injury would therefore have implications for society's policy toward those whose jobs disappear.[106]

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104. For good historical accounts of the attitudes of those who added disability protection to the U.S. Social Security system in the 1950s, the growth in the number of recipients to levels beyond those predicted, the legislative effort by the Carter administration to remove from the rolls those no longer eligible, and the political firestorm that erupted when the Reagan administration sought to implement the 1980 statutory amendments, see Berkowitz, supra note 102, at 61–78, 106–43; Lance Liebman & Richard B. Stewart, Bureaucratic Vision, 96 Harv. L. Rev. 1952, 1955–56 (1983) (reviewing Jerry L. Mashaw, Bureaucratic Justice (1983)).

Of course, there is already in place a very substantial income maintenance program for the elderly. The "OA" (for "old age") in OASDHI is a vast program making $157 billion in payments each year to retired persons. See Statistical Abstract, supra note 9, at 360. Benefits are a formulaic replacement keyed to covered wages during the final years of work. See 42 U.S.C. § 402(a) (1988). In addition, the old-age segment of the Supplemental Security Income program provides a minimum income to the elderly poor; to be eligible an individual must have very little income and few assets. This program pays approximately $3 billion per year. See Committee on Ways and Means, 102d Cong., 2d Sess., Overview of Entitlement Programs (1992 Green Book) 823 (1992).

105. This is the reason for the dramatic growth since World War II, in the United States and Europe, in the percentages of persons above age 50 leaving the workforce and seeking disability benefits. Given improving levels of health, the growth of disability claimants is anomalous. Explanations include the availability of income transfer benefits, evolving social norms (how much pain should an individual bear, for example), and rapidly changing technology.

106. See Virginia P. Reno & Daniel N. Price, Relationship Between the Retirement, Disability, and Unemployment Insurance Programs: The U.S. Experience, Soc. Security Bull., May 1985, at 24. Pursuant to a federal statute, all states administer Unemployment Insurance programs. See id. at 26. These provide roughly $15 billion per year in income replacement benefits, paid as a percentage of prior salary up to a maximum, to individuals who have become involuntarily unemployed after establishing eligibility by an adequate period of covered employment. In all states eligibility is for 26 weeks and in some states it continues for 39 weeks. See id. at 27. To maintain eligibility, an individual must be available for work and accept a suitable job if one is offered.

States vary widely in their evaluations of reasons for leaving work. In some states, good personal reasons—a sick relative, the desire to follow a friend to another city—make a departure involuntary. In other states, resigning rather than being dismissed usually results in ineligibility for Unemployment Insurance benefits. See Saul J. Blaustein, Job and Income Security for Unemployed Workers (1981) (discussing and

d. *Temporary Disability*. — In five states, government programs pay benefits to persons medically disabled for a temporary period.[107] In addition, sick leave is a largely unregulated system of temporary disability insurance, subject to the discretion of employers and, where applicable, collective bargaining. It would be possible to expand these programs into a general compensation scheme offering payments to all who do not work for a period of time and whose nonwork is socially approved.[108] Such a program might compensate those medically unable to work; those who lost jobs under circumstances not regarded as their "fault" and who do not have new jobs; and those not working because of pregnancy or the need to care for elderly parents ("family leave"[109]).

Our own view is that from an insurance standpoint, such a program should receive relatively low priority among the alternatives that might be adopted.[110] Temporary disabilities are by definition less catastrophic than permanent disabilities and therefore less sensible to insure against than the latter. Indeed, the absence of such coverage can be considered a kind of deductible or self-insurance requirement of existing permanent disability compensation devices. Sick leave is a popular fringe benefit, perhaps in part because it is the kind of insurance which many, rather than just a few beneficiaries, actually recover. But this is precisely the reason that this form of coverage should be a low priority for inclusion in a universal disability insurance program—short-term disability is less a risk than an expected and fairly predictable loss.

The advantage of a temporary disability compensation program, however, would be its capacity partially to fill certain gaps now plugged by the tort and cause-based systems of compensation. The new program would identify those out of work for less than six months, select those among them who should be barred from receiving benefits (for example, those whose behavior at work was egregious), and compensate all others to an appropriate extent. The cost could be met either by a payroll tax or by mandated benefits from employers. The major

evaluating state programs); Paul L. Burgess & Jerry L. Kingston, An Incentives Approach to Improving the Unemployment Compensation System (1987) (same); Walter Corson et al., Nonmonetary Eligibility in State Unemployment Insurance Programs: Law and Practice 1–10 (1986) (same).

107. See supra note 45 and accompanying text.

108. See Stephen D. Sugarman, Short Term Paid Leave: A New Approach to Social Insurance and Employee Benefits, 75 Cal. L. Rev. 465, 465–66 (1987) (offering the outlines of such a program, with benefits of one day of sick leave for every eight days of work). Currently, about two-thirds of American medium- and large-size firms offer sick leave. See Statistical Abstract, supra note 9, at 420.

109. See supra note 88 and accompanying text.

110. We set aside here the separate question whether, for reasons of gender equity or other social policies, compensation for pregnancy or family leave should receive a higher priority than we would accord it for purely insurance purposes.

issues in designing the new program would include how to relate the compensation level to prior income; how to supervise work searches, and what standards to adopt for reviewing refusals of work; how to establish a benefit structure that would provide economic incentives to take a job; and whether payments should be made only for an arbitrarily fixed period, as is the case under the current unemployment insurance program. But the fundamental and most difficult question would be whether only sub-groups of those in need should be compensated. If individuals who worked and lost their jobs due to injury, illness, or reduced demand for their kind of labor are eligible, why not include those who have never been lucky enough to have a job?

2. *Model II: Full Subsistence.* — A second model would expand loss insurance beyond the broader categorical subsistence described above by assuring full subsistence protection to the entire American population. In connection with illness and injury, the major additional changes required would be the provision of catastrophic health insurance to the thirty million or more individuals who are now uninsured and the roughly similar number who have limited health insurance, and the expansion of total disability insurance to assure that persons suffering such disability were assured of subsistence-level income in the event of their inability to work. This is a simple enough expansion to describe, although as we indicated earlier, it would be politically and economically difficult to implement. Setting aside these difficulties, however, some of the most interesting issues this model poses involve the roles that would be played by fault- and cause-based compensation systems.

The first issue would be whether use of fault- and cause-based systems for corrective justice and deterrence purposes should continue. On the one hand, nothing in a societal decision to assure that the victims of illness and injury receive subsistence-level protection would preclude the effort to achieve either of these other goals through fault- and cause-based systems. On the other hand, the requirements of these goals might change as universal loss insurance lost its initial status as a newly acquired individual asset and evolved into a characteristic of residency in the United States. For example, we might cease to consider the negligent infliction of the economic costs of illness and injury (such as health care expenses or lost wages) to be a wrong requiring corrective justice through the imposition of tort liability, since such costs would be automatically insured. In effect, these expenses would no longer be considered personal losses, because they would be automatically reimbursed. This change in attitude might suggest complete repeal of the collateral source rule in tort law as it applies to subsistence-level loss insurance,[111] though the rule might be retained as ap-

111. See supra text accompanying note 67.

plied to voluntarily purchased private insurance against losses above subsistence level.

From a deterrence perspective, however, the issue would be more complicated. Because the economic costs of accidents are real even when they are fully insured, it would be rational to deter those accidents worth deterring even under a full-subsistence system. Retention of this goal would require application of the traditional collateral source rule in tort law and its analogues in cause-based systems. Otherwise, the parties paying the claims under these systems would not be held responsible for the full cost of the losses they had caused. Interestingly, then, although corrective justice concerns might become weak enough to permit the partial withering away of the fault- and cause-based systems under a full-subsistence model, deterrence concerns might require these systems to continue in the same forms they have taken in the past. And since a compensation gap with respect to above-subsistence losses would remain, the current tendency to employ fault- and cause-based systems to fill part of this gap would probably persist.

3. *Model III: Full Welfare.* — Our vision of a full-welfare system of compensation for the consequences of illness and injury consists of full-subsistence protection plus one other component: relatively "full" insurance against economic loss resulting from both total and partial disability, up to a fairly high ceiling—for example, insurance that would fully replace the lost income of all but the top 10% of American wage earners, subject to a coinsurance provision designed to mitigate moral hazard. In describing this model as a "welfare" scheme, we do not mean to suggest that it would be governmentally operated, that the health and disability benefits provided to the middle and upper classes should not be financed entirely by these classes, or that the financing scheme should not be income-redistributional. On the contrary, we expect that the political and economic conditions that would make any such scheme possible would require self-financing by these classes and include a heavy element of redistribution to those with lower incomes.

The major implication for the fault- and cause-based systems of the adoption of a full welfare system would be the elimination of virtually all need to employ these systems in order to fill compensation gaps. Full-welfare loss insurance would assure nearly full compensation for the consequences of illness and injury. In turn, fault- and cause-based systems would be designed exclusively to promote corrective justice and deterrence, but only to the extent that these goals persisted and only to the extent that these systems could be effectively used to promote these goals.

Since most economic losses would be covered by a combination of private and social insurance, tort liability might be imposed only in cases of severe wrongdoing or in the limited number of situations in which noneconomic losses cried out for compensation. In effect, there

would be high thresholds of harm and blame below which causes of action in tort would normally be abolished. With occasional exceptions, it might then be preferable to pursue deterrence of recurring injury or illness through more easily administrable cause-based compensation systems, financed by the parties largely responsible for these losses. The reason for imposing fault- or cause-based liability, then, would ordinarily have little to do with the provision of compensation for economic loss, since loss insurance would already be available to perform this function. Rather, the fault- and cause-based systems would exist almost exclusively to right severe wrongs and to influence future behavior. Therefore, as in the full-subsistence system we described above,[112] in order to perform these functions, each fault- and cause-based system would have to be a primary source of coverage whenever its jurisdiction was triggered. A version of the traditional collateral source rule in tort and its equivalent in the causal systems would be applied,[113] and responsible parties would be directly liable to the loss insurance system for all losses paid or payable to the victim by that system.

Interestingly, this approach might begin the transformation of the fault and causal systems into little more than cost-accounting mechanisms. Concern for administrative efficiency would dictate that the loss insurance system bundle its claims for economic losses against tortfeasors and process them collectively against these parties' liability insurers, except in cases in which detailed fact-finding was necessary. Processing of claims compensable in the causal systems would be even more collective and clerical, for disputes over coverage and the need for fact-finding would be even rarer here than in the case of claims compensable in tort. Only in cases in which an individual was entitled to pursue a claim for compensable pain and suffering might tort claims continue to exist.

In short, under a full-welfare system, conventional tort liability would not be abolished. But it might slowly wither away, as the demands of corrective justice declined in the face of socially provided insurance against the economic consequences of injury and disease. The liability that remained would be imposed almost exclusively for the purposes of deterrence, under circumstances that would resemble the allocation of expenses among different components of a conglomerate business, not the adjudication of civil liability.

Conclusion

It is time for the United States to develop a coherent system for compensating the victims of illness and injury. This system need not be based exclusively on principle; cost is certainly an appropriate concern,

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112. See supra part III.B.2.
113. See supra text accompanying note 67.

as is the difficulty of making the transition from the series of categorical compensation programs that have grown up independently. But as the boundaries of these programs have reached toward and actually overlapped each other, the justifications for their independence have weakened. The programs are no longer normatively or even logically independent, since many of the arguments for the very existence and character of any particular program depend on the existence and character of the others.

In our view, the necessary first step is to assure basic health care insurance to the entire population. It is difficult to justify a set of programs that assures the middle class and the very poor basic health care and compensates the victims of tortious, work-related, and auto accidents for their health care expenses, but denies the working poor full access to health care unless their needs fall fortuitously into one of the foregoing categories. Although providing such insurance will not be inexpensive, some of the additional cost will be more apparent than real. The uninsured currently receive some care from public and nonprofit hospitals. Some savings could be generated by incorporating more effective measures to contain the cost of health care provided to the already-insured population, and the extension of preventive care to those who are now uninsured could result in long-run savings in health care costs and increased national productivity.

A second step would require addressing the disability insurance gap. This is admittedly a more substantial challenge, because adverse selection, moral hazard, and other factors that impede the effective functioning of disability insurance cannot be completely combatted. The rationale for a program providing compensation for disability-related losses but not for other misfortunes is also open to question. Are the disabled any more deserving of compensation than, for example, those who have become homeless because of unemployment? As a "system" for compensating the victims of illness and injury in this country emerges, therefore, it will have to be harmonized with broader policies toward social welfare in general. Nonetheless, if for no other reason than the high priority we almost automatically accord to relieving physical suffering, compensation of the disabled for the losses consequent to their disability should follow the provision of basic health care to the American population.

Once a system containing these elements of compensation is developed, the role of the tort system in compensating the victims of illness and injury could be de-emphasized. Because compensation for health care expenses and lost income would already be assured independently of the tort system, the desirability of providing compensation for these losses through tort recoveries would substantially decline. Tort law could return to its traditional role of assuring corrective justice and deterrence, and what corrective justice required by way of compensation might even decline, since compensation for out-of-pocket health care

expenses and wage losses would already be provided to all who incurred those costs, regardless of their cause. Tort law would thus become an even more ancillary feature of the constellation of American compensation programs than it is at present.

Although we are not sanguine about the immediate prospects for the emergence of a full-blown compensation "system" in this country, the recent presidential campaign debate about health insurance provides considerable evidence that a new era may be beginning, in which the scope of previously obscure compensation programs is a continuing political issue, and the unsystematic character of these programs a matter of public concern. Public recoguition of these issues may not be a sufficient condition for change to occur, but it certainly is a necessary condition. With the additional ingredient of informed analysis from a variety of quarters, we may find it possible to move toward a new vision of compensation for illness and injury in the United States.