

# Compensation for Injury & Illness: An Update of the Conard-Morgan Tabulations

JEFFREY O'CONNELL\*

JAY BARKER\*\*

## PREFACE

In 1964 Professors Alfred F. Conard and James Morgan of the University of Michigan and their colleagues Robert W. Pratt, Jr., Charles E. Voltz, and Robert L. Bombaugh completed *Automobile Accident Costs and Payments: Studies in the Economics of Injury Reparation*,<sup>1</sup> a monumental study of systems of reparation for injury (as well as illness) in the United States. The seminal first chapter of that study described all the various systems of reparation for injury and illness that might cover a victim, and analyzed the total amount of annual reparation each system actually made. This Article follows in the footsteps of that chapter, tabulating and (in primer form) summarizing those same systems of reparation—as well as some new offshoots—in the more than twenty years since the original Conard-Morgan study.

## I. INTRODUCTION

The economic repercussions of an accident or ailment are far-reaching. The losses a victim incurs can trigger a broad range of systems of reparation into motion. The oldest of these systems, the legal system, built up a structure of rules and principles allowing victims, especially of accidents, “to sue for, and recover, all their losses: their hospital bills, their medical bills, their lost wages, their lost opportunities for self-employment, their lost comfort and their lost pride.”<sup>2</sup> Much has long been said about the adequacies or inadequacies of this system. While such discussion has gone on and on, other reparations systems have grown, treating the victims of accidents or ailments in a way quite different from the legal system. Instead of officiating the victim’s contest with a defendant, these systems look to compensate the injured party without an eye to anyone else’s faulty conduct or product. Such systems involve massive numbers of people and payments. Over eighty percent of the United States population has purchased—voluntarily or as part of their employment contract—hospital or medical insurance to alleviate the cost of health care if the need

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\* John Allan Love Professor of Law, University of Virginia. B.A. 1951, Dartmouth College; J.D. 1954, Harvard University. Invaluable research assistance was provided by Christopher Spera, Class of 1987, University of Virginia Law School, and James Guinivan, Class of 1988, University of Virginia Law School, who, for all practical purposes, were co-authors of this piece.

\*\* Associate, Schwalb, Donnenfeld, Bray & Gilbert, member, Maryland Bar; B.A. 1975, Brown University; J.D. 1985, University of Virginia.

1. A. CONARD, J.N. MORGAN, R.W. PRATT, JR., C.E. VOLTZ, & R.L. BOMBAUGH, *AUTOMOBILE ACCIDENT COSTS AND PAYMENTS: STUDIES IN THE ECONOMICS OF INJURY REPARATION* (1964) [hereinafter cited as A. CONARD].

2. *Id.* at 23.

should arise.<sup>3</sup> Disability insurance is available to provide subsistence if the insured cannot work. In addition, in the words of the Conard-Morgan study,

[e]mployers have introduced sick leave plans; work[ers'] compensation has provided medical benefits and cash benefits for those whose accidental injuries are work related; [s]ocial security has brought disability payments to most employed workers who are permanently and totally disabled; [p]ublic hospitals furnishing services free to those who cannot pay have multiplied.<sup>4</sup>

Since those words were written, Medicare and Medicaid have exponentially expanded coverage for health care for the aged and impecunious.

What has the legal system done in response to all these new additions to the reparations field? The Conard-Morgan study in 1964 stated:

The law of tort has maintained its even gait without much regard to the effects of competition by these newcomers in the relief of [accident] victims. When it has noticed them, it is to say that they make no difference. The defendant is bound to pay the workman all the wages he has been prevented from earning, even though the workman has received disability benefits in lieu of part or all of them. The defendant must pay the amount of the plaintiff's hospital bill even if Blue Cross has already paid it.

In [some] . . . instances, the law has recognized that what the plaintiff gets should go to the person who has paid the bill, who is said to be "subrogated" to the plaintiff's rights. In other cases, there is no subrogation. In neither event does it make any difference in the amount which the court will order the defendant to pay.

This may well be as it should be. But the many sources of payment cannot be ignored by everyone. Those who lament the fate of the poor traffic victim cannot afford to ignore entirely what [that victim] may receive from other sources. Neither can those who are concerned with the costs of accidents and the costs of insurance against the effect of accidents.<sup>5</sup>

As this Article indicates, not enough has changed since the study by Professors Conard and Morgan and their colleagues. It is the purpose of this Article—using 1980s data to replace that of the 1960s—to discuss the relatively small place of tort law in the overall picture of reparation for accident and ailments in American society.<sup>6</sup>

## II. SOME CASES IN POINT

### A. *The Case of the Carpenter*

The Conard-Morgan study posed the following hypothetical case to illustrate the multiplicity of reparations systems, as well as the interaction between the legal system and nonlegal systems.

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3. HEALTH INSURANCE ASS'N OF AMERICA, 1982-83 SOURCE BOOK OF HEALTH INSURANCE DATA 7.

4. A. CONARD, *supra* note 1, at 24.

5. *Id.* at 24-25.

6. A massive study done in the United Kingdom indicates even more dramatically the relatively small role played by common law tort claims versus other systems of private and social insurance. See D. HARRIS, M. MACLEAN, H. GENN, S. LLOYD-BOSTOCK, P. FENN, P. CORFIELD, AND Y. BRITAN, COMPENSATION AND SUPPORT FOR ILLNESS AND INJURY (1984). For American commentary on this work, see reviews of same by Abel, 73 CAL. L. REV. 1003 (1985) and Kornhauser, 73 CAL. L. REV. 1024 (1985).

“On his way to work one morning, a carpenter became involved in a complicated three-car collision. As a result, he was badly injured, and was taken to a public hospital for emergency treatment; he was later removed to a private hospital where, after extended treatment, he died. He suffered severe losses, and so did his family. If some part of these losses was compensated, where did the financial resources come from?

“Taking the sources of reparation in the order in which they affected the injury victim, the first was free emergency medical care. The ambulance and emergency hospital service the carpenter received were provided by his local municipality. Although such patients are theoretically liable for the value of services received, public hospitals rarely collect more than nominal charges, so that their services are ‘free’ to most of their emergency patients.

“After the carpenter was removed to the private general hospital, his group hospital medical insurance paid the lion’s share of his hospital and surgical expenses and, in addition, paid for a good part of the expenses of his personal physician.

“While medical treatment was going on, pay days were slipping by, and the family expenses for food, shelter, and clothing continued. Fortunately for this carpenter, his employer had a liberal sick leave plan which gave him almost full pay for several weeks. But after a while, his accumulated sick leave ran out, and his family had to look elsewhere for a wage substitute. After six months, he might have started receiving disability benefits under social security, if he had remained alive but permanently and totally disabled.

“The eventual death of the patient was a signal point for the termination of most of the benefits that he and his family had been receiving, but the fact of death also qualified them for other benefits. His personal and group life insurance provided a fund to help his family adjust to the permanent removal of the principal source of family income. In addition, the family was able to qualify for substantial social security benefits. . . .

“If the carpenter’s accident had occurred about a half hour later, when he was on his way from his employer’s office to the job site, his injury might have been considered to have arisen ‘out of and in the course of’ his employment so that he would have been entitled to workmen’s compensation benefits. These would have consisted of free medical care provided by his employer, weekly disability payments, and upon his death survivor payments to his widow. His eligibility for these benefits would probably have simultaneously disqualified him from some part of the benefits he received for the nonoccupational accident, that is, sick leave and group health insurance.

. . . .

“As a coda to this little story, it might be added that two years after her husband’s death, the widow received a tort settlement from the insurance company which had insured the liability of the driver who was finally determined to have caused the accident. It was a tidy sum—part of which she used to pay her attorney, part to pay off the mortgage, and part to buy a new car.”<sup>7</sup>

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7. A. CONARD, *supra* note 1, at 25–27.

While a variety of loss shifting systems covered the carpenter, the list of sources that covered him is by no means exhaustive. Public assistance programs, aid to the crippled and blind, a variety of charities, and union health and welfare funds, to name a few, are also available to help meet the needs of the injured and his or her family.<sup>8</sup>

### B. *The Case of the Doctor*

Another more recent case can be derived from data prepared by the Health Insurance Association of America,<sup>9</sup> showing the multiple sources available to the victim of an injury or ailment which occasionally lead to overinsurance. This situation involves a doctor in Florida with a wide variety of sources available to compensate him for an injury.

The doctor is an orthopedic surgeon, 56 years of age, with a wife. All of his children are grown and no longer dependents, so support of his children is no longer a consideration. He has no prior military or civil service, and is therefore not covered by military or civil retiree benefits. Before suffering a stroke, the doctor made approximately \$80,000 a year. After the stroke, which left his left arm paralyzed, the doctor was no longer able to continue working as a surgeon. He is now a full-time staff member at a medical school, making \$50,000 a year.

The doctor obviously makes too much money to receive any support from public assistance or private charity. His disability, a paralyzed left arm, is not sufficiently severe to qualify him for Social Security disability benefits. Despite not qualifying for these sources of reparation, the doctor now has more income than before due to the private insurance he has purchased. The doctor purchased an insurance policy for himself that provides him with \$2,500 per month in benefits because of his disability. In addition, as a member of a particular medical association, he was able to purchase another policy which compensates his disability at a rate of \$2,000 a month. Both of these policies promised to pay if the doctor was unable to perform "his own occupation." Finally he receives \$600 a month on a mortgage disability policy on his home. Combine all these benefits with the salary he receives from the medical school and some investment income and the "disabled" doctor now receives a gross income of over \$120,000 per year.

The varied sources available to the doctor, and his ability to continue to work after his stroke, thus provide him with approximately fifty percent more income after his disability. The doctor's case reveals that the existing compensation systems make it possible to cover one's self in a manner that more than adequately provides benefits, even if the victim doesn't qualify for federal or state programs, workers' compensation, or had no injuring party to recover damages from.

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8. *Id.* at 28.

9. This hypothetical case uses statistical data presented in DISABILITY INSURANCE COMMITTEE, HEALTH INSURANCE ASS'N OF AMERICA, COMPENSATION SYSTEMS AVAILABLE TO DISABLED PERSONS IN THE UNITED STATES 12 (1979).

### C. Cases of Underinsurance and Overinsurance

The availability of numerous sources of compensation often creates underinsurance in some situations and overinsurance in others. The following cases illustrate the patchwork system of insurance coverage which can lead to these problems:

#### Case 1—Underinsurance

##### Situation

Mr. B: Self-employed farmer, age 45, single, no prior military or civil service, resides in Kansas.

**Pre-Disability Income Sources:** Current income, \$18,000 per year. "Average indexed monthly earnings" for Social Security purposes is \$1,000.

**Nature of Disability:** Nonoccupational injury resulting in partial paralysis—totally and permanently disabled.

**Disability Income Sources:** Social Security Primary Insurance Amount is \$424 per month.

**Principal Problem:** Mr. B relied on Social Security but it is inadequate for a person with a moderate income and no dependents.

#### Family Income (Monthly)

	Pre- Disability	Post Disability	
		Short Term	Long Term
Personal Earned Income	\$ 1,500		
Spouse Income			
Unearned Income			
Social Security—P.I.A.			\$ 424
Social Security—Dependents			
State Cash Sickness Benefits			
Workers' Compensation			
Creditor/Mortgage Disability			
Salary Continuance			
Employer Sponsored LTD			
Automobile Insurance			
Other Private Insurance			
<b>GROSS INCOME</b>	<u>\$ 1,500</u>	<u>\$ 0</u>	<u>\$ 424</u>
Less:			
Federal Income Tax	226		
State Income Tax	39		
Social Security Tax	122		
State Cash Sickness Premium			
Insurance Premiums			
<b>NET INCOME</b>	<u>\$ 1,113</u>	<u>\$ 0</u>	<u>\$ 424</u>
Gross Income Replacement Ratio (55–65% Recommended)		0.0%	28.3%
Net Income Replacement Ratio (70–80% Recommended)		0.0%	38.1%

Source: Disability Insurance Committee, Health Insurance Association, *Compensation System Available to Disabled Persons in the United States* (1979). Note that in the charts (Case 1 and Case 2), "P.I.A." stands for the Primary Insurance Amount under Social Security (the earnings-based monthly payment to a worker retiring at age 65 or disabled at a younger age without having received retirement benefits), and "LTD" stands for long-term disability insurance.

## Case 2—Overinsurance

**Situation**

Mrs. C: Registered nurse, age 29, married, 2 children, no prior military or civil service, resides in New Jersey.

**Pre-Disability Income Sources:** Current earned income is \$18,000 annually. Husband's earned income is \$20,000 annually. Her average indexed monthly income for Social Security purposes is \$1,193.

**Nature of Disability:** Complication of pregnancy caused permanent paralysis of lower limbs.

**Disability Income Sources:** She receives \$467 per month in Primary Social Security Benefits and \$350 per month in dependent benefits. The New Jersey Cash Sickness plan pays \$117 per week for 26 weeks. Her employer provides a salary continuation plan for 26 weeks and a long term disability program thereafter under which the benefits are  $\frac{2}{3}$  of salary minus New Jersey Cash Sickness Benefits and Primary Social Security Benefits. She receives \$150 per month from a credit disability policy on her auto loan for the next 48 months and \$850 per month from a disability income policy which she purchased while with a former employer who did not have a disability program.

**Principal Problem:** Her employee benefits are offset for primary, but not dependent Social Security benefits. Also, she has retained an individual policy which is no longer necessary.

**Family Income (Monthly)**

	Pre- Disability	Post Disability Short Term	Long Term
Personal Earned Income	\$ 1,500		
Spouse Income	1,667	\$ 1,667	\$ 1,667
Unearned Income			
Social Security—P.I.A.			467
Social Security—Dependents			350
State Cash Sickness Benefits		507	
Workers' Compensation			
Creditor/Mortgage Disability		150	150
Salary Continuance		493	
Employer Sponsored LTD			533
Automobile Insurance			
Other Private Insurance		850	850
<b>GROSS INCOME</b>	<b>\$ 3,167</b>	<b>\$ 3,667</b>	<b>\$ 4,017</b>
Less:			
Federal Income Tax	554	343	283
State Income Tax	63	20	27
Social Security Tax	194	102	102
State Cash Sickness Premium	6	6	3
Insurance Premiums	48		
<b>NET INCOME</b>	<b>\$ 2,302</b>	<b>\$ 3,196</b>	<b>\$ 3,602</b>
Gross Income Replacement Ratio (55–65% Recommended)		100.9%	113.7%
Net Income Replacement Ratio (70–80% Recommended)		138.8%	156.5%

Source: Disability Insurance Committee, Health Insurance Association, *Compensation Systems Available to Disabled Persons in the United States* (1979).

### III. LOSS SHIFTING SYSTEMS

Every reparation system shares the characteristic of shifting to someone else the loss falling on the original accident victim.<sup>10</sup> The differences between the systems are in the manner and the degree to which this distribution takes place.<sup>11</sup> The Conard-Morgan study described the major differences:

[S]ome of the systems of reparation involve an initial shift of the loss to some other private person—whether an individual or a corporation—who is said to be “liable”; the loss will be borne by him instead of the original victim, except to the extent that the second person carries insurance equal to the liability. Other sources operate through the medium of “loss insurance,” in which the insurance company makes its contract directly with the persons whose injury is to be paid for. Some sources of reparation come through the tax system; the funds are raised by compulsory taxation either on persons who are in some way related to the prospective beneficiaries, or on the general tax-paying public.<sup>12</sup>

The Conard-Morgan study divided the various systems of reparation into five classifications.<sup>13</sup> In reexamining that work, the same five groups are used here:

- (1) legal liability systems (tort, including no-fault auto, and workers' compensation),
- (2) private loss insurance systems (*e.g.*, life and health insurance),
- (3) sick leave and nonoccupational disability systems,
- (4) social insurance systems, and
- (5) other public expenditures.

### IV. THE DOLLAR PAYOUTS OF SYSTEMS OF REPARATION

The statistical data in the following charts indicate recently reported expenditures of the various reparations systems at work in the United States. It is important to note that the data are compiled as expenditures by a system, not as compensation received for a particular cause or loss. The fact that the data exist in this form indicates two things: (1) “that [the] cause of a death or disability is usually irrelevant to the problem of relieving the hardship . . . in its wake,” and (2) “that society has found it more efficient in some areas to insure against all (or almost all) causes, rather than developing a piecemeal system of separate coverages for losses attributable to different causes.”<sup>14</sup>

It is also noteworthy that, while it is customary for statistics to distinguish between results of “injury” and “illness,” in practice the distinction depends upon whether the cause of death or disability can be traced to an identifiable event or activity.<sup>15</sup> While it is true that most injuries can be traced to such causes and most

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10. A. CONARD, *supra* note 1, at 28.

11. *Id.*

12. *Id.* at 29.

13. *Id.*

14. A. CONARD, *supra* note 1, at 43.

15. *Id.* at 44.

illnesses cannot, an "illness" like pneumonia which can be traced to exposure following an airplane crash, will be considered an injury, since it has a specific event as its cause.<sup>16</sup> This kind of categorization makes it difficult to enumerate expenditures by causal events, and as previously mentioned, many systems virtually ignore the issue of causation. Even so, one way to get an effective overview is to look at the undifferentiated aggregate reparations expenditures for each system.<sup>17</sup>

#### A. Total Benefits Paid

In considering the amounts of benefits paid under the different systems of reparations, the Conard-Morgan study (and this study as well) adds another category—miscellaneous—to the five indicated earlier, and consolidates the categories of private loss insurance, sick leave and nonoccupational disability systems, and social insurance systems into one broad category. The four groups that emerge are: (1) legal liability, (2) loss insurance and allied plans, (3) public aid (noninsured), and (4) a miscellaneous catch-all category including private health care expenditures.<sup>18</sup> Total payments for these groups in 1983 were as follows:

**Table A**  
**General Category of Systems—Expenditures (1982)**  
**(dollars in millions)**

	Survivor Benefits	Disability Benefits	Medical Benefits	Total Benefits
Legal Liability (Tort—plus no-fault auto—and Workers' Compensation)	not segregated	not segregated	not segregated	49,081m
Loss Insurance (private and social plus sick leave payments)	53,992m	40,345m	121,834m	221,195m
Public Aid (noninsured) (includes Veterans' Aid and Public Hospitals)	3,113m	16,329m	51,992m	71,434m
Miscellaneous	—	—	10,900m	10,900m

See page 925, *infra*, for citations.

This classification shows how broadly society relies upon loss insurance (and related compensation) as the primary source of reparations payments for the

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16. *Id.*

17. *Id.*

18. *Id.*



economic hardships which result from injury, illness, and death. As the foregoing chart shows, this category made up over half of the entire amount of reparations expenditures.

### B. Legal Liability Systems

Legal liability systems, on the other hand, equal less than a fourth of the total expenditures of the loss insurance systems, and less than a sixth of total reparations expenditures. Tort (including no-fault auto) and workers' compensation benefits can be broken down as follows:

**Table B**  
**Legal Liability Payments (1982)**  
**(dollars in millions)**

	Survivor Benefits	Disability Benefits	Medical Benefits	Total Benefits
Tort Liability				
Auto Personal Injury Claims:				
Insured	—	—	—	21,807m
Uninsured	—	—	—	261m
Other Personal Injury Insurance Payments:				
Medical Malpractice	—	—	—	1,994m
Other	—	—	—	5,467m
Personal Injury Payments Made by Railroad and Motor/Carriers	—	—	—	<u>1,783m</u>
Total Tort Liability				31,312m <sup>1</sup>
Workers' Compensation	1,500m	9,825m	4,820m	16,145m
Other: (State)	—	1,568m	—	1,568m
(R.R.)	—	56m	—	<u>56m</u>
Total Workers' Compensation				17,769m
TOTAL LEGAL LIABILITY SYSTEMS PAYMENTS				49,081m

See page 925, *infra*, for citations.

### C. Loss Insurance and Allied Plans

As we have seen, the largest single category is that of "loss insurance and allied plans," which includes those benefit plans in which a person is entitled to defined benefits as a matter of right upon the occurrence of a loss, and are financed through the individual's own (or the employer's) contributions. The three major groups within this category are private insurance, formal sick leave plans, and governmentally administered or social insurance. The expenditures are as follows:

**Table C**  
**Loss Insurance and Allied Plans (1982)**  
**(dollars in millions)**

	Survivor Benefits	Disability Benefits	Medical Benefits	Total Benefits
Private Insurance (life, loss of income, and medical)				
Individual policies	7,776m	1,385m	3,572m	12,404m
Group policies	<u>6,953m</u>	<u>4,144m</u>	<u>79,082m</u>	<u>90,179m</u>
Total private loss insurance	14,729m	5,529m	82,654m	102,912m
Formal Paid Sick Leave	—	10,607m	—	10,607m
Social Insurance				
OASDI	33,612m	17,338m	—	50,950m
Rail Retirement	1,644m	668m	—	2,312m
Fed. Civ. Serv.	2,507m	3,664m	—	6,171m
Other Federal	424m	1,428m	—	1,852m
State/Local	739m	1,035m	—	1,774m
Medicare A	—	—	30,875m	30,875m
Medicare B	—	—	15,071m	<u>15,071m</u>
Total Social Insurance				<u>109,005m</u>
<b>TOTAL LOSS INSURANCE AND ALLIED PLANS</b>				<b>221,524m</b>

See page 925, *infra*, for citations.

### D. Public Aid

Noninsured public aid consists of public assistance, veterans' benefits, and public health care facilities. This category reflects free aid to qualified individuals and not a return on any type of payment or saving, as in the case of loss insurance. This is the second largest general category of expenditures, comprising slightly over a fifth of total reparations expenditures. The public aid expenditures are as follows:

**Table D**  
**Public Aid (1982)**  
**(dollars in millions)**

	Survivor Benefits	Disability Benefits	Medical Benefits	Total Benefits
Public Assistance				
Medicaid	—	—	29,399m	29,399m
General Assistance	—	—	1,442m	1,442m
SSI	—	6,126m	—	6,126m
Other	—	—	2,100m	<u>2,100m</u>
Total Public Assistance				<u>39,067m</u>
Veteran's Benefits (nonservice connected)	3,113m	10,203m	5,851m	19,167m
Other Public Health Service Expenditures	—	—	13,200m	13,200m
TOTAL PUBLIC AID				71,434m

See page 925, *infra*, for citations.

#### *E. An Overview of All Loss-Shifting Systems*

The figures from Table A through D, together with miscellaneous loss-shifting not reported in any other table, are compiled in Table E, which gives an overview of all loss-shifting systems and their relative shares of the total. For purposes of comparison, Conard and Morgan's comparable figures for 1960 are presented in Table F, and a summary comparison is made in Table G.

**Table E**  
**Benefits Paid for Injury and Illness**  
**By Principal Loss-Shifting Systems, 1982**  
 (dollars in millions)

	Survivors	Disability	Medical	Total	% of All Benefits
<b>Tort Liability</b>					
Auto P.I.					
Insured	—	—	—	\$ 21,807 <sup>2</sup>	
Uninsured	—	—	—	261 <sup>3</sup>	
Other P.I.					
Ins. Claims					
Medical Malpractice	—	—	—	1,994 <sup>4</sup>	
Other	—	—	—	5,467 <sup>5</sup>	
R.R. and Motor Carriers	—	—	—	1,783 <sup>6</sup>	
<b>Total Tort</b>				<b>31,312</b>	<b>8.9%</b>
Workers' Comp.	\$ 1,500	\$ 9,825	\$ 4,820	\$ 16,145 <sup>7</sup>	
Other: (State)	—	1,568	—	1,568 <sup>8</sup>	
(R.R.)	—	56	—	58 <sup>8</sup>	
<b>Total Workers' Comp</b>				<b>\$ 17,769</b>	<b>5.0%</b>
<b>Private Loss Insurance</b>					
Individual Policies	\$ 7,776	\$ 1,385	\$ 3,512	\$ 12,404	
Group Policies	6,953	4,144	79,082	90,179	
<b>Total Private Loss Insurance</b>	<b>\$ 14,729<sup>9</sup></b>	<b>\$ 5,529<sup>10</sup></b>	<b>\$ 82,654<sup>11</sup></b>	<b>\$ 102,912</b>	<b>29.2%</b>
Sick Leave	—	10,607 <sup>12</sup>	—	10,607 <sup>12</sup>	3.0%
<b>Social Insurance</b>					
					<b>30.9%</b>
OASDI	33,612	17,338	—	50,950 <sup>13</sup>	
Rail Ret.	1,644	668	—	2,312 <sup>14</sup>	
Fed. Civ. Serv.	2,507	3,664	—	6,171 <sup>15</sup>	
Other Fed.	424	1,428	—	1,852 <sup>16</sup>	
State/Local	739	1,035	—	1,774 <sup>17</sup>	
Medicare A	—	—	30,875	30,875 <sup>18</sup>	
Medicare B	—	—	15,071	15,071 <sup>19</sup>	
<b>Public Assistance</b>					
					<b>11.1%</b>
Medicaid	—	—	29,399	29,399 <sup>20</sup>	
Gen.	—	—	1,442	1,442 <sup>21</sup>	
SSI	—	6,126	—	6,126 <sup>22</sup>	
Other	—	—	2,100	2,100 <sup>23</sup>	
Veterans	3,113 <sup>24</sup>	10,203 <sup>25</sup>	5,851 <sup>26</sup>	19,167	5.4%
Other Public Health	—	—	13,200	13,200 <sup>27</sup>	3.7%
Private Health	—	—	10,900	10,900 <sup>28</sup>	3.1%
<b>TOTAL ALL SYSTEMS</b>				<b>352,939</b>	<b>100.0%</b>

## SOURCES FOR THE TABLES

1. Because of the lump sum nature of tort awards, the benefits awarded under that system cannot be reported in terms of the components of survivor, disability, and medical benefits. Note that the figure for tort awards also reflects damages received for noneconomic loss (*i.e.*, pain and suffering) and does not include certain uninsured tort payments (*i.e.*, products liability damages paid by a self-insuring manufacturer). Even so, tort payments comprise only about nine percent of the total reparations systems expenditures. (See Table E).

2. BUREAU OF THE CENSUS, U.S. DEPT. OF COMMERCE, 1985 STATISTICAL ABSTRACT OF THE UNITED STATES 512, Table 865. Because of the nature of lump-sum tort awards, no categorization of payments is possible. Also, no-fault auto insurance benefits were not reported separately in our source, so we have assigned them to this category, where the source appears to include them. According to other figures published by A.M. Best Company, no-fault payments for personal injury amounted to 11.2 percent of all bodily injury claims paid in 1982. 1983 BEST'S EXECUTIVE DATA SERVICE, tables A2-00-41 through A2-99-44. Multiplying this percentage by total payment for auto liability payments yields an estimate of \$2.44 million paid for no-fault auto claims in 1982.

3. This figure was computed by assuming that uninsured motorist's personal injury payments equaled an amount that is 1.2% of the insured personal injury claims. (The same method was used by Conard and Morgan, based on survey results from 1960.) So: 21,807 million (total insured payments) X 1.2% = 261 million.

4. 1983 BEST'S AGGREGATES AND AVERAGES, PROPERTY-CASUALTY 47. Calculated by multiplying the Net Premiums Written (1,490 million) by a combination of the Pure Loss Ratio (102.9%) and the Loss Adjustment Expense (30.9%). So: 1,490 million X 133.8% = 1,994 million.

5. *Id.* Same formula used. So: 5,671 million X (69.6% + 27.5%) = 5,467 million.

6. We could not find a source for this information, so the figure stated is 5.7% of the amount of total tort liability, the same percentage as in the Conard-Morgan study.

7. Price, *Workers' Compensation: Coverage, Benefits and Costs, 1982*, SOCIAL SECURITY BULLETIN, (December, 1984) at 8.

8. SOCIAL SECURITY BULLETIN, 1983 ANNUAL STATISTICAL SUPP. 218, Table 146.

9. Total death benefits from private insurance companies, veterans' life insurance, and fraternal and savings bank life insurance were \$16,622 million, of which \$6,953 million came from group insurance policies and \$9,969 million came from other plans. AMERICAN COUNCIL OF LIFE INSURANCE, 1984 LIFE INSURANCE FACT BOOK 37, 40, 100-01. Under plans other than term insurance, death benefits do not simply represent a shifting of loss but include a return of savings roughly approximated by the reserves released by death in insurance company accounts. Using this approximation, Conard, Morgan and their colleagues estimated that, in 1960, 32% of death benefits represented return on savings. A. CONARD, J.N. MORGAN, R.W. PRATT, JR., C.E. VOLTZ, & R.L. BOMBAUGH, *AUTOMOBILE ACCIDENT COSTS AND PAYMENTS: STUDIES IN THE ECONOMICS OF INJURY REPARATION* 50 n.58 (1964). That percentage would not be accurate today because, in 1960, 59% of the life insurance in force in the U.S. was whole life insurance with a savings element, but in 1982, the figure had fallen to 40% (a loss of 32% of its former proportion). *Id.* at 12. This means that a much smaller proportion of death benefits under life insurance policies represents return on savings. We were unable to find the updated equivalent of the data which Conard, Morgan and their colleagues used to compute the proportion, so we have taken this proportion (32%) and reduced it by 32% of itself (reflecting the decline of whole-life and permanent life insurance by 32% of its former proportion). This yields a proportion of 22%, representing roughly the percentage of total death benefits in nongroup policies which are a return on savings. (Group policies provide almost entirely for loss shifting. *Id.*) Subtracting the proportion from total death benefits in nongroup policies yields the figure of \$7,776 million reported in the chart.

10. HEALTH INSURANCE ASS'N OF AMERICA, 1984-85 SOURCE BOOK OF HEALTH INSURANCE DATA 20-21, Tables 2.1, 2.2.

11. *Id.* The amount for group policies excludes an estimated duplication in reported benefits, as explained in a note to Table 2.1 in the SOURCE BOOK.

12. BUREAU OF THE CENSUS, U.S. DEPT. OF COMMERCE, 1986 STATISTICAL ABSTRACT OF THE UNITED STATES 370, Table 626 (1981 figures). Of the total figure, \$6,026 million was provided in sick leave for government employees, and \$4,581 million was sick leave for workers in private employment. *Id.*

13. SOCIAL SECURITY BULLETIN, 1983 ANNUAL STATISTICAL SUPP. 218, Table 146.

14. *Id.*

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.* at 205, Table 132.

19. *Id.* at 207-08, Table 134.

20. BUREAU OF THE CENSUS, U.S. DEPT. OF COMMERCE, 1985 STATISTICAL ABSTRACT OF THE UNITED STATES 374, Table 269.

21. SOCIAL SECURITY BULLETIN, 1983 ANNUAL STATISTICAL SUPP. 225, Table 190 (1980 figures).

22. *Id.* at 234, Table 163.

23. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, SEPT. 1983 HEALTH CARE FINANCING REVIEW 13, Table 9.

24. SOCIAL SECURITY BULLETIN, 1983 ANNUAL STATISTICAL SUPP. 218, Table 146.

25. *Id.*

26. ADMINISTRATOR OF VETERAN'S AFFAIRS, 1982 ANNUAL REPORT. The figure was computed by taking the cost of VA-provided medical care (6,999 million, found on p. 13 of the report) and reducing it by 16.4%, the percentage of service-connected injuries/illnesses treated. *Id.* at 63.

27. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, SEPT. 1983 HEALTH CARE FINANCING REVIEW 13, Table 9 (combined figures for "State and Local Hospitals" and "Other Public Expenditures for Personal Health Care").

28. *Id.* at 7, Table 3.

**Table F**  
**Benefits Paid for Injury and Illness**  
**By Principal Loss-Shifting Systems, 1960**  
**(dollars in millions)**

	Survivor Benefits	Disability Benefits	Medical Benefits	Total Benefits	% of All Benefits
<b>Tort Liability</b>					
Automobile personal injury					
Insured payments	*	*	*	\$ 1,494	
Uninsured payments	*	*	*	18	
Other insured personal injury liability payments	*	*	*	269	
Railroad and motor carrier personal injury claims	*	*	*	103	
Total tort liability	*	*	*	\$ 1,884	7.9%
Workmen's compensation	\$ 105	\$ 754	\$ 435	\$ 1,294	5.4%
<b>Private loss insurance</b>					
Individual policies	\$ 1,761	\$ 386	\$ 446		
Group policies	1,115	619	4,403		
Total private loss insurance	\$ 2,876	\$ 1,005	\$ 4,849	\$ 8,730	36.5%
Sick leave payments		\$ 1,209		\$ 1,209	5.1%
Social insurance	\$ 1,954	\$ 1,379		\$ 4,333	18.1%
Public assistance	\$ 90	\$ 876	\$ 530	\$ 1,496	6.3%
Veterans benefits (nonservice-connected)	\$ 357	\$ 882	\$ 521	\$ 1,760	7.3%
<b>Public health service facilities</b>					
General hospital and hospital care			\$ 2,174		
Medicare			59		
Medical rehabilitation			18		
Total public health service facilities			\$ 2,251	\$ 2,251	9.4%
<b>Private health service facilities</b>					
Industrial in-plant services			\$ 265		
Philanthropic			\$ 700		
Total private health service facilities			\$ 965	\$ 965	4.0%
<b>TOTAL, ALL SYSTEMS</b>				\$ 23,922	100.0%

\*Segregated amounts not reported

Source: A. CONARD, J. N. MORGAN, R. W. PRATT, JR., C. E. VOLTZ, AND R. L. BOMBAUGH, *AUTOMOBILE ACCIDENT COSTS AND PAYMENTS: STUDIES IN THE ECONOMICS OF INJURY REPARATION* 48-49 (1964). Conard and Morgan's voluminous source references are not reproduced but may be consulted in the original.

The Conard-Morgan study reported that in 1960 legal liability systems accounted for 13.3 percent of benefits paid under all systems.<sup>19</sup> This proportion was about the same in 1982, when 13.9 percent of total reparations was provided by legal liability systems. Between 1960 and 1982, tort liability came to account for a slightly larger share of total payments, while workers' compensation lost a small amount of its percentage of the whole. Table G presents an overview of the changes in the dollar amounts and the relative percentage of the different groups of loss-reparation systems.<sup>20</sup>

**Table G**  
**Percent of Benefits Paid for Injury**  
**And Illness by Principal Loss-**  
**Shifting Systems—1960 and 1982**

	Dollars		% of Total		Change in % of Total
	1960	1982	1960	1982	
Total Tort (incl. no-fault)	2b.	30b.	7.9%	8.9%	+ 1.0%
Workers' Comp.	1.3b.	18b.	5.4%	5.0%	- .4%
Private Loss Ins.	9b.	103b.	36.5%	29.2%	- 7.3%
Sick Leave	1.2b.	11b.	5.1%	3.0%	- 2.1%
Social Insurance	4.3b.	109b.	18.1%	30.9%	+ 12.8%
Public Assistance	1.5b.	39b.	6.3%	11.1%	+ 4.8%
Veteran's Benefits	1.8b.	19b.	7.3%	5.4%	- 1.9%
Other Public Health	2.3b.	13b.	9.4%	3.7%	- 5.7%
Private Health	1b.	11b.	4.0%	3.1%	- 0.9%
Total	24b.	353b.	100.0%	100.0%	

Source: Table E and Table F, *supra*.

## V. SYSTEMS OF REPARATION

The following descriptions and facts about various systems, many of which (as indicated) have expanded exponentially since the Conard-Morgan study, attempt both to illustrate the diversity in approaches to the reparation of accident victims and to explicate more fully the application of those approaches.

19. A. CONARD, *supra* note 1, at 48-49, Table 1-2.

20. Much greater changes were found in the shares which private loss insurance and social insurance held of the total amount. Private loss insurance slipped from 36.5% to 29.1%, while social insurance rose from 18.1% to 30.9%. This reflects not only generous increases in benefits, especially for Social Security, but also the appearance of Medicare health insurance and Supplemental Medical Insurance, programs not yet enacted in 1960. The increase in the share held by public assistance, from 6.3% to 11.1%, also reflects the appearance of new programs, such as food stamps (1964) and Medicaid (1965), as well as increases in existing programs.

The rise of Medicare and other public assistance programs like Medicaid has been accompanied by a relative decline in "other public health expenditures," which primarily comprise hospital services not reimbursed by other sources.

### A. *The Tort System*

The tort system attempts to shift the losses caused by personal injury by trying to determine the party or product at fault and requiring that party to make whole the injured party by paying damages. The injured party may recover almost any form of measurable and foreseeable financial loss, including medical expenses (both past and prospective), loss of income (past and prospective), property loss, and other miscellaneous expenses resulting from injury. In addition, the injured party may collect compensation for noneconomic losses (principally pain and suffering, but in some instances recovery for such things as humiliation due to disfigurement, inability to lead a normal life, or loss of consortium is also allowed).<sup>21</sup> In order to recover damages, however, the injured party must show that the injury was caused by the defendant, that the defendant's conduct or product was faulty, and that the injured party was not contributorily (or perhaps comparatively) at fault.

While it is obvious that one cannot fully explain the tort system in such brevity, greater detail seems unnecessary in an article aimed at lawyers and law students comparing tort as a system of reparation for personal injury with other such systems. As the Conard-Morgan study pointed out twenty-five years ago, there are two characteristics of the tort system that are most important when making such a comparison:

The first is the adaptability of the remedy to all kinds of losses; it attempts to measure the losses for injured workers, students, and housewives alike. The second characteristic of the tort remedy is its concentration on a single lump-sum payment, which results in delaying all reparation until the total effects of the injury have become manifest, so that a good part of the compensation arrives after the immediate need for it has passed.<sup>22</sup>

The lump-sum problem has been addressed in recent years by the development of both structured settlements—where the two parties agree to divide up the damages into an initial lump-sum payment and supplemental installments made over a longer period of time—and statutes allowing periodic payments of judgments. The statutory payments are similar to a structured settlement, but are scheduled and implemented by law, not by a private settlement between the parties.

While structured settlements and periodic payment of judgments were designed in an attempt to deal with the lump-sum payment problem, plaintiffs have often been unwilling to accept structured settlement plans,<sup>23</sup> due to the more complicated computations required in figuring out the actual settlement,<sup>24</sup> problems with anticipating inflation over a long-term payment period,<sup>25</sup> and the difficulty in figuring attorneys' fees.<sup>26</sup> Although some states have adopted periodic payment of judgment laws, most of these limit their application to medical malpractice or products liability

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21. A. CONARD, *supra* note 1, at 30.

22. *Id.*

23. Hillard, *Alternative Recovery Methods: Structured Settlements and Periodic Payments of Judgments*, 34 FED'N INS. COUNS. Q. 237, 243 (1984).

24. *Id.* at 255.

25. *Id.* at 256.

26. *Id.* at 258.



cases in which future damages are expected to exceed a certain sum.<sup>27</sup> Therefore, while parties and legislatures have sometimes attempted to answer the problem of lump-sum tort awards, change is by no means uniform.

In addition to the two characteristics the Conard-Morgan study mentions, it is also important to point out that the injured party, who may have had little or nothing to do with causing his or her own injury, could quite possibly come away from the tort system uncompensated (or at least relatively so) if he or she finds difficulty in proving the faulty nature of the defendant's conduct or product or his or her own lack of contributory or comparative negligence. (And one must not overlook the often vast difference between what actually happened and what can later be proven to have happened.) The initial goal of the tort system, then, is to establish fault, which must occur before reparation is ever made.

The single largest source of tort liability payments is automobile accident insurance. In 1982, almost four and a half million individuals were injured in motor vehicle accidents,<sup>28</sup> and automobile insurers paid out over twenty-one billion dollars for personal injury caused by automobile accidents,<sup>29</sup> approximately two-thirds of the total amount of personal injury payments made under the whole tort system.

Products liability has grown rapidly in recent years as a part of the total amount of tort liability payments. The United States Consumer Product Safety Commission estimated that in 1982 thirty-three million people were injured in consumer product-related cases.<sup>30</sup> These injuries resulted in over eight and a half billion dollars in emergency room treatment alone.<sup>31</sup>

Medical malpractice is another major part of total tort payments for personal injury that has increased dramatically since the Conard-Morgan study. Before 1975, it was subsumed in insurance data as a part of general liability insurance.<sup>32</sup> Since then, it has been recorded as a separate line of insurance, and has become increasingly larger, so that in 1982, medical malpractice insurers made almost two billion dollars in personal injury payments.<sup>33</sup>

In addition, railroads, airlines, buses, and other motor carriers make personal injury payments on account of tort liability, as do landlords, property owners, and municipalities on account of "building and sidewalk" injuries. These liabilities are usually insured under a general liability coverage plan unless the defendant has enough resources and loss experience to warrant becoming "self-insured."<sup>34</sup>

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27. *Id.* at 263. For a general discussion of recent legislation, see *N.Y. Times*, July 14, 1986, at A1, A15.

28. BUREAU OF THE CENSUS, U.S. DEPT. OF COMMERCE, 1985 STATISTICAL ABSTRACT OF THE UNITED STATES 599, Table 1041.

29. *Id.* at 512, Table 865. Because of the lump-sum nature of tort awards, no categorization of payments is possible.

30. U.S. CONSUMER PRODUCT SAFETY COMMISSION, 1982 ANNUAL REPORT 3.

31. *Id.* at Appendix A, Table 3. There seems no way to be certain of how much of this amount was paid by products liability insurance, by businesses that self-insure, or by the consumer (or the consumer's insurer).

32. INSURANCE INFORMATION INSTITUTE, 1982-83 INSURANCE FACTS 26.

33. 1983 BEST'S AGGREGATES AND AVERAGES, PROPERTY-CASUALTY 4. Calculated by multiplying the premiums earned (\$1,358 million) by the ratio of losses incurred to premium earned (102.9%). So: \$1,358m X 1.029 = \$1,752m.

34. A. CONARD, *supra* note 1, at 31.

### B. No-Fault Automobile Insurance

No-fault automobile insurance was designed to circumvent some of the problems of the fault-based tort system as it applies to automobile accidents. Under a no-fault system, each injured party is compensated for his out-of-pocket losses, regardless of fault. To a corollary extent, no injured party can claim either loss based on fault or noneconomic loss, such as pain and suffering.<sup>35</sup>

No-fault automobile insurance was designed to make the following improvements in automobile accident compensation: First, it was designed to assure that every person who was injured in an auto accident was eligible for insurance payments, regardless of any ability to prove fault-based claims; second, it was designed to spend less on smaller, relatively trivial claims, and more on serious injury; third, it was designed to pay claims promptly; fourth, no-fault automobile insurance was designed to pay more efficiently by using less of the premium dollar on insurance overhead and legal fees; finally, no-fault insurance was designed to reduce, or at least to stabilize, the costs of automobile insurance.<sup>36</sup>

Massachusetts enacted the first no-fault automobile plan in 1970 and twenty-three other states later enacted their own version of a no-fault automobile insurance scheme. There are three basic categories of no-fault plans. The first are modified no-fault laws, which provide only modest no-fault benefits and eliminate only relatively few fault-based claims.<sup>37</sup> The second type of no-fault plans enacted are known as add-on plans which, although calling for a modest amount of no-fault benefits to be paid to accident victims, do not eliminate any right to pursue a fault-based claim for pain and suffering.<sup>38</sup> The third category of no-fault plans are plans approaching pure no-fault, which eliminate most claims based on fault and substitute relatively unlimited benefits for all medical expenses and wages lost.<sup>39</sup> While twenty-four states passed some form of no-fault automobile insurance law between 1970 and 1975, no new no-fault law has been passed in any state since then. Statutes in Nevada and Pennsylvania (and the District of Columbia's law, passed in 1983) have been repealed, and an attempt to pass a federal no-fault bill narrowly failed in the Senate in 1976.<sup>40</sup>

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35. O'Connell, *Operation of No-Fault Auto Laws: A Survey of the Surveys*, 56 NEB. L. REV. 23, 24 (1977).

36. For a fuller explanation of these designed improvements, see *id.* at 24-26; U.S. DEPT. OF TRANSPORTATION, COMPENSATING AUTO ACCIDENT VICTIMS: A FOLLOW-UP REPORT ON NO-FAULT AUTO INSURANCE (1985).

37. The states that have this kind of plan are Colorado, Connecticut, Florida, Georgia, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, Nevada, New Jersey, North Dakota, Pennsylvania, and Utah. O'Connell, *supra* note 35, at 26.

38. The states that have this kind of plan are Arkansas, Delaware, Maryland, Oregon, South Carolina, South Dakota, Texas, and Virginia. *Id.* at 27.

39. No law really comes that close to a pure no-fault plan, but Michigan and New York come closest. The Michigan plan covers unlimited medical expenses and a maximum of about \$46,000 of wage loss (as of 1982), while eliminating fault-based claims unless the victim suffers death, serious disfigurement, or serious impairment of bodily function. The New York plan provides \$50,000 in no-fault benefits, with a similar tort threshold. *Id.*

40. *Id.* at 23. For a discussion of the impact of no-fault legislation and a comparison with the effects of leaving the automobile tort liability system intact, see U.S. DEPT. OF TRANSPORTATION, *supra* note 36.

### C. Workers' Compensation

In the United States, an entire category of personal injury—workplace injuries—is compensated primarily by means of state workers' compensation systems instead of tort law. At common law, injured workers had to prove that employer negligence had caused their accidents, an expensive and uncertain task. As increased American industrialization led to a burgeoning number of negligence claims, state legislatures began to institute changes in the rules regarding compensation for industrial accidents. At the heart of the workers' compensation system lies a compromise: abrogated are covered workers' rights to sue their employers in tort for common law damages (including pain and suffering) arising from negligently caused workplace injuries; in return injured employees receive a guaranteed payment of their medical costs and a portion of their lost wages. Workers' compensation pays less than full damages to injured workers, aiming instead to answer subsistence level needs without undue delay.<sup>41</sup>

In 1980, state workers' compensation laws covered eighty-nine percent of all wage and salary employees.<sup>42</sup> The laws do not cover all workers because most states have excluded from mandatory coverage certain classes of workers such as farm laborers, casual workers, domestic servants, and employees of very small businesses.<sup>43</sup> The rationale for these exclusions is supposedly the administrative difficulty of including workers whose employers are engaged in commerce that is not readily measurable.<sup>44</sup> All states, however, permit such employers voluntarily to include an exempted employee class under their plan's coverage.<sup>45</sup>

Under most workers' compensation statutes, employers must carry insurance against the risks of work-related accidents. Nearly all states<sup>46</sup> permit an employer to self-insure and about half the states also allow smaller employers to pool their risks and self-insure as a group. Private insurance companies, or in some states, state insurance funds, supply workers' compensation insurance to those employers who do not self-insure. The amount of premiums an employer pays reflects generally the level of risks faced by its workers. Premiums for large businesses are custom-crafted on the basis of the accident experience of each,<sup>47</sup> while small firms' premiums are

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41. While the workers' compensation system was intended to provide exclusive remedy for industrial accidents, another element of these accidents has established another possible means of compensation. Plaintiff's lawyers have increasingly realized that third parties, such as suppliers of industrial equipment to the place of employment, are amenable to products liability suits. According to one study, almost one-half of the total of product liability payments for personal injury (42%) goes to employees injured on the job and therefore presumably already covered by workers' compensation. See INSURANCE SERVICES OFFICE, 1976 PRODUCT LIABILITY CLOSED CLAIM SURVEY, PRELIMINARY ANALYSIS OF SURVEY RESULTS 59 (1976), cited in O'Connell, *Transferring Injured Victims' Tort Rights to No-Fault Insurers: New Sole Remedy Approaches to Cure Liability Insurance Ills*, 1977 U. ILL. L.F. 749, 766; see also Larson, *Third-Party Action Over Against Workers' Compensation Employer*, 1982 DUKE L.J. 483.

42. UNITED STATES CHAMBER OF COMMERCE, 1982 ANALYSIS OF WORKERS COMPENSATION LAWS I [hereinafter cited as U.S. CHAMBER OF COMMERCE].

43. *Id.* at 5-8.

44. J. CHELIUS, WORKPLACE SAFETY AND HEALTH 22 (1977).

45. U.S. CHAMBER OF COMMERCE, *supra* note 42, at 5-8.

46. North Dakota, Texas, and Wyoming do not permit self-insurance. *Id.* at 3-4.

47. Approximately one-quarter of the employers who purchase workers' compensation insurance are large enough to be eligible for experience-rated premiums. J. CHELIUS, *supra* note 44, at 26.

based on broader industrial classifications. In 1979, employers paid out over twenty billion dollars to insure or self-insure the risks of work injuries.<sup>48</sup>

Compensable injuries under workers' compensation are restricted to those "arising out of and in the course of employment."<sup>49</sup> The injury's connection to the employee's work activity thus replaces fault as the linchpin of the employer's liability. Not surprisingly, the work connection issue is the most heavily contested aspect of workers' compensation disputes.<sup>50</sup> In general, an injury "arises out of" employment if the risk of the injury is directly related to the worker's employment. For example, the risk of being struck by lightning may be considered part of a forest ranger's work risks, but not a lawyer's.<sup>51</sup> The "course of employment" component of the work connection test focuses on when and where the injury occurred. An accident occurring on the employer's property and during working hours is almost certainly covered whereas a mishap during lunch may not be.<sup>52</sup>

One of the persistent ambiguities in the work-connected disability area is the compensability of diseases (as opposed to injuries) allegedly attributable to work activity. While all states regard occupational diseases as "injuries" coverable by workers' compensation, claimants are required to assume the often formidable burden of proving the causal nexus between the disease and the work activity.<sup>53</sup> Only approximately 30,000 occupational disease claimants per year are compensated by workers' compensation, less than one-thirteenth of the estimated number of workers disabled annually by occupational illnesses.<sup>54</sup>

As indicated above, state workers' compensation statutes guarantee injured workers something less than total accident costs. Injured workers may recover nonmonetary losses—pain and suffering—in ordinary tort actions for those injuries occurring outside the scope of workers' compensation, yet they are not compensated for those losses by workers' compensation. States typically require the employer to pay two-thirds of the totally disabled worker's lost weekly wages, subject to a weekly maximum that varies widely from two-thirds of the state average weekly wage up to twice the state average.<sup>55</sup> Some states also limit the duration and/or the total amount of income replacement benefits payable.<sup>56</sup> Subject to similar restrictions, workers' compensation pays income benefits to surviving families of workers killed on the job. In addition, there are usually further limitations peculiar to survivor benefits.<sup>57</sup>

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48. U.S. CHAMBER OF COMMERCE, *supra* note 42, at viii.

49. W. MALONE, M. PLANT, & J. LITTLE, *CASES AND MATERIALS ON WORKERS' COMPENSATION AND EMPLOYMENT RIGHTS* 113-14 (2d ed. 1980) [hereinafter cited as W. MALONE].

50. J. CHELUS, *supra* note 44, at 22.

51. W. MALONE, *supra* note 49, at 187-230.

52. *Id.* at 113-86.

53. U.S. CHAMBER OF COMMERCE, *supra* note 42, at 10-13.

54. Note, *Compensating Victims of Occupational Disease*, 93 HARV. L. REV. 916, 925 (1980).

55. U.S. CHAMBER OF COMMERCE, *supra* note 42, at 14-17.

56. Alaska, Iowa. *Id.*

57. *Id.* at 20-21.

In addition, under statutory "schedules," workers' compensation redresses loss from certain specified injuries that cause permanent partial disabilities, such as losses of or damage to limbs, eyes, hearing or other functions. Income benefits for scheduled injuries may vary dramatically from state to state.<sup>58</sup> Compensation for nonscheduled injuries causing permanent partial disabilities usually consists of a percentage of wage loss determined by the state workers' compensation administrative body.<sup>59</sup>

By foregoing inquiries over fault, workers' compensation originally aimed at eliminating a substantial amount of "friction" in the injury compensation process. But payment of workers' compensation benefits—amounting to over 16.2 billion dollars in 1982<sup>60</sup>—can still pose a complex administrative task. All state governments play an administrative role in their workers' compensation systems. Most states administer via special boards or commissions; a few use only their state court systems.<sup>61</sup> The state workers' compensation agencies' responsibilities are to keep records of accidents, disseminate workers' compensation information to employers and workers, police the system for abuse, and resolve disputes. The costs of these activities are commonly met through the state's general appropriation.<sup>62</sup>

Despite its critics, the workers' compensation system is clearly the best widely applicable system of insurance, public or private, in place in the United States. It provides insurance that is far more generous and comprehensive than the typical private insurance plan, and only a handful of the most generous fringe benefit plans available exceed the total level of benefits that the workers' compensation system offers workers.

#### D. Employers' Liability Systems

Employers' liability systems were the forerunners to workers' compensation laws and various states implemented them in a variety of ways. The Conard-Morgan study described them in the following way:

[The employers' liability laws'] . . . common element is that they give the injury victim some advantage over his status under tort law—usually by relieving him of some or all of the notorious "common-law defenses," which were assumption of risk, contributory negligence, and the fellow-servant rule. These laws fill an interstitial space in many states,

58. This chart indicates benefits for selected scheduled injuries in selected states as of January 1982. U.S. CHAMBER OF COMMERCE, *supra* note 42, at 18, Chart VI.

	Arm at Shoulder	Hand	Thumb	Leg at Hip	One Eye	Hearing Both Ears
Arkansas	28,000	21,000	8,400	24,500	14,000	21,000
District of Columbia	123,795	96,814	29,759	116,653	63,485	79,356
Massachusetts	11,140	8,675	—	9,900	9,900	19,800
Michigan	82,583	66,005	19,955	66,005	49,734	49,734
Pennsylvania	116,440	95,140	28,400	116,440	78,100	73,840

59. *Id.* at 14.

60. BUREAU OF THE CENSUS, U.S. DEPT. OF COMMERCE, 1986 STATISTICAL ABSTRACT OF THE UNITED STATES 375, Table 637. In 1983, payments amounted to over \$17.5 million. *Id.*

61. U.S. CHAMBER OF COMMERCE, *supra* note 42, at 27–31.

62. *Id.* at 38–39.

where [workers'] compensation laws do not reach because of the number of employees involved, or because of the exclusion of particular injuries.

However, there is one "employers' liability law" which covers a very important segment of employees, and an equally important segment of injury payments. That is the Federal Employees Liability Act [(FELA)], which applies to the employees of interstate railroads, and has been extended to seamen employed on navigable waters.

Viewed as reparation devices, employers' liability laws share most of the characteristics of tort actions. All losses are recoverable, and in a lump sum. The chief difference is that recovery is permitted to many claimants whom the tort law would disqualify.<sup>63</sup>

## E. *Private Loss Insurance*

### 1. *Life Insurance*

Life insurance has long been a common form of individual personal protection against the economic losses that result from premature death due to illness or injury. A life insurance policy normally pays a fixed sum, the policy's face value, upon the death of the insured. In 1982, two-thirds of all Americans owned some form of life insurance, and in eighty-six percent of American families, life insurance protected at least one family member.<sup>64</sup> The average amount of life insurance protection per family was \$57,300,<sup>65</sup> equalling about twenty-five months of the average family's total disposable personal income.<sup>66</sup> The total amount of life insurance in force in the United States during 1982 was almost four and a half trillion dollars.<sup>67</sup>

Despite a bewildering number of varieties, traditionally there have been basically two types of life insurance—whole life insurance and term life insurance. Whole life insurance pays benefits to a beneficiary at the death of the insured whenever that occurs. In addition, whole life insurance builds cash value that the insured can recover prior to death by cancellation of the policy. Term life insurance policies offer benefits to beneficiaries only when an insured dies within a specified period. Most term life insurance policies do not build cash value. As of 1982, about three-quarters of life insurance protection in the United States involved an element of savings, as in whole life insurance, while the remaining twenty-five percent was term insurance.<sup>68</sup>

Nearly three-fourths of new life insurance protection purchased in the United States in 1982 was bought on an individual basis—that is, by personal or family decision—usually through a life insurance agent.<sup>69</sup> The average face amount of an individual regular life insurance policy purchased in the United States was \$37,000.<sup>70</sup>

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63. A. CONARD, *supra* note 1, at 32–33.

64. AMERICAN COUNCIL OF LIFE INSURANCE, 1983 LIFE INSURANCE FACT BOOK 6.

65. *Id.* at 5.

66. *Id.* at 14.

67. *Id.* at 15.

68. *Id.* at 12. In recent years, a new form of coverage called "universal life" allows one to mix the benefits of term insurance and insurance which builds a cash value. "[I]n the last four years, sales of universal life have eclipsed sales of whole life. Universal life is fast becoming the industry's new bread-and-butter product, already accounting for nearly forty percent of all life insurance sold." CONSUMER REPORTS, August 1986, at 155.

69. AMERICAN COUNCIL OF LIFE INSURANCE, 1983 LIFE INSURANCE FACT BOOK 8.

70. *Id.* at 10.

Many families receive death benefits from retirement plans, but since this is almost always exclusively a return of savings, it is not included here among loss shifting reparations systems.<sup>71</sup> In addition to death benefits, many life insurance policies provide for waiver of premiums, and sometimes payment of monthly income, if the insured becomes totally and permanently disabled.<sup>72</sup>

## 2. Health Insurance

Health insurance provides protection for hospital, surgical, and other medical expenses. In 1981, 188 million Americans—eighty-four percent of the population—were protected by one or more forms of private health insurance.<sup>73</sup> Various forms of private health insurance are available from a variety of insurers: insurance companies, hospital and medical service plans like Blue Cross and Blue Shield, and group medical plans operating on a prepayment basis such as health maintenance organizations.<sup>74</sup>

There were over 1,000 private health insurers writing individual and/or group health insurance policies in 1981 in the United States.<sup>75</sup> The benefits these policies provide are either paid directly to the insured or, if assigned by the insured, to the provider of services for reimbursement of expenses incurred. Insurance companies provide two basic types of accident and health insurance—medical expense insurance and disability income insurance. Medical expense insurance provides benefits to cover expenses connected with hospital and medical care and related services. Disability income insurance provides periodic payments when the insured is unable to work due to injury or illness. Disability income insurance is more fully discussed in the following section on sick leave and disability insurance.

Blue Cross and Blue Shield best exemplify hospital and medical service plans. These nonprofit member plans serve statewide and other geographical areas, offering both individual and group coverage. Blue Cross plans provide hospital care benefits on a service-type basis, under which the organization, through a separate contract with member hospitals, reimburses the hospital for covered service to the insured. Blue Shield plans provide benefits for surgical and medical services performed by a physician. The typical Blue Shield plan provides benefits similar to those provided under the benefit provisions of hospital-surgical policies issued by insurance companies. In 1982, there were sixty-eight Blue Cross and sixty-nine Blue Shield plans in the United States.<sup>76</sup>

Health maintenance organizations provide comprehensive health care services for their members for a fixed periodic payment, rather than the typical “fee for service” method otherwise used by most health care providers. In such plans, a group of physicians, surgeons, dentists, or optometrists furnishes needed care as specified

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71. A. CONARD, *supra* note 1, at 34.

72. *Id.*

73. HEALTH INSURANCE ASS'N OF AMERICA, 1982-83 SOURCE BOOK OF HEALTH INSURANCE DATA 7.

74. *Id.*

75. *Id.*

76. *Id.*

in the contract to subscribers. In 1982, there were 277 health maintenance organizations, with approximately eleven million subscribers, in the United States.<sup>77</sup>

Group insurance plans are another major form of health insurance. Insurers often administer such plans through employers or labor unions, fraternal societies, communities, or through rural and consumer health cooperatives. Usually, these groups tailor the amount of protection provided to the amount desired and affordable by a specific group of people—auto factory workers, veterans, or retirees, for instance.<sup>78</sup>

Most medical insurance covers loss regardless of the cause of the injury, and limits payment only in terms of the facilities used. For example, a hospital expense insurance policy provides only for expenses incurred while the insured is in a hospital—dental, optical, or psychiatric care is excluded. Similarly, other policies exist that cover only surgical expenses, or dental expenses. In addition, major medical expense insurance, designed to provide broad and substantial protection for large, unpredictable medical expenses, with few internal limits on reparation, is available as a supplement to hospital or surgical expense insurance programs. In 1982, health insurance paid thirty percent of the country's total health care expenditures.<sup>79</sup>

#### F. Sick Leave and Private Disability Insurance

When workers are disabled temporarily<sup>80</sup> as a result of *nonwork* activity, wage-loss compensation may flow from two private sources: employers' sick leave plans or "accident and sickness"<sup>81</sup> coverage purchased from a private insurance carrier.

Sick leave plans may be formal programs or informal arrangements between employer and employee. Informal sick leave describes the situation in which it is the practice of the employer simply to continue to pay workers who are out sick or injured. Employers generally keep no formal records of benefits or absences—hence it is difficult to estimate how much of this sort of protection is provided. Clearly, informal sick leave arrangements are most viable and widely used in small businesses—where managers can effectively monitor the plan's performance and control abuse.<sup>82</sup>

Formal sick leave plans are explicit contractual benefit arrangements between employers and workers. These plans cover nearly all federal employees and most state and local government workers,<sup>83</sup> with public employees far more likely to be

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77. *Id.* at 8.

78. *Id.* About 56% of the insured population of the U.S. in 1981 was insured by a group program. *Id.* at 14.

79. *Id.* at 39.

80. Long term disability plans usually begin to take effect after three to six months of disability. B. SPENCER, *GROUP BENEFITS IN A CHANGING SOCIETY* 87 (3d ed. 1981).

81. Also called weekly indemnity plans. *Id.* at 90.

82. *Id.* at 87.

83. C.A. WILLIAMS, JR., J. TURNBULL, & E. CHEIT, *ECONOMIC AND SOCIAL SECURITY, SOCIAL INSURANCE AND OTHER APPROACHES* 309 (5th ed. 1982) [hereinafter cited as C.A. WILLIAMS].



covered under these formal plans than are private employees.<sup>84</sup> The federal plan is nonetheless representative of many formal sick leave programs. Federal workers can accumulate up to thirteen days of sick leave per year. They receive full pay<sup>85</sup> while disabled, until their accumulated supply of sick leave is exhausted. Unused sick leave can be converted at retirement into service credit, entitling the federal worker to a higher pension.<sup>86</sup> Unlike most formal sick leave plans, however, the federal program does not limit the total amount of sick leave that an employee can accumulate.

Accident and sickness (A&S) plans fulfill essentially the same function as sick leave plans, but are usually insured rather than financed directly out of the employer's pocket. A&S plans are used most often for hourly employees of private employers. The employer usually purchases the coverage for its workers, although plans are also available from insurance carriers on an individual basis. The typical A&S plan pays benefits of seventy percent of the absent workers' weekly wages. There is normally a seven-day elimination period for absences due to sickness, during which the plan pays no benefits. There is no elimination period for absences attributed to accidents, presumably because the moral hazard problem of workers feigning disabilities is perceived to be less severe where an accident has occurred than in the case of sickness.<sup>87</sup>

In 1982, some form of short-term disability insurance, including formal sick leave plans, covered 68.6 million wage and salary workers in the United States, or sixty-two percent of the civilian labor force.<sup>88</sup> On the other hand, in 1982 long-term disability insurance covered only 25.3 million workers (twenty-three percent of the civilian labor force).<sup>89</sup>

Group long-term disability income insurance pays benefits for an extended period of time—usually at least five years and sometimes up to age 65 or for life—after a waiting period.<sup>90</sup> Typically, this kind of insurance plan pays benefits for the first one or two years if the insured is totally disabled from performing his or her own occupation. After that period, the insured may continue to receive benefits only if unable to engage in *any* occupation for which he or she is fitted by education, training, or experience.<sup>91</sup> Benefits are a percentage of the wage or salary received before the disabling injury or illness; they are usually reduced by any benefits the insured receives from Social Security, workers' compensation, and other public programs.<sup>92</sup>

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84. Private employers' formal sick leave plans tend to apply only to upper level employees.*Id.*

85. Some private plans provide for full pay for a certain period, followed by a longer period in which the employee is paid half wages. B. SPENCER, *supra* note 80, at 88–89.

86. R. MYERS, *SOCIAL SECURITY* 813 (2d ed. 1981).

87. B. SPENCER, *supra* note 80, at 90–95.

88. HEALTH INSURANCE ASS'N OF AMERICA, 1984–85 SOURCE BOOK OF HEALTH INFORMATION 16; BUREAU OF THE CENSUS, U.S. DEPT. OF COMMERCE, 1986 STATISTICAL ABSTRACT OF THE UNITED STATES 392, Table 661.

89. HEALTH INSURANCE ASS'N OF AMERICA, 1984–85 SOURCE BOOK OF HEALTH INFORMATION 4. The HIAA defines "long-term" as longer than two years. *Id.* at 8.

90. HEALTH INSURANCE ASS'N OF AMERICA, 1984–85 SOURCE BOOK OF HEALTH INFORMATION 8; C.A. WILLIAMS, *supra* note 83, at 310–11.

91. C.A. WILLIAMS, *supra* note 83, at 311.

92. *Id.*; HEALTH INSURANCE ASS'N OF AMERICA, 1984–85 SOURCE BOOK OF HEALTH INFORMATION 8.

Disability income insurance is also available through individual policies. These plans generally pay fixed dollar amounts rather than a percentage of wages lost.<sup>93</sup> Private disability insurance contracts, unlike group contracts, often allow benefits for partial as well as total disability due to accidental injury.<sup>94</sup> Benefits under the partial disability provision are a fixed amount for a specific period if the insured is unable to perform some of the duties of his or her job. These benefits are paid whether or not the insured takes an actual cut in wages.<sup>95</sup>

Residual disability insurance, compensating for reduction in wages, may be available for insured workers whose wages are reduced twenty percent or more because of injury-caused disability.<sup>96</sup>

Eligibility for total disability benefits under an individual accident-disability contract is similar to that under a group contract. For a certain number of weeks or months, the insured must be unable to perform his or her own occupation. After this period, the insured must be unable to perform any job for which he or she is suited by education, training, or experience, in which case benefits are paid for a fixed additional number of years, or until age 65 or for life.<sup>97</sup>

Individual insurance for disability due to illness is usually not available except in conjunction with a policy that also covers accident-caused disability. Illness disability policies usually cover only total disability, although partial and residual disability policies are becoming more common.<sup>98</sup> Long-term benefits (over two to five years) are usually available up to age 65, and only if the insured is unable to perform any occupation for which he or she is suited by education, training, or experience.<sup>99</sup>

### G. Social Insurance

Social insurance usually refers to insurance administered by the government,<sup>100</sup> which is primarily financed by taxes on covered persons and/or their employers, though general government funds may sometimes play a part. Eligibility and the method of computing benefits are prescribed by law, and participation of all eligible persons is compulsory (with a few exceptions described below). Finally, eligibility is most often based on contributions participants have made to the programs, not on financial need.<sup>101</sup>

The major social insurance programs in the United States are the federal programs of Old Age, Survivors and Disability Insurance (OASDI) and the Hospital Insurance (Part A) segment of Medicare (HI). The old-age retirement benefits which OASDI provides are commonly known as "Social Security," though they make up

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93. HEALTH INSURANCE ASS'N OF AMERICA, 1984-85 SOURCE BOOK OF HEALTH INFORMATION 8.

94. C.A. WILLIAMS, *supra* note 83, at 325.

95. *Id.* at 326.

96. *Id.*

97. *Id.* at 327.

98. *Id.*

99. *Id.*

100. Workers' compensation is social insurance, but it is not administered by the government.

101. See R. MYERS, *supra* note 86, at 867; C.A. WILLIAMS, *supra* note 83, at 11-15.

only one of several systems established by the Social Security Act of 1935 and subsequent amendments. The old-age benefits do not compensate for the loss of earnings due to injury or illness and are not emphasized in this study.<sup>102</sup> OASDI also includes, however, benefits paid in event of death and illness or injury ("survivors" and "disability" benefits, the "SD" in OASDI), which are among the programs discussed in this section.

### 1. OASDI

Like old-age insurance, both survivors' and disability insurance cover the vast majority of people who work for a living in the United States (including the self-employed). In 1977 survivors' insurance (SI) covered ninety-four percent of American workers.<sup>103</sup> Amendments to the Act in 1983 extended coverage even further, adding for the first time federal workers hired after 1983 and all employees of nonprofit organizations.<sup>104</sup>

Monthly benefits under both survivors' and disability insurance are based on the insured workers' previous earnings. Workers (and others eligible for benefits through them) with relatively low earnings receive a higher proportion of their past earnings than those who earned relatively high wages.<sup>105</sup> This redistributive weighting purports to recognize the greater economic needs of low earners and the probability that better paid workers will have saved more money and have other pension plans.<sup>106</sup> All payments under both systems have been annually adjusted for changes in the cost of living.<sup>107</sup>

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102. Full retirement benefits begin at age 65. Younger retirees beginning at age 62 may also receive benefits, but the benefit amount will be permanently reduced for each month below 65 down to a minimum of 80% of full benefits at 62. (The normal retirement age will gradually be raised from 65 to 67 over the next 40 years, taking complete effect in 2027, and age 62 benefits will slowly be lowered to 70% of full benefits.) Almost 20 million retired workers received \$6.6 billion in benefits in 1980; eight million spouses and eligible children received another \$1.4 billion. A worker who earned between \$16,000 and \$22,000 at retirement at age 65 in 1983 received approximately \$631 a month. The 65-year-old spouse or eligible child of such a worker would have received \$315 a month—50% of the full benefit. Spouses aged 62 receive 37.5% of the full benefit, and spouses of any age caring for a child under 16 or a disabled child, receive 50% benefits. Benefits, like those under survivors' or disability insurance, are adjusted yearly to reflect changes in the cost of living. See R. MYERS, *supra* note 86, at 43–44; C. A. WILLIAMS, *supra* note 83, at 81; D. DETLEFS, MEIDINGER GUIDE TO SOCIAL SECURITY 10–17 (11th ed. 1983) [hereinafter cited as MEIDINGER]; G. KOLLMAN, THE SOCIAL SECURITY AMENDMENTS OF 1983 10–12 (Cong. Res. Serv., Issue Brief No. IB83070, 1983) [hereinafter cited as SOCIAL SECURITY].

103. C. A. WILLIAMS, *supra* note 83, at 79.

104. SOCIAL SECURITY, *supra* note 102, at 11–12. The few remaining exceptions are federal employees hired before 1984, employees of state and local governments which have decided not to participate (about 75% of such governmental units have elected the coverage), employees of nonprofit organizations which could opt out prior to March 31, 1983 (again, most are covered), and railroad workers covered (like older federal workers) by a separate federally-administered plan. *Id.*

Some critics of Social Security have drawn attention to the tension between the system's social welfare aim (to prevent destitution among the aged, disabled, widowed, and orphaned) and its financing as an insurance system (with benefits based more on contributions than on need). This tension, the critics argue, makes it more difficult to correct the long-term threats to the system's financial stability. See, e.g., M. J. BOSKIN, TOO MANY PROMISES: THE UNCERTAIN FUTURE OF SOCIAL SECURITY (1986) and review of same by Chapman, *Blasting Away at Social Security*, in *FORTUNE*, August 4, 1986, at 235.

105. R. MYERS, *supra* note 86, at 25–26.

106. NATIONAL COMMISSION ON SOCIAL SECURITY, SOCIAL SECURITY IN AMERICA'S FUTURE 153 (1981) [hereinafter cited as NATIONAL COMMISSION].

107. MEIDINGER, *supra* note 102, at 5.

### a. *Survivors' Benefits*

Survivors' benefits protect a worker's dependents from complete loss of income upon his or her death. These benefits are based on the full retirement benefit a deceased worker would have received on retirement at age 65. To be eligible for all survivors' benefits, a worker must be "fully insured" for the purposes of the OASDI system. This requires that the worker have worked ten years in covered employment if born after 1928 and made at least \$250 a calendar quarter after 1977 or \$50 a quarter prior to that year. If the worker was born before 1928, fewer quarters of work are required.<sup>108</sup> Some survivor benefits are also available to those who are "currently insured," meaning that they have worked during six of the last thirteen calendar quarters.<sup>109</sup>

Those eligible for survivors' benefits when an insured worker dies are spouses aged 60 or over (including divorced spouses who were married to the worker for ten years); disabled spouses aged 50 or over; eligible children; disabled spouses caring for certain eligible children; and dependent parents aged 62 or over.<sup>110</sup> If a worker is "currently insured" (as opposed to fully insured), only eligible children and spouses or divorced wives caring for an eligible child qualify for survivorship benefits.

In 1982, the average survivor benefit for a qualifying widow or widower was \$379 a month. A total of 4.6 million widows or widowers and 515,000 surviving spouses with young children received these benefits.<sup>111</sup>

Survivors' benefits are limited by several restrictions. Remarriage by a surviving spouse under 60 terminates benefits, unless the new marriage is to another survivor beneficiary.<sup>112</sup> Survivors' benefits may not duplicate other benefits payable under OASDI. Two persons in a family may receive benefits based on the earnings of one deceased worker but, if three or more persons are eligible, a maximum of 150 to 188 percent of the full benefits is allowed.<sup>113</sup> Any earnings by a survivor over a certain amount will reduce the benefits paid to that survivor by one dollar for every three dollars in income over the threshold.

Survivors' Insurance is administered by the federal Social Security Administration (SSA). Claimants must apply to SSA to receive benefits and may appeal decisions on benefit applications through SSA and from there to the federal courts.<sup>114</sup>

### b. *Disability Insurance*

Disability Insurance (DI) is designed to replace earnings lost as a result of severe long-term injury or illness. To qualify for benefits, a worker must meet requirements of "insured status" and be disabled for at least five months by a physical or mental

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108. R. MYERS, *supra* note 86, at 41-42.

109. MEDINGER, *supra* note 102, at 31.

110. *Id.* at 30-32.

111. SOCIAL SECURITY ADMINISTRATION, U.S. DEPT. OF HEALTH AND HUMAN SERVICES, SOCIAL SECURITY BULLETIN, 1983 ANNUAL STATISTICAL SUPPLEMENT, 136-37, Tables 62, 64 [hereinafter cited as 1983 STATISTICAL SUPPLEMENT].

112. R. MYERS, *supra* note 86, at 52.

113. MEDINGER, *supra* note 102, at 24.

114. NATIONAL COMMISSION, *supra* note 106, at 217.

problem expected to lead to death or to continue for at least twelve months.<sup>115</sup> In 1983, approximately 3.9 million persons received DI benefits (2.6 million of whom were disabled workers). The average benefit for single disabled workers was \$426 a month in October 1982, and \$842 per month for disabled workers with dependents.<sup>116</sup> Benefits are keyed to the worker's past earnings, but also depend on the age at disability: the younger the worker, the smaller the benefit.

Requirements for insured status are more restrictive under DI than under survivors' insurance. To qualify for DI benefits, the worker must be fully insured under OASI and have worked at least twenty of the last forty quarters in covered employment.<sup>117</sup> More lenient conditions apply to persons disabled before age 31.<sup>118</sup>

The definition of disability is also restrictive, and is intended to separate truly incapacitated persons from those who are out of work for other reasons.<sup>119</sup> Workers are considered disabled only if, due to a "medically determinable" impairment, they cannot do either their previous job or any other "substantial gainful work" that exists anywhere in the nation. Age, education, and work experience are considered, but it is not relevant whether suitable work exists within commuting distance. It is also not relevant whether an appropriate job vacancy actually exists or whether the claimant really would be hired for a job.<sup>120</sup>

Earnings by the disabled worker above a modest amount (\$300 a month in the early 1980s) will usually cause benefits to be discontinued. (Disabled persons may attempt a nine-month trial work period approved by SSA without losing benefits).<sup>121</sup> Other limitations include a possible reduction in benefits if the disabled worker is also receiving workers' compensation or other disability benefits,<sup>122</sup> and a requirement that a beneficiary accept any rehabilitation services the government makes available.<sup>123</sup>

In practice, it has been estimated that close to eighty percent of disability awards are made to those with serious medical impairments. The remaining awards involve combinations of medical impairment and vocational factors such as level of education, work experience, and age that effectively disable a worker.<sup>124</sup>

SSA pays disability benefits but state agencies make almost all initial disability determinations. State vocational rehabilitation agencies are thought to have more experience with disability (SSA primarily handles the old-age program) and to be closer to the disabled population.<sup>125</sup> SSA does review a large sample of decisions for

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115. R. MYERS, *supra* note 86, at 44-45.

116. D. KOITZ, *SOCIAL SECURITY: REEXAMINING ELIGIBILITY FOR DISABILITY BENEFITS 1* (Cong. Res. Serv., Issue Brief No. IB82078, 1984).

117. C.A. WILLIAMS, *supra* note 83, at 241; R. MYERS, *supra* note 89, at 42-43.

118. R. MYERS, *supra* note 86, at 42-43.

119. C.A. WILLIAMS, *supra* note 83, at 242.

120. R. MYERS, *supra* note 86, at 45-46; C.A. WILLIAMS, *supra* note 83, at 242. Note that this is a much stricter definition of damages than is required in a tort action or under private disability insurance.

121. NATIONAL COMMISSION, *supra* note 108, at 200-01 (1981).

122. R. MYERS, *supra* note 86, at 89.

123. MEDINGER, *supra* note 102, at 26; C.A. WILLIAMS, *supra* note 83, at 244.

124. R. MYERS, *supra* note 86, at 45; C.A. WILLIAMS, *supra* note 83, at 242.

125. C.A. WILLIAMS, *supra* note 83, at 246. Concerning the bitter accusations (and litigation) over what was deemed by some to be the overzealousness of the Reagan Administration's rejection of disability benefit claims, see *N. Y. Times*, July 28, 1986, at A9.

adherence to national standards, and appeals may be made to the hearings division of SSA and then to the federal courts.

Payroll tax on employees and employers finance the social security system, including the survivors' and disability insurance systems. Each group pays half of the taxes (which total seven percent of a worker's pay up to a present cap of \$37,800 a year of eligible earnings), while the self-employed pay a full share (or double the employee rate) until 1990, when their share will approximate the employee rate.<sup>126</sup> These payroll tax contributions are deposited in trust funds which pay for current benefits and earn some additional income through investment in government securities.

### c. *Railroad Retirement*

Railroad employees are virtually the only nongovernment workers in the United States not covered by OASDI.<sup>127</sup> Instead, they are covered by the Railroad Retirement System (RR), a federally administered program financed by taxes on both railroad employers and employees. RR requires ten years of rail service for a worker to be eligible.<sup>128</sup> The RR system paid out over 2.3 billion dollars for illness and injury in 1982.<sup>129</sup>

Benefits are figured similarly to those under OASDI: they are wage-related, and the bulk of benefits actually represents the amount the beneficiary would have received if covered by OASDI. A secondary component of benefits is based solely on railroad service.<sup>130</sup> RR pays benefits to basically the same categories of beneficiaries as OASDI, with the single major exception that no payment is made to children of disabled workers (child's survivorship benefits are paid, however).<sup>131</sup> Earnings tests similar to those under OASDI may reduce benefits. Benefit levels are relatively generous, replacing almost all of a deceased or disabled worker's earnings if he or she had a spouse and children.<sup>132</sup> RR also provides benefits for temporary disability due to sickness or injury financed by a separate tax on employers.<sup>133</sup> This system covered about 660,000 workers in 1978.<sup>134</sup> Average monthly benefits for disabled workers in 1979 were \$542 for those over 65 and \$499 for those under 65; \$315 for widows and widowers 60 or over; and \$302 for child survivors.<sup>135</sup>

126. The 7% total tax includes 1.3% for Medicare's Hospital Insurance and 5.7% for OASDI. Also, the pay cap rises each year with average national wage rates. The tax rate will also rise to a high of 7.65% in 1990. *SOCIAL SECURITY*, *supra* note 102, at 12-13; *MEIDINGER*, *supra* note 102, at 7; *J. O'SULLIVAN & G. MARCUS, MEDICARE 1-3 (Cong. Res. Serv., Issue Brief No. IB82044, 1983) [hereinafter cited as MEDICARE]*.

127. *R. MYERS*, *supra* note 86, at 658.

128. A worker must also have worked for a railroad 12 of the 30 months before death or disability to receive survivors' or disability benefits. If a worker does not qualify, his or her records are transferred to SSA, and OASDI benefits are paid based on combined railroad and nonrailroad employment. *R. MYERS*, *supra* note 86, at 662; *C.A. WILLIAMS*, *supra* note 83, at 430-33.

129. 1983 *STATISTICAL SUPPLEMENT*, *supra* note 111, at 218, Table 146.

130. *C.A. WILLIAMS*, *supra* note 83, at 429-34; *R. MYERS*, *supra* note 86, at 661-73.

131. *C.A. WILLIAMS*, *supra* note 83, at 432; *R. MYERS*, *supra* note 86, at 663.

132. *R. MYERS*, *supra* note 86, at 670-71.

133. *C.A. WILLIAMS*, *supra* note 83, at 435.

134. *R. MYERS*, *supra* note 86, at 675.

135. *Id.* at 677.

d. *Civil Service Retirement*

The Civil Service Retirement System (CSR) assured death and disability benefits comparable to OASDI to almost all federal employees prior to the Social Security Amendments of 1983, which, as mentioned above, added federal workers hired after that year to OASDI.<sup>136</sup>

Disability annuities are paid to federal workers with five or more years of service whose disability prevents them from following their usual or similar occupations.<sup>137</sup> This definition of disability is thus much more liberal than OASDI's. Survivorship benefits also incorporate more relaxed rules than OASDI: pensions for widows, widowers and dependent children of active workers are paid without regard to age or the rearing of children. The civil service system also imposes no earnings limitation on income outside federal employment, and allows a family to receive multiple civil service pensions without reductions.<sup>138</sup>

Benefit amounts are based on years of service and the average salary during the highest three consecutive years of service, up to a maximum of eighty percent of the highest three-year average salary for disability benefits and fifty-five percent of that maximum for survivors' benefits. In disability cases, a minimum benefit of forty percent of the highest salary period is provided.<sup>139</sup> In 1982, CSR paid out almost 6.2 billion dollars in death and disability benefits.<sup>140</sup>

Medical insurance is offered to federal employees (both active and retired) on a voluntary basis through private carriers. Three types of plans are offered: government-wide plans, employee organization plans (open only to members of those groups, such as unions), and comprehensive medical plans (health maintenance organizations offering prepaid care).<sup>141</sup> About ten million federal employees, retirees and dependents are covered.<sup>142</sup> The government pays from fifty to seventy-five percent of the premiums, and employees pay the remainder depending on how much coverage they select. About eighty-five percent of federal employees participate.<sup>143</sup> A sick-leave plan also provides full pay for a limited period of absence due to illness or injury each year (which can be accumulated from one year to the next). This plan is relatively liberal, providing seventy-five percent wage replacement for workers with dependents and containing no limit on total length of disability.<sup>144</sup>

Employee and employer contributions jointly finance the civil service system. Substantial additional funding comes from general federal funds, unlike under OASDI and RR, and typically exceeds the total employee/employer share.<sup>145</sup>

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136. *Id.* at 799; SOCIAL SECURITY, *supra* note 102, at 11.

137. C.A. WILLIAMS, *supra* note 83, at 437-39.

138. R. MYERS, *supra* note 86, at 800-01.

139. C.A. WILLIAMS, *supra* note 83, at 438.

140. 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 218, Table 146.

141. J. LUNDY, THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: ISSUES AND PROBLEMS 1-2 (Cong. Res. Serv., Issue Brief No. IB83134, 1984).

142. *Id.*

143. R. MYERS, *supra* note 86, at 810.

144. C.A. WILLIAMS, *supra* note 83, at 442.

145. *Id.* at 439.

CSR covered about 2.7 million federal workers in 1979. Of a total of 1.6 million persons receiving benefits, 1.2 million were receiving retirement and/or disability pensions (including 221,000 disability recipients under age 65) and 427,000 were receiving survivor benefits.<sup>146</sup>

e. *State and Local Systems*

Retirement systems which many state and local governments operate for their employees also provide disability and survivorship benefits. These plans cover almost eighty percent, or ten million persons, of those employed by such governments. Under an average plan, benefits for disabled workers (using a "liberal" definition) who had served a minimum of ten years equaled the system's ordinary retirement benefit (which is keyed to wages in the five highest paid of the last ten years). Survivorship benefits have only recently become widely available, and in many systems are provided only for long-term workers. Governments generally pay two-thirds of the cost, with employees paying the other one-third.<sup>147</sup>

Many state and local systems are merely supplements to OASDI. In other areas, OASDI is the sole coverage available. Health insurance is provided through private plans, along with some group life insurance. Work-related injuries often yield higher benefits than ordinary disability (particularly for high-risk jobs such as police). Sick leave benefits are also widespread.<sup>148</sup>

In 1978, 169,000 individuals received disability benefits and 290,000 received survivors' benefits under state and local plans.<sup>149</sup> State and local government employee systems paid out almost 1.8 billion dollars in survivors' and disability benefits in 1982.<sup>150</sup>

## 2. *Medicare*

The Medicare program provides federally administered health care insurance for the aged and disabled. It consists of two separate plans: Hospital Insurance (HI), and Supplementary Medical Insurance (SMI). Each program covers about twenty-nine million Americans.<sup>151</sup> HI is universally provided and covers a major part of medical services provided in hospitals and skilled nursing care facilities and at home following hospitalization. HI is financed through payroll taxes placed in a trust fund. In 1982, it paid out almost thirty-one billion dollars.<sup>152</sup> SMI is a voluntary individual insurance plan which is administered by the government.<sup>153</sup> It covers physicians' and other outpatient services, laboratory services and some medical equipment. The

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146. R. MYERS, *supra* note 86, at 806-07.

147. C.A. WILLIAMS, *supra* note 83, at 442-45; R. MYERS, *supra* note 86, at 814-16.

148. R. MYERS, *supra* note 86, at 815.

149. C.A. WILLIAMS, *supra* note 83, at 444.

150. 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 218, Table 146.

151. MEDICARE, *supra* note 126, at 1-3.

152. 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 205, Table 132.

153. R. MYERS, *supra* note 86, at 396-98. Neither program will pay for medical services provided for by one of several other sources (such as the Veterans' Administration) or workers' compensation. *Id.* at 398.



program is financed by premiums and by payments from the federal treasury.<sup>154</sup> Over fifteen billion dollars were expended by SMI in 1982.<sup>155</sup>

Before 1983 providers of HI were reimbursed the "reasonable cost" of the services. Intermediaries, either public bodies or private insurers or health plans, decided what qualified under this criterion, using federal statutory and regulatory guidelines.<sup>156</sup> The 1983 Social Security Amendments, however, replaced "reasonable cost" with a system of paying only predetermined, regionally-adjusted rates for each service. Each case is classified to one of about 470 "diagnostic related groups."<sup>157</sup> The Social Security Administration (SSA) will pay the predetermined fee for that group, leaving the health services provider to pocket the difference if it can provide the service at lower cost, and requiring it to bear the loss if its costs are higher than the fee.<sup>158</sup>

The plans share some criteria for coverage. Both plans cover diagnosis or treatment of an illness or injury or improvement in functioning of a malformed body part. Routine physical exams and dental work, prescriptions for eyeglasses and hearing aids, most inoculations and services for cosmetic purposes are not covered.<sup>159</sup>

#### a. Hospital Insurance (Part A)

Hospital Insurance is automatically available to anyone reaching age 65 who is entitled to retirement benefits under OASDI or RR, and to all disabled beneficiaries under both programs who have received disability benefits for at least two years. HI coverage may also be chosen and paid for on a premium basis by those 65 or older who are not entitled to receive HI benefits based on their earnings records.<sup>160</sup> Unlike OASDI, HI benefits are available to a worker's dependents or survivors only if they are at least 65 years old.<sup>161</sup>

Benefits cover most normal in-hospital and post-hospital services, but are limited by several factors. These include a limit on how long HI will pay for any episode of institutionalized care, and provisions requiring set patient deductibles and cost-sharing after a certain time in a health care facility.<sup>162</sup>

154. MEDICARE, *supra* note 126, at 2.

155. 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 207-08, Table 134.

156. C.A. WILLIAMS, *supra* note 83, at 285.

157. "Diagnostic related groups" are defined as "class[es] of patients defined by medical characteristics, such as primary diagnosis, secondary diagnosis, age, and surgical procedure, representing a consistent amount of resource consumption as measured by some unit (patient days, dollars, etc.)." J. FINLEY, USING DIAGNOSIS RELATED GROUPS (DRGs) AND HOSPITAL PAYMENT: THE NEW JERSEY EXPERIENCE (Office of Tech. Assessment Working Paper 1983), *quoted in* Phillips and Wineburg, *Medicare Prospective Payments: A Trial Revolution*, 87 W. VA. L. REV. 13, 29-30.

158. This system applies only to inpatient hospital care, but its potential for reducing health care costs has led to suggestions that prospective payment be adopted for physicians' services and outpatient care under Medicare and even for health services provided by other third-party payers such as Blue Cross and Blue Shield. In fact, it has been suggested that unless prospective payment is imposed on all third-party payers, health care providers will cover their losses by raising the fees charged to non-Medicare patients, and prospective payment will fail to accomplish its purposes of containing overall health care costs. *See* Phillips and Wineburg, *Medicare Prospective Payments: A Trial Revolution*, 87 W. VA. L. REV. 13, 52-55 (1984).

159. R. MYERS, *supra* note 86, at 398-99.

160. MEDICARE, *supra* note 126, at 2.

161. R. MYERS, *supra* note 86, at 399-401.

162. In 1982, for example, HI required hospital patients to pay a \$260 deductible for each 90 day period of care plus \$65 a day for the 61st through 90th days. Patients in a skilled nursing facility received benefits for 100 days, but were

### b. *Supplementary Medical Insurance (Part B)*

As stated above, participation in SMI is voluntary, in contrast to the payroll contributory basis of HI. Virtually all aged persons, whether HI beneficiaries or not, can enroll. HI eligibles are automatically enrolled but may then decline coverage.<sup>163</sup> Over fifteen billion dollars in medical benefits were expended to these voluntary SMI enrollees in 1982.<sup>164</sup>

SMI benefits, as the program's name indicates, supplement those of HI. Physicians' and surgeons' services are covered in a hospital, clinic, office, and at home (including home health services that do not follow hospitalization), along with outpatient diagnostic services, ambulances, and rental of durable medical equipment. Payments for outpatient mental treatment and physical therapy are limited to set amounts. Starting in 1982, patients paid an annual \$75 deductible, and twenty percent of the cost of each covered service.<sup>165</sup>

### H. *Public Assistance*

Some compensation systems allocate benefits based on recipients' need, rather than on contributions made (as under the social insurance programs covered in the previous section). These programs may be described as public assistance. They provide cash benefits, medical care and other services for those who show a need for such aid.

Three major programs of public assistance in the United States today provide benefits to compensate for misfortune, including the effects of accident or illness. These programs are Supplemental Security Income (SSI), Medicaid, and General Assistance (GA). Medicaid and SSI are federally funded, while GA is financed by the states.

#### 1. *Supplemental Security Income*

Supplemental Security Income guarantees a certain monthly income to recipients.<sup>166</sup> The amount varies according to how much income from other sources a recipient takes in. It is available to all sufficiently needy persons who are over 65,

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required to pay \$32.50 daily after the first 20 days. No deductibles or copayments were required for home health services. 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 33, 36; *see also* MEDICARE, *supra* note 126, at 2.

163. C.A. WILLIAMS, *supra* note 83, at 282.

164. 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 207-08, Table 134.

165. C.A. WILLIAMS, *supra* note 83, at 282-83; MEDICARE, *supra* note 126, at 2; 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 33-34, 36. Medicare only pays for 80% of what it deems to be reasonable for physicians' fees. Doctors' fees often exceed Medicare's allowed rates, creating a problem of undercompensation. *See* Null, *Plans Designed to Supplement Medicare Often Aren't What Policy Holders Expect*, Wall St. J., July 29, 1985, at 17.

166. SSI replaced three state-run programs of aid to the aged, blind, and disabled that were financed in part by federal grants. The federally standardized payment levels increased the benefits available in most states. Where states had provided higher benefits under their old programs, Congress required them to supplement SSI payments to recipients transferred from the state programs to keep the recipients' income at its earlier level. C.A. WILLIAMS, *supra* note 83, at 478.

disabled, or blind.<sup>167</sup> SSI is paid for out of the federal government's general tax revenues and is administered by the Social Security Administration.<sup>168</sup>

Like other public assistance programs, SSI is essentially a welfare program.<sup>169</sup> It provides benefits only for persons of low economic means who also meet categorical requirements such as being aged, disabled, or blind. In 1982, 1.58 million aged persons, 2.25 million disabled persons, and 78,000 blind persons received SSI benefits.<sup>170</sup>

The basic SSI monthly payment for disabled and blind recipients was \$264.70 in 1981.<sup>171</sup> Like OASDI, the benefit amount is adjusted each year to reflect increases in the cost of living. Couples in which both members are eligible receive 100 percent of the basic benefit, rather than double that amount.<sup>172</sup> If a recipient lives in a household neither the recipient nor a spouse heads, the benefit is reduced by one-third.<sup>173</sup> SSI expended over six billion dollars in 1982 in disability benefits to qualifying needy individuals.<sup>174</sup>

## 2. Medicaid

Medicaid provides medical assistance for low-income families and individuals.<sup>175</sup> The program generally services the "categorically needy"—those eligible for cash payments under SSI.<sup>176</sup> A state may choose to apply its program to the "medically needy"—those who have too much income to qualify for public assistance but who cannot afford decent medical care.<sup>177</sup>

Medicaid is designed and run by the states under federal guidelines. Federal law establishes basic services to be offered to each group but the states may decide the

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167. SSI payments for the aged are figured exactly as are payments to the other two eligible categories, the blind and disabled. The discussion in the text of benefits to other eligibles therefore will also apply to aged beneficiaries. See R. MYERS, *supra* note 86, at 604.

168. C.A. WILLIAMS, *supra* note 83, at 478.

169. See discussion of this point in R. MYERS, *supra* note 86, at 603, 607-09, and in C.A. WILLIAMS, *supra* note 83, at 476, n.6.

170. 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 233.

171. C.A. WILLIAMS, *supra* note 83, at 477. The basic benefits are reduced to the actual payment by subtracting a recipient's "countable" income from the program's guaranteed monthly payment. This includes veterans' and OASDI benefits, interest, rents, pensions, and workers' compensation. Also, \$65 per month of earned income plus one-half of earnings above that amount is not counted. *Id.*; see also 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 40, 43.

172. C.A. WILLIAMS, *supra* note 83, at 477.

173. *Id.*

174. 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 234, Table 163.

175. Medicaid served almost 21.5 million persons in 1983. The largest category of recipients was dependent children under age 21 (9.4 million individuals). Other categories of recipients included: adults in families with dependent children (5.5 million); and those aged 65 or older (3.2 million); the eligible disabled (2.9 million); blind persons (76,000); and other eligibles (1.3 million). 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 216, Table 143.

176. Federal law requires the states to offer seven basic services to categorically needy recipients. These include in-patient and out-patient hospital services; laboratory and x-ray services; skilled nursing facility and home health services for those over age 21; physicians' services; and family planning services and supplies. Additional medical services, including drugs, eyeglasses, in-patient psychiatric care, physical therapy, and dental services may be provided. States may limit the amount of care paid for under each category. See MEDICAID (Cong. Res. Serv., Issue Brief No. IB82041, 1983) [hereinafter cited as MEDICAID ISSUE BRIEF].

177. States may offer fewer types of services to the medically needy than to the categorically needy but, at a minimum, states with medically needy programs must cover ambulatory services for children and prenatal and delivery services for pregnant women. *Id.* at 2.

scope of the service offered to either type of recipient.<sup>178</sup> The federal government pays from fifty to seventy-eight percent of the program's cost, a share that rises as the per capita income of a state declines.<sup>179</sup>

Medicaid programs pay vendors directly for their services to eligible persons.<sup>180</sup> The providers must accept this as full payment. The Medicaid payment level, however, must be adequate to meet costs incurred by "efficiently and economically operated facilities." Overall, the sum paid cannot be more than the total deemed reasonable under Medicare.<sup>181</sup>

### 3. General Assistance

General Assistance (GA) is wholly operated and financed by state and local governments. It serves people who are too poor to meet their basic needs but who cannot qualify for federal-state programs because they do not meet requirements of age, disability, or other criteria.<sup>182</sup> GA is not limited to compensating for losses caused by illness or injury but two-thirds of the states provide medical care benefits under GA.<sup>183</sup> The program served about 900,000 recipients in 1980, with average monthly payments per beneficiary of about \$130, for a total of about \$1.4 billion.<sup>184</sup>

#### I. Veterans' Benefits

Qualifying veterans and their families can be eligible for payment of expenses brought about by both service-connected (as a right) and nonservice-connected (on an as-available basis) disabilities and deaths. The Veterans' Administration (VA) estimates that about thirty-six percent of the resident population of the United States, some 83.8 million people, are potential recipients of veterans' benefits.<sup>185</sup> The VA health care system is extensive, providing care in almost 200 hospitals and over 200 clinics, with nursing homes and domiciliaries as well.<sup>186</sup> Almost 1.4 million in-patients and eighteen million out-patients received VA-funded treatment for illness

178. For example, states may limit the number of days of in-patient hospital care or the number of physicians' visits covered; states may also determine levels of reimbursement to providers, except for hospital care (where they must follow Medicare's reasonable-cost payment system). 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 37.

179. MEDICAID ISSUE BRIEF, *supra* note 176 at 1.

180. Total payments in 1982 equaled almost 29.4 billion. BUREAU OF THE CENSUS, U.S. DEPT. OF COMMERCE, 1985 STATISTICAL ABSTRACT OF THE UNITED STATES 374, Table 269. The most spent on any service was \$8.8 billion for general in-patient hospital services; four other services required over \$2 billion (care of mentally retarded in intermediate care facilities, care of other eligibles in those facilities, skilled nursing facilities, and physicians' services). 1983 STATISTICAL SUPPLEMENT, *supra* note 113, at 217, Table 144. Categories of recipients who received the most in payment for services were the aged (\$11.9 billion) and the disabled (\$11.2 billion). The two categories of individuals in families with dependent children, the next two largest groups of recipients, received a combined total of \$8.3 billion, less than either of the biggest categories. *Id.* at Table 145.

181. C.A. WILLIAMS, *supra* note 83, at 506; for use of diagnostic related groups to control Medicare costs, see *supra* note 157 and accompanying text.

182. C.A. WILLIAMS, *supra* note 83, at 500.

183. *Id.* at 501. About 60% of the states restrict GA benefits to emergency needs, short-term assistance, or specified situations that include chronic illness, transportation, and foster care. *Id.*

184. R. MYERS, *supra* note 86, at 617.

185. ADMINISTRATOR OF VETERANS' AFFAIRS, 1982 ANNUAL REPORT 5.

186. *Id.* at 13.

or injury,<sup>187</sup> totaling over nineteen billion dollars in personal injury and illness reparations in 1982.<sup>188</sup>

## VI. CONCLUSION

From the time they begin law school, future lawyers learn the law and, by extension, the wide range of human problems which the law may address, through the narrow lense of the case method, a pedagogical technique that allows students to focus on issues in the context of a dispute between parties to a conflict. So even if law students, professors, and practitioners do not consciously think of illness and injury solely as occasions for invoking tort law, their training and experience may nonetheless lead them to focus on the tort implications of these misfortunes. Illness and injury impose costs on their victims, and lawyers, using the tools available to them, have devised remedies in tort law to compensate these costs, tangible and intangible.

It is inevitable and even desirable that a specialist, in whatever field, should be alert to potential application of his or her specialty to meet human needs. But lawyers also need to be alert to the capacities of other fields to meet these needs. When "what may have been Britain's first traffic accident suit"<sup>189</sup> was decided in 1695<sup>190</sup> concerning an accident victim named Gibbons, there was not much need for policymakers to consider nonlegal means of compensating the plaintiff's injuries: "[F]or one may safely assume that Gibbons had no National Health Insurance, no Blue Cross plan, no sick leave pay, no liability benefits, no health insurance, no rehabilitation center, and probably no free hospitalization."<sup>191</sup> In the nearly three hundred years since then, all sources of compensation mentioned by the Conard-Morgan study, and more, have grown. Yet lawyers continue too often to focus myopically on tort rights in thinking of compensation for incapacity. This study, following the work of Conard, Morgan, and their colleagues in the early 1960s, illustrates the mountainous importance of other forms of compensation.<sup>192</sup>

Regardless of the role that tort law will have in the future, it behooves law students and lawyers to be more aware than they often are of the gamut of compensation systems sometimes applicable to victims of injury and illness. We hope that this admittedly derivative—and even relatively crude—work will help somewhat to remedy that imbalance.

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187. *Id.* at 14.

188. *Id.* at 63. See also 1983 STATISTICAL SUPPLEMENT, *supra* note 111, at 218, Table 146.

189. A. CONARD, *supra* note 1, at 23.

190. *Gibbons v. Pepper*, 1 *Ld. Raym.* 38, 91 *Eng. Rep.* 922 (K.B. 1695).

191. A. CONARD, *supra* note 1, at 23.

192. The senior author expects shortly to do a further piece expanding on the significance—from a general, as well as tort law perspective—of the relative roles of tort liability insurance and other forms of public and private insurance.

