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The Growth of Subrogation and the Future of Personal Injury Litigation

Stephen J. Spurr

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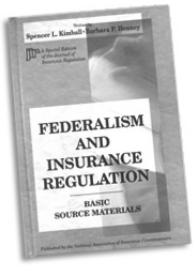

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The Growth of Subrogation and the Future of Personal Injury Litigation

Stephen J. Spurr*

Abstract

This paper examines how personal injury litigation has been, and will continue to be, transformed by the growth of subrogation. While the use of subrogation has increased gradually over the last four decades, the recoveries of personal injury victims are now fully subject to subrogation claims by Medicare, Medicaid and private health insurance companies when they have previously paid for the victim's health care expenses. These developments raise the question of how the recovery should be divided between the plaintiff and the insurer, and how the rule on its apportionment affects the incentives of plaintiffs and plaintiffs' lawyers, and the decision whether to sue in the first place. We examine these issues in the order in which the law has been thoroughly developed, i.e., first for Medicare, then Medicaid and finally for private health insurers. We find that the Medicare statutes are carefully designed to preserve the incentives of plaintiffs' lawyers to pursue personal injury actions. However some state statutes providing for subrogation of health care expenses by Medicaid and private health insurers could sharply reduce the incentives of plaintiff's lawyers to pursue personal injury actions. State statutes abrogating the collateral source rule may also reduce settlement payments and the filing of lawsuits by tort victims and thus the deterrence of tortious behavior.

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Introduction

Victims of torts who bring lawsuits have often obtained compensation or services from sources other than the defendant, such as from their own health insurance. However, the victim's first-party insurer can now often recover the health care expenses it has paid its insured via the doctrine of subrogation, which enables it to intervene in the lawsuit and obtain reimbursement of its expenditure from the amount that would otherwise be paid by the defendant to the plaintiff. The use of subrogation by insurance companies has increased tremendously over the last four decades. This paper examines how personal injury litigation has been transformed by the growth of subrogation. The recoveries of tort victims are now fully subject to subrogation claims by Medicare and Medicaid, and often by private health insurance companies when they have previously paid for the victim's health care expenses.

The increasing role of subrogation in personal injury litigation raises a number of questions:

- Should subrogation be allowed? That is, do the social benefits of subrogation exceed its social costs?
- If a substantial portion of the victim's recovery will be taken by the victim's own insurer, how will this affect the incentives of victims to sue?
- Will an insurer be able to claim a portion of the plaintiff's recovery without paying for any part of the plaintiff's legal expenses that made the recovery possible?
- Will the insurer be able to sue the tortfeasor directly, or share in the recovery only if its insured party sues?
- How will the insurer learn of the personal injury claim being pursued by its insured? (If it does not learn about the litigation, it will be unable to exercise its right of subrogation.)

We examine these and other issues in the order of the subrogation claimants for which the applicable law has been developed, i.e., first for Medicare, then Medicaid and finally for private health insurers. We find that the Medicare statutes have been carefully designed to preserve the incentives of plaintiffs' lawyers to pursue personal injury actions. However, some state statutes providing for subrogation of health care expenses by Medicaid and private health insurers could sharply reduce the incentives of plaintiff's lawyers. State statutes abrogating the collateral source rule of the common law may also reduce settlement payments and the filing of lawsuits by tort victims and their lawyers and, thus, the deterrence of tortious behavior. We also analyze the conflict between subrogation and state statutes that modify or abolish the collateral source rule of the common law. We conclude that the question whether the collateral source rule should be preserved or abolished depends on which kind of moral hazard is more serious: that of the tortfeasor, who may take less precautions to avoid injuring others, or that of the

victim, who may take less precautions to avoid being injured. This is an issue that should be settled by empirical research.

What is Subrogation?

Until recently, most individual personal injury claims involved a single plaintiff and one or more defendants.[1] Tort victims often obtain compensation or services from sources other than the defendant, such as from health insurance, disability insurance or workers' compensation insurance.[2] Under the collateral source rule of the common law, the defendant was liable for all damages caused to the plaintiff, even if the plaintiff had received payment or services from a third party. However, an insurer can now often recover the health care expenses it has paid via "subrogation."[3] Subrogation is "an equitable doctrine under which one who has paid a debt for which he is secondarily responsible takes over the creditor's rights and remedies against the party primarily responsible for that debt."[4] Suppose that an insured person, Joseph Smith, has been injured by a negligent driver, Bill Jones. Smith's medical expenses in the amount of $300,000 were paid by his own health insurer, X Co. Smith sues Jones and obtains a judgment in the amount of $500,000, representing $300,000 in medical bills and $200,000 in pain and suffering. X Co., which paid Smith's medical bills although it was only secondarily liable for them, can step into his shoes and obtain subrogation of its outlay of $300,000 from Jones, the injurer who was primarily responsible, leaving Smith with only $200,000 in damages. (The question whether a party is primarily or secondarily liable is determined by common law or statute.) The defendant Jones would still be liable for full damages of $500,000, but X Co. has recovered the $300,000, either directly from Jones or from Smith, who has already collected this amount from Jones. In many jurisdictions X Co. can recover the $300,000 as reimbursement from Smith by filing a lien in the negligence case.[5]

1. Smith et al. (1995)

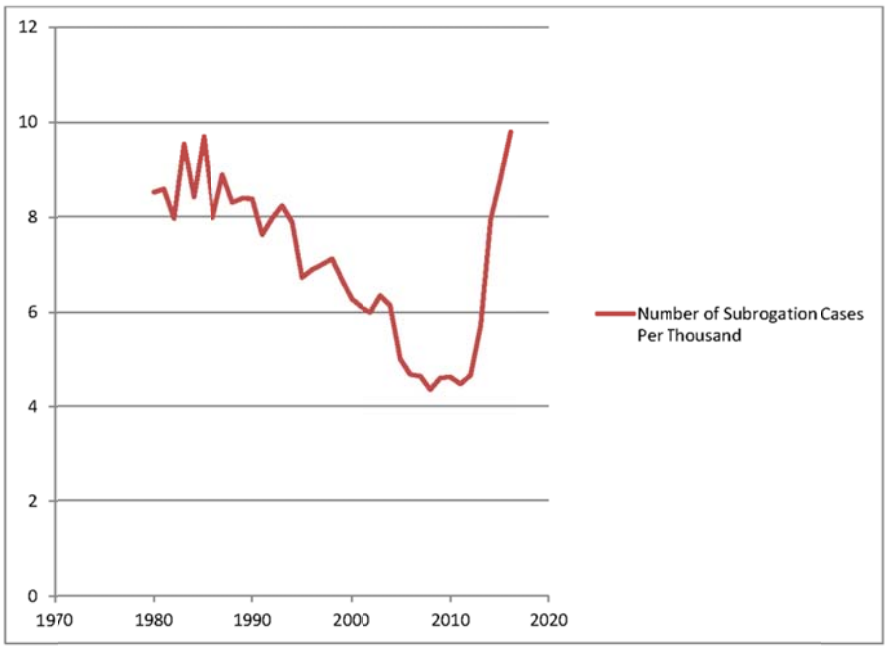
2. Baron (1992) at 583. See also Kimball and Davis (1962), at 842: "Increasing use of insurance has led to duplicated coverage with respect to medical and hospital expenses."

3. Greenblatt (1997), Baron (1992) and Baron (1996).

4. Greenblatt (1997), at 1338, citing Horn (1964), pp. 13–14.

5. For our purposes, it does not matter whether the insurer proceeds against the tortfeasor or against an insured who has already collected from the tortfeasor. See Greenblatt (1997), 1338 at n. 9, and *Automobile Insurance Co. of Hartford v. Conlon*, 153 Conn. 415, 216 A. 2nd 828, 829 (1966): "The proposition is well established that an insurer's right to subrogation …. includes a claim against any judgment secured by the insured against any party at fault for the amount paid by the insurer in satisfaction of the insured's damage claim …"

Figure 1:
Growth of Appellate Cases Involving Subrogation



Rights of subrogation may arise under common law, principles of equity or by statute. They may also be available by contract, provided that subrogation clauses do not violate statutes or common law.[6] Rights of subrogation generally apply only to "economic damages," such as medical expenses, lost earnings and the lost value of household services. They do not apply to "noneconomic damages," a term that is applied to "nonpecuniary damages," i.e., pain and suffering, loss of consortium and punitive damages.[7] The reason subrogation rights do not apply to noneconomic damages is that these kinds of damages are virtually never insured,[8] even though studies find that noneconomic damages constitute one-half to two-thirds of the average tort recovery in personal injury cases.[9] Although subrogation was not generally available under the common law for health and medical insurance policies, in most states it is now available when such policies include subrogation clauses.[10]

6. Keeton and Widiss (1988), Sec. 3.10 (a)(1).
7. Reinker and Rosenberg (1997), at S263.
8. Ibid., S265 at n. 6, American Law Institute 1991, Croley and Hanson (1995).
9. Reinker and Rosenberg (1997), at S263, citing Viscusi (1991) and Vidmar (2005).
10. Baron (1992) and Baron (1996).

Although subrogation has a long history, with its origin attributed variously to Roman civil law or Talmudic Law,[11] its application to personal injury litigation has increased dramatically in the last four decades. Figure 1 shows the trend of cases that involve issues of subrogation in the U.S. in either state appellate courts or any federal courts.[12] The graph shows the change over time in the share of subrogation cases of all cases.[13] This share declined from 1980 to 2008, then leveled off, but began to climb abruptly in 2011.

Figure 2:
Comparison of Growth of Subgrogation Cases with All Cases

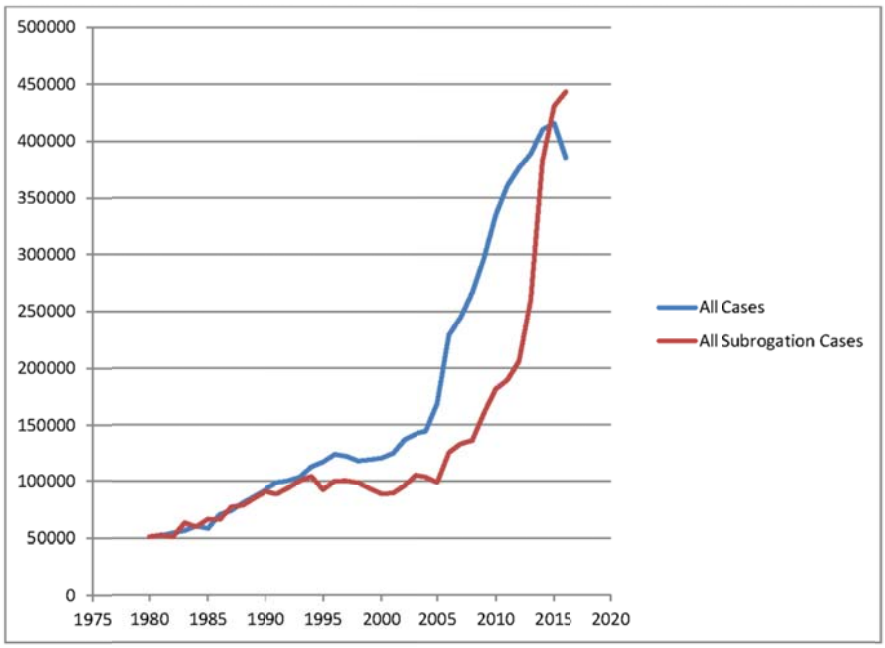


Figure 2 compares the growth in absolute numbers of subrogation cases with the growth of all cases. (The number of subrogation cases is rescaled[14] so that both curves start at the same origin in 1980.) Figure 2 shows that the reason for the earlier decline in Figure 1 was not that fewer subrogation cases were filed, but rather that there was more growth of litigation of cases of all kinds. In any case,

11. Greenblatt (1997), 1339 at n. 10.

12. The data was obtained from Lexis-Nexis Academic Universe by doing a search of all reported and unreported cases that used the keyword "subrogation." The annual number of such cases was then divided by all reported and unreported cases in the U.S. in either state or territorial appellate courts or any federal courts.

13. Figure 1 shows the number of subrogation cases per 1000 cases.

14. In Figure 2, the number of subrogation cases is multiplied by 117.5.

the basic point of Figure 1 and Figure 2 is that litigation of subrogation cases essentially exploded around 2011. It is likely that part of the explanation for the jump was a federal statute, which became effective in 2011, that imposed data collection and reporting requirements on insurance companies, to give the federal Centers for Medicare & Medicaid Services (CMS) more tools to enforce Medicare's right to subrogation. (See the discussion below.)

The general increase in subrogation activity has increased the demand for specialists. A trade association, the National Association of Subrogation Professionals (NASP), was founded in the U.S. in 1998, and its membership has grown from 80 to approximately 3,000.

The Economics Literature on Subrogation

The economics literature on subrogation provides some basic insights on what kind of subrogation arrangements are optimal, in the sense of maximizing the expected utility of the insured. Sykes (2001) argues that if there is an accident and the tortfeasor cannot pay the full amount of damages, it is efficient for the insurer to take priority over the insured every time. The basic idea is that if a purchaser of insurance had a choice between two policies, one giving him priority and the other giving the insurer priority, and a clear understanding of the economic consequences, i.e., the reduction in premiums he or she would enjoy through giving priority to the insurer, he would choose that option. Sykes's argument runs as follows: Suppose Mr. Jones is in an accident for which an injurer is liable. In this case, Jones will be able to collect not only the amount C from his insurance company, but also damages from the injurer. The injurer is liable for damages of D, and Jones can decide in advance how much he will retain (D_1) and how much to assign to his insurer via subrogation ($D_2 = D - D_1$). (He can make this decision by choosing among different insurance policies.) If insurance companies are perfectly competitive, whatever amount D_2 he assigns to his insurer via subrogation will increase his income by reducing his premiums over a period of multiple years.[15]

Now since Jones can decide the amounts of D_1 and D_2, and because he has diminishing marginal utility,[16] the question is whether, for example, he should

15. It should, however, be noted that some courts and commentators contend that insurers' recoveries through subrogation will not be passed through to customers in the form of lower premiums. See the references in Reinker and Rosenberg (2007), S270 at n. 13. These conclusions are typically based on the observation that historically, insurers have not taken subrogation recoveries into account when setting insurance premiums. However, this practice is bound to change, if it has not done so already, in view of the increasing importance of subrogation.

16. Income has diminishing marginal utility for a person who is risk-averse, i.e., the more income he has, the less he gains from an additional dollar. People buy insurance because they are risk-averse. In the theory of finance, everyone is assumed to be risk-averse.

have a much larger income in one year than all the others, by the amount D in the year of the accident, or instead a slightly larger income over many years:

$$n, \frac{D}{n}.$$

Because Jones has diminishing marginal utility, he will choose the latter, which means that he wants $D_1 = 0$ and $D_2 = D$. It is optimal for A to assign all the damages he could recover to his insurance company in return for lower premiums over many years.

Sykes's model, while elegant, does not consider how a strict rule of insurer priority might affect the incentives of Jones to file a lawsuit in the first place. One can imagine a different model that finds that the optimal subrogation contract would give Jones a share of the recovery, to ensure that the lawsuit will be filed, so that the insurer gets the remaining share of a recovery and there is deterrence to tortfeasors. One way to do this would be to adopt Sykes's suggestion of giving the insurer priority, but make it subject to a minimum recovery by the plaintiff, for example 25% of the total recovery net of procurement expenses.

Reinker and Rosenberg (2007) take the idea of assigning the recovery of damages further, by proposing that victims of medical malpractice assign their entire claims to first-party insurers *ex ante* in exchange for lower premiums, an approach that they call "unlimited insurance subrogation." They define first-party insurers very broadly, but we can think of them as health insurance companies. Reinker and Rosenberg argue in particular that "replacing the current amalgam of parties that make up the plaintiff's side with the first-party insurer will eliminate the potential for conflicts that could disrupt or derail prosecution of meritorious malpractice claims." Here again, however, there is a potential problem with incentives since the patients, the victims of medical malpractice, would not have the direct financial stake they now have in litigation outcomes. This could cause difficulties at both the extensive margin (learning whether malpractice has occurred) and the intensive margin (obtaining the patient's full cooperation in pursuing the lawsuit).[17] It is also possible that there are diseconomies of scope arising from combining the provision of first-party insurance with plaintiff's litigation of medical malpractice claims (Panzar and Willig (1977), (1981)).[18] Polinsky and Shavell (2017) consider a related idea: that the insureds could sell their claims *ex post*, after accidents occurred, to their insurers or others. They note, however, that this would not be optimal because the insured would not avoid litigation risk: The prices received by insureds would vary depending on the expected value of their claim.

17. Reinker and Rosenberg recognize these problems but argue, for example, that insurers can induce malpractice victims to cooperate by compensating them for their time and expenses related to the litigation.

18. Another alternative would be to adopt a suggestion made by Becker and Stigler (1974), to assign ownership of the entire claim to the plaintiff's lawyer.

Polinsky and Shavell evaluate different possible subrogation arrangements on the basis of which variation maximizes the expected utility of a risk-averse consumer of insurance. They find, as did Sykes, that if one assumes insurance companies have no costs, the entire award from tort litigation should be retained by insurers; the insured benefits through uniformly lower premiums and by avoiding the risk of litigation. If, however, one takes into account that insurers have administrative costs, they find (unlike Sykes) that it is optimal for the insurer to pay some fraction of the award to the insured. They also consider a case in which there is subrogation, insurers have zero costs, and the insurer recovers a court award that includes a "monetary component," such as lost earnings or medical expenses, and a "nonmonetary component," such as pain and suffering or loss of consortium. Here they find that the optimal amount of insurance coverage is for the monetary loss alone and that the insured should not share in the court award. The conclusion that the policy should not cover non-monetary losses is based on their assumption that a non-monetary loss does not affect the insured's marginal utility of wealth, which they argue is "more realistic" than an assumption that it does. This is certainly debatable. One might think, for example, that if severe emotional trauma reduces the insured's total utility, it might also affect the marginal utility of his or her wealth, although the direction of the change is unclear. See Sykes (2001) at 387, 390. Polinsky and Shavell also recognize that since the cooperation of the insured will often be important to a successful lawsuit, it might be a good idea for him to receive a share of the recovery to induce him to cooperate.

How Subrogation Evolved Under Medicare and Medicaid, and in the Private Sector

The economic issues involved in application of the right of subrogation in tort litigation apply to Medicare, Medicaid and private health insurance companies. However, analysis of these issues has been most highly developed and coherently explained in situations involving Medicare. Therefore, we begin with Medicare, then address these questions with Medicaid and finally describe the evolution of the use of subrogation by private automobile and health insurance companies. The rules applicable to private insurers are not yet well defined, but they are likely to be strongly influenced by those established for Medicare and Medicaid.

The Federal Government's Right to Subrogation Under Medicare

The Medicare program was enacted by the U.S. Congress in 1965 under Title XVIII of the federal Social Security Act to provide health insurance to people age 65 and older, regardless of their income or medical history. Under Medicare, the federal government provides health care to persons who are at least 65, disabled or afflicted by end-stage kidney disease. As of August 2017, the number of Americans covered by Medicare was estimated to be 56,838,848.[19]

The Medicare program was initially the ultimate or "primary" payer for medical services provided to its beneficiaries, whether or not the beneficiary had other insurance available, with the exception of those who were covered by workers' compensation. In that case, Medicare was a secondary payer, so the workers' compensation carrier was obliged to reimburse Medicare for expenses paid by Medicare for the care of injured workers. In 1980, Congress, concerned about the rapidly increasing costs of Medicare, took action to provide some revenue by enacting the federal Medicare Secondary Payer Act,[20] (MSP Act), which essentially made Medicare a secondary payer in virtually any situation where the beneficiary had some other type of insurance. In other words, if Medicare had paid for someone's health care but another insurer was also obligated to pay, Medicare had the right to be reimbursed by that insurer. In 1984, the MSP Act was amended to give Medicare a right of subrogation against the insurer, as well as a direct right of action.[21] Suppose, for example, a 65-year-old man, Ed Smith, is injured in an auto accident by negligence of Dave Thompson. Smith is hospitalized and Medicare, unaware that he has health insurance with X Co., pays $100,000 for his health care. Smith sues Thompson and recovers damages of $200,000: $100,000 for health care expenses and $100,000 for other damages. Medicare now has a right to be reimbursed for its expenses by Smith via subrogation. If Smith has spent all the money without reimbursing Medicare, Medicare can obtain reimbursement from X Co.

There were, however, serious problems with enforcement of the MSP Act in tort cases, because Medicare had no systematic way to learn when its beneficiaries were plaintiffs in tort litigation. To deal with this problem, the MSP Act was amended in 2007 by a statute[22] that imposed data collection and reporting

19. This represents the total in the "Eligible" column of the "Monthly Enrollment by State" data posted on *https://www.cms.gov* in August 2017.

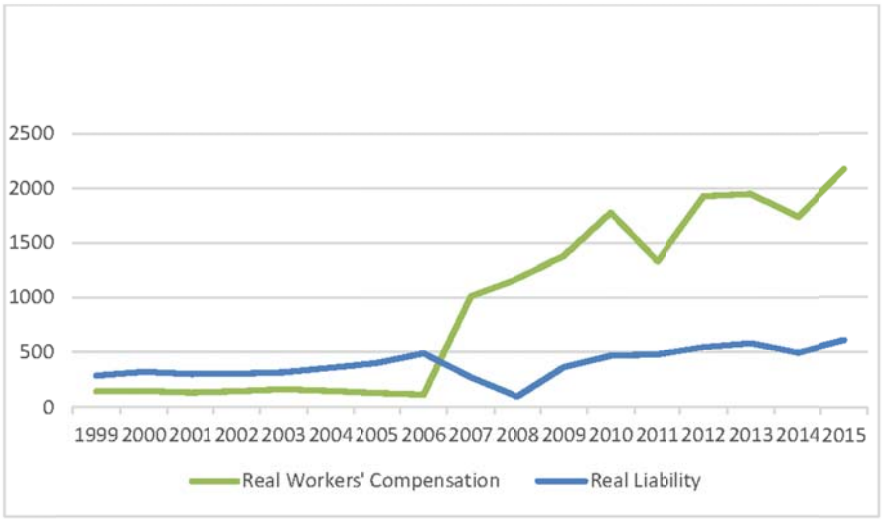
20. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599, 42 U.S.C. § 1395y(b)(2)(A) (1980).

21. See 42 C.F.R. 411.26(a), and Denekas v. Shalala, 943 F. Supp. 1073, 1079 (S.D. Iowa 1996).

22. The Medicare, Medicaid and SCHIP Extension Act of 2007, Pub. L. No. 110-173, 121 Stat. 2492 (2007), codified in 42 U.S.C. Sec. 1395y(b)(7-8).

requirements on insurance companies to give the CMS more tools to enforce Medicare's right to subrogation. The new reporting requirements became effective on Jan. 1, 2011, for settlements entered into on or after Oct. 1, 2010. The penalties for noncompliance are severe.[23] Figure 3 shows the effect on Medicare revenues from liability and workers' compensation insurers of the reporting requirements and sanctions for noncompliance.[24]

Figure 3:
Reimbursement of Medicare from Tort Liabililty Insurers
($ Millions in 2016)



Although the rate of growth of liability reimbursements is not smooth, they have increased by 114% in real terms from 1999 to 2015. Workers' compensation revenues, on the other hand, were basically flat until 2007, when there was a seven- or eight-fold increase owing to the inclusion in this category of Medicare Set-Aside arrangements by workers' compensation insurers, which ensured that not only past, but also future, payments to workers would be made by these

23. If the CMS must resort to litigation to obtain reimbursement for its payments, the statute allows it double damages plus interest. If primary payers fail to report settlements and judgments, they are liable for a fine of $1000 per day, per claim. 42 U.S.C. Sec. 1395y(b)(2)(B)(iii), 1395y(b)(3)(A), 1395y(b)(7)(B)(i), and 1395y(b)(8)(E)(i); 42 C.F.R. 411.24(c)(2).

24. Source: CMS Statistics Reference Booklet, various years, Table III.9, "Medicare Savings Attributable to Secondary Payer Provisions by Type of Provision." Amounts have been converted to 2016 dollars. The amount of liability reported for 2008 was obtained from Daniel Aibel, of the Office of General Counsel, Centers for Medicare and Medicaid Services.

Note: Medicare reports that "liability savings of the global settlements recovered by CMS" are reported beginning in fiscal year 2011. Workers' compensation includes "set-asides" for future payments beginning in fiscal year 2007. These are discussed in the text below.

insurers rather than by Medicare. Thus, these additional "revenues" are really reductions in future costs, i.e., future payments to be made by Medicare. We explain this matter more fully below.

Potential Recovery of Future Health Care Expenses Under Medicare

Suppose a tort victim recovers damages of $500,000, $300,000 of which is for health care, which was entirely paid for by Medicare. As we have seen, Medicare is entitled to reimbursement of the $300,000 via subrogation. Since the tort victim received $300,000 from Medicare and $200,000 from the tortfeasor, he or she has not been overcompensated. Since the tortfeasor has paid total damages of $500,000, equal to the social cost of his actions, there is no problem of under-deterrence, and all is well. In the real world, however, a problem arises: Often a substantial portion of health care damages is for future expenses, but a party claiming reimbursement via subrogation normally has the right to be compensated only for amounts that are already paid.[25] Thus, if $100,000 of the health care damages are for past expenses and $200,000 are for future expected expenses, Medicare would be entitled only to payment of $100,000.[26] Medicare has, therefore, proposed[27] that the parties set aside the portion of the recovery attributable to future health care expenses in a fund, to be used thereafter to pay those expenses as they arise.

This procedure, known as a Medicare Set-Aside (MSA) arrangement, has long been used in workers' compensation matters, and is designed to ensure that Medicare will not have to resume paying the plaintiff's health care expenses until after the fund has been exhausted. Figure 3 shows the remarkable and explosive growth of Medicare "reimbursements," or more precisely the future payments avoided by Medicare, resulting from MSA arrangements by workers' compensation insurers beginning in 2007. This gives one an idea of the potential savings for Medicare if tort liability insurers were to make similar MSA

25. In Ontario, Canada, health insurance is provided by the Ontario Health Insurance Plan. Through subrogation, the Ministry of Health and Long-Term Care recovers its costs for health care, including the costs for future insured health care services that an injured person may need. Health Insurance Act, Section 30-36 and Regulation 552, Section 39, and Long Term Care Act, Section 59 (ss1-13).

26. Since Congress has granted Medicare a direct action for reimbursement as well as a right of subrogation, Medicare could in theory sue the tort victim repeatedly for reimbursement as it made additional expenditures after the case was settled. This apparently does not happen in practice.

27 In 2012, Medicare issued an advance notice of proposed rulemaking that would have required Medicare beneficiaries to set aside money from settlements to pay for future medical care related to the settlement. However, in October 2012, CMS withdrew its notice of proposed rulemaking without public comment. Rooney (May 2016), at 18.

arrangements. However, the exact procedures to be used in personal injury cases outside of workers' compensation have not yet been specified.

Incentive Issues Arising from Subrogation

Suppose the share of a plaintiff's damages attributable to medical expenses is $200,000, all of which have been paid by his health insurer. The plaintiff would have no incentive to sue for this component of damages, since there are costs of doing so but no benefit, if all those damages must simply be handed over to the insurer. Thus, there is room for disagreement and manipulation if the health insurer is not represented by a lawyer in the tort action. The plaintiff's lawyer is normally on a contingent fee, and his compensation will depend on the net amount he or she recovers for the plaintiff insured. Therefore, the plaintiff's lawyer has an incentive to minimize the portion of the recovery that is subject to a right of subrogation (medical expenses in this example).[28] He could do so, for example, by convincing the defendant's lawyer to agree that the recovery is for damages other than medical expenses, or that the victim's medical expenses were not attributable to the tortious conduct. Because of this problem, some health insurers have gone so far as contacting the plaintiff's lawyer to inform them that they will make some payment to him or her to the extent he or she obtains a recovery for medical expenses.

How Medicare Deals with Incentive Issues

A. Preventing Manipulation of the Terms of Settlement

Congress has adopted two measures to alleviate this incentive problem for Medicare. First, it has provided by regulation that one cannot avoid reimbursement to Medicare by classifying a recovery in settlement documents as something other than for medical benefits, such as pain and suffering or loss of consortium, or by stating in settlement documents that none of the recovery is for medical expenses.[29] The only way Medicare will recognize allocation of any portion of a recovery to non-medical losses is when a court or other adjudicator of the merits

28. Posner (1986), at 537, explains a related problem that arises in a class action, when the plaintiff's and defendant's lawyers can collude to reduce the size of the plaintiff's recovery but increase the plaintiff lawyer's legal fee. Spurr (2010), at 166, describes how, in a state that takes a share of punitive damages awarded to the plaintiff, the plaintiff's and defendant's lawyers can agree among themselves to reduce the amount of punitive damages in return for an increase in compensatory damages.

29. United States, Health Care Finance Administration, *Medicare Intermediary Manual* Sec. 3418.7.

(i.e., a jury or arbitrator) designates amounts for pain and suffering or other non-medical losses.[30]
This rule eliminates the possibility of manipulation that would disadvantage Medicare.[31]

It has been argued that this rule both: 1) encourages socially wasteful litigation rather than settlement; and 2) given the additional costs and uncertainty of litigation, may well deter some tort victims from pursuing their right to compensation, resulting in inadequate deterrence and depriving Medicare of reimbursement of its expenses.

Suppose Mr. Adams was injured in an auto accident by Ms. Brown, and Medicare has paid $100,000 of his medical expenses. Assume first that Adams claims damages of $200,000, but settles for $100,000. Since there has been no court determination, Medicare assumes the entire settlement payment is made for medical expenses[32] and demands the entire $100,000, less procurement expenses.[33] Now assume that the case went to trial, and the court awarded Adams $100,000 that was apportioned $50,000 to medical expenses and $50,000 to pain and suffering. In this case, Medicare would receive $50,000 less procurement costs. The obvious effect of this rule is to encourage litigation. On the other hand, it has been argued that one could avoid the necessity of going to court by obtaining the government's advance agreement to an allocation.[34] One would have to resort to court only if the federal government's allocation was unreasonable. (There have been objections in the practice-oriented law journals that the federal government does not respond to parties requesting approval of an allocation in a timely

30. 42 U.S.C. Sec. 1395y(b)(2)(B)(ii)-(iii); 42 C.F.R. Sec. 411.24(c); Centers for Medicare and Medicaid Services, *Medicare Secondary Payer (MSP) Manual*, CMS Publication 100-05, Ch. 7, Sec. 50.4.4

31. This was recognized by the Court *in Zinman v. Shalala*, 67 F. 3rd 841, 845 (9th Cir. 1995): "Apportionment of Medicare's recovery in tort cases would require either a fact-finding process to determine actual damages or would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages."

32. Centers for Medicare and Medicaid Services, *Medicare Secondary Payer (MSP) Manual*, CMS Publication 100-05, Ch. 7, Sec. 50.4.4. This rule was upheld in *Zinman v. Shalala*, 67 F. 3rd 841, 845 (9th Cir. 1995).

33. Medicare can, however, waive its right to subrogation if CMS determines that enforcement of its right would cause undue hardship. 42 U.S.C. 1395y(b)(2)(B)(iv) provides that there can be a waiver "if the Secretary determines that the waiver is in the best interests of the program established under this title [42 USCS §§ 1395 et seq.]." See also 42 U.S.C. 1395gg(c) and 42 C.F.R. 411.28. Anecdotal accounts by lawyers indicate that such waivers are not unusual.

34. *In Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006), the U.S. Supreme Court noted that "… the risk that parties to a tort suit will allocate away the state's interest can be avoided either by obtaining the state's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." Although this case involved reimbursement to a state from a tort recovery under Medicaid, the logic applies equally to reimbursement of the federal government under Medicare.

manner; Congress has responded with legislation requiring Medicare to do electronic claims processing in an efficient manner.[35])

B. Providing Incentives to Plaintiffs' Lawyers to Pursue the Case

Second, Congress has dealt with the incentive problem of lawyers by effectively making the government a co-plaintiff that is fully responsible for its share of attorney fees. Assuming the Medicare claim is less than the total recovery, it is reduced by a proportionate share of the attorney's fees and expenses.[36] Thus, the plaintiff's attorney is in essentially the same position as if there were no subrogation, and has an incentive to pursue the portion of the plaintiff's claim for medical expenses vigorously.[37]

A State's Right to Subrogation Under Medicaid

The Medicaid program was enacted by Congress in 1965 to provide medical care to individuals who are unable to pay their own medical costs.[38] It is funded jointly by the federal government and the state; the federal government pays between 50% and 83% of the costs incurred by the state for patient care.[39] Although states are not required to participate in Medicaid, all of them do. In April 2016, the total number of Americans covered by Medicaid and a closely related program, the state Children's Health Insurance Program (CHIP), was estimated to be 72,394,275.[40]

The Medicaid program is regulated by both federal and state law, but the federal law establishes parameters for the state statutes. The basic scheme of the federal Medicaid program is to put the state in exactly the same position that the federal government is in under Medicare.[41] Accordingly, under Medicaid, the state

35. The Strengthening Medicare and Repaying Taxpayers (SMART) Act of 2012, Public Law No. 112-242, 126 Stat. 2374 (2013).

36. 42 C.F.R. 411.37(c) (1995); *Estate of Washington*, 53 F. 3rd 1173, 1175 (10th Cir. 1995).

37. Normally, the real filter that would determine whether a lawsuit is pursued will be the plaintiff's lawyer, not the plaintiff. This is easy to see by comparing the respective cost-benefit problems faced by the tort victim and the lawyer, if one makes the (admittedly strong) assumption that it is strictly a financial decision for each of them. See the Appendix for an empirical estimate.

38. 79 Stat. 343, 42 U.S.C. Sec. 1396 et seq.

39. The percentage of the federal contribution is determined by a formula based on each state's per capita income. 42 U.S.C. Sec. 1396d(b).

40. Source: The Henry J. Kaiser Family Foundation.

41. For example, federal statutes require the state: 1) to learn whether third parties are liable for a Medicaid recipient's medical care—for example, because of a tort; 2) to enact a state law

has a right to reimbursement for its paid benefits from the beneficiary's recovery of damages in a personal injury action.

Some of the implementing statutes adopted by the states are less sophisticated than those of Medicare in dealing with incentive issues, which has resulted in litigation. For example, in one case,[42] an Arkansas statute gave the state the right to reimbursement for all its expenditures on Medicaid, with no deduction for attorney's fees and other costs of procurement of the recovery. The Arkansas statute violated a provision of the federal Medicaid law that prohibited a state from imposing liens for the amount of Medicaid payments it made.[43] Imposing a lien for health care expenses, without reducing it by a proportionate share of the plaintiff's attorney fees and expenses, could drastically reduce the incentive to bring lawsuits that would provide optimal deterrence of tortfeasors and recoveries by the state for its Medicaid payments.

Other states have adopted schemes that seem to deal more effectively with incentive issues. For example, in California and South Dakota, a state agency allows attorneys 25% of any amount that is recovered for Medicaid.[44]

How Subrogation Evolved in the Private Sector

When we turn our attention from subrogation by Medicare and Medicaid to the evolution of subrogation in the private sector, the dates of major changes become less exact, since we are now dealing not with a pre-emptive federal statute but instead with the different laws of 50 states; nonetheless, it is possible to make some generalizations. The doctrine of subrogation has long been employed without controversy in the area of property/casualty (P/C) insurance.[45] It was, however, not generally available to automobile and health insurance companies, because of the common law prohibitions against the assignment of personal injury claims and the splitting of causes of action based on personal injuries.[46] Beginning roughly in the 1960s, automobile and health insurers began to insert rights of subrogation against tortfeasors in their policies and to press for the right of

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that gives the state a right of subrogation against the third party in such a case; and 3) to collect from third parties amounts for which it has a right to reimbursement. See 42 U.S.C. Sec. 1396a(a)(25)(A); 1396a(a)(25)(B); 1396a(a)(25)(H); 1396k(a); and 1396k(b).

42. *Arkansas Department of Health and Human Services v. Ahlborn,* 547 U.S. 268 (2006).

43. Sec. 1396p(a)(1).

44. California Code Sec. 14124.72(d); *Branson v. Sharp Healthcare, Inc.*, 193 Cal. App. 4th 1467, 123 Cal. Rptr. 3rd 462, 466 (2011); South Dakota Administrative Rule 67:48:04:03. In South Dakota, the attorney is allowed a larger share of the recovery in certain cases, e.g., a one-third share if the amount of the award is determined through mediation, an administrative hearing or by a trial court, and 40% if the amount is determined by an appellate court.

45. Baron (1992), at 582; Trefz (2013), at 65.

46. Baron (1992), at 583.

subrogation in state courts and legislatures.[47] An argument often cited was that if the insurers had no right of subrogation, claimants would be unjustly enriched by a double recovery, from both the insurer and the tortfeasor. Those who opposed a right of subrogation frequently contended that giving insurance companies a right of subrogation, and thereby increasing their revenues, would yield policyholders no benefit in the form of lower premiums.[48] This argument is, however, universally rejected by economists, as seen from the discussion above.

In any case, the use of subrogation of tort recoveries by health and motor vehicle insurers has expanded greatly in the last 50 years. A study by Ward using data from 1992–1996 on subrogation by auto insurers examined the percentage of total annual paid losses that could be recovered through subrogation. He found that "high-performing" insurers recovered 23.7% of losses, while the figure for the average insurer was 11.6%.[49] Subsequent studies by the NASP have found that approximately 15% of annual loss totals can now be recovered through subrogation and that this fraction has increased significantly since the 1990s.[50] In addition, Figure 1 in this paper strongly suggests that the use of subrogation has increased dramatically since about 2011. Insurers with limited staffs have the option of farming out subrogation to third parties, who take over the risks of litigation and assume all costs involving the exercise of subrogation rights.[51] Technical change and the increasing availability of data, which reduce the costs of subrogation, have led health and automobile insurers to increase their efforts at subrogation substantially.

The exact same issues that arose with subrogation by Medicare and Medicaid have emerged with the increasing use of subrogation by private health or automobile insurers. One issue is whether the insurer can claim most or all of the insured plaintiff's recovery in order to be fully reimbursed for the expenditure it made for the insured. Some states have enacted statutes limiting the amount of the insurer's lien to either a fixed percentage of the plaintiff's recovery or a fixed dollar amount.[52]

Another issue is whether an insurer can satisfy its claim out of the plaintiff's recovery without paying for any of the plaintiff's legal expenses that made the recovery possible. Some state courts have decided that for reasons of fairness, or to preserve the incentives of plaintiffs to sue for their tortious injuries, the

47. Kimball and Davis (1962), pp. 842–843; Baron (1992). Kimball and Davis also suggest that in the early 1960s, there was increasing interest in subrogation recoveries for fire insurance. Kimball and Davis (1962), at 844 n. 12.

48. See. e.g., Baron (1992) at 582: "The prospect of a successful subrogation collection is not a factor in the insurer's rate determination."

49. Ward (1998).

50. Tzankova et al. (2015).

51. Ibid.

52. See, e.g., 770 Illinois Comp. Stat. Sec. 23/10 (the total amount of all such liens cannot exceed 40% of the award); North Carolina General Stat. Sec. 44-50 (lien cannot exceed 50% of damages); and Tennessee Code Ann. Sec. 29.22-101(b) (a hospital lien cannot exceed one-third of the damages).

insurer's subrogation claim must be reduced by a proportionate amount of the plaintiff's legal fees.[53]

Finally, the early history of subrogation efforts made by Medicare and Medicaid strongly suggests that private health insurers will often lack the information they would need to recover amounts from defendants via subrogation. As we have seen, Medicare solved this problem by imposing data collection and reporting requirements on insurance companies, but private insurance companies do not have the ability (at least directly) to enact laws forcing others to provide them information. Some states have dealt with this issue by enacting legislation requiring plaintiffs to notify any parties entitled to subrogation of their lawsuit, to give them an opportunity to intervene in the litigation.[54]

Subrogation, the Collateral Source Rule and Moral Hazard

To understand the issues arising from the growth of subrogation, one must know the relationship between subrogation, the collateral source rule and the recent waves of state statutes abrogating the collateral source rule. The collateral source rule barred from the trial evidence of any compensation received by the plaintiff from "collateral" sources such as health, disability or workers' compensation insurance.

Some commentators have expressed concern that the collateral source rule would lead to overpayment of damages. Suppose again that Mr. Evans has been injured by a negligent driver, but assume now there is no subrogation. Evans' medical expenses in the amount of $300,000 were paid by his own health insurance. Evans sues and obtains a judgment against the negligent driver in the amount of $500,000, representing $300,000 in medical bills and $200,000 in pain and suffering. This raises the possibility that Evans would obtain total compensation of $800,000 ($500,000 from the tortfeasor and $300,000 from his health insurer) when he has incurred only $500,000 in damages. The concern is that the scheme of compensation being considered would lead to moral hazard, viz., substantially reducing one's level of care, or in the extreme, intentionally

53. See, e.g., *Martinez v. St. Joseph Healthcare System*, 871 P. 2nd 1363, 1364 (New Mexico 1994), and Schulte (2013).

54. As of 2016, seven states had enacted legislation requiring a plaintiff to send notice either of its claim, or of a verdict in its favor, to "all persons entitled by contract or by law to either subrogation or a lien against the proceeds of the plaintiff's recovery." In Florida, Hawaii, Kentucky, Minnesota and Utah, the notice must be sent when or before the plaintiff's action is filed, whereas in Maine and Michigan, notice of the verdict must be sent "after the verdict." Feeley, Horan and Schap (forthcoming); see also Schap and Feeley (2008) for the applicable rules in 2005. See, e.g., Michigan Complied Laws Sec. 600.6303 (3): "Within 10 days after a verdict for the plaintiff, plaintiff's attorney shall send notice of the verdict by registered mail to all persons entitled by contract to a lien against the proceeds of plaintiff's recovery."

becoming an accident victim. That is, does the insurance, when combined with a potential recovery in tort, induce him to use less than an efficient level of care to avoid an accident? Some state statutes seem to be based on the assumption that the relevant measure of potential gain from the insurance is the present value of the insurer's total payments in the event of an accident, minus the present value of the premiums historically paid.[55] This is not correct because once the policy is in effect, the insured would consider the premiums that were paid a sunk cost (and the insurer's prior payments for health care a sunk benefit). The measure of gain would, roughly speaking,[56] be the insurer's expected payments in the event of an accident.

In theory, this could induce a potential victim to use less than an efficient level of care, resulting in an excessive level of accidents or other tortious activity. However, to the extent that this is a problem, it can be avoided by the remedy of subrogation. If in the previous case there were subrogation, Evans' health insurer, which paid his medical bills although it was only secondarily liable for them, could step into his shoes and obtain reimbursement of its $300,000 from the injurer who was primarily responsible, leaving Evans to recover $200,000 in damages. The defendant would still be liable for full damages of $500,000, but Evans' health insurer has recovered the $300,000 from the defendant in a subrogation action. Thus, the collateral source rule, combined with the right of subrogation for health insurers, avoids overpayment to the tort victim but ensures that the tortfeasor is fully liable for the damages he has caused. Researchers have

55. Thus, for example, some state statutes that modify the collateral benefits rule reduce the deduction for the insurer's payment by the total amount of premiums paid. See, e.g., Indiana Code 34-44-1-2(2) (West 2007), and Michigan Compiled Law Statutes Sec. 600.6303(2). For the post-verdict reduction of the recovery in a personal injury action, the Michigan statute provides that: "The court shall determine the amount of the plaintiff's expense or loss which has been paid or is payable by a collateral source. Except for premiums on insurance which is required by law, that amount shall then be reduced by a sum equal to the premiums, or that portion of the premiums paid for the particular benefit by the plaintiff or the plaintiff's family or incurred by the plaintiff's employer on behalf of the plaintiff in securing the benefits received or receivable from the collateral source." Note, however, none of the state statutes we have seen allow for accumulation of interest on the premium payments, and most do not consider the possible increase in premiums resulting from the accident. (An exception is the New York statute cited below.)

Two state statutes that allow introduction of collateral benefits into evidence at trial in medical malpractice cases allow the plaintiff to respond by introducing evidence of insurance premiums "paid or contributed" by him. Arizona Revised Statute 12-565; California Civil Code Sec. 3333.1.

A New York statute provides that a post-trial reduction of a personal injury award by the amount of collateral benefits should be offset by "an amount equal to the premiums paid by the plaintiff for such benefits" over the last two years, plus "an amount equal to the projected future cost to the plaintiff of maintaining such benefits." New York Civil Practice Law and Rules 4545(a). Maine has a similar statute. Maine Rev. Stat. Ann. 24 Sec. 2906 (2000).

56. There should also be an adjustment for the expected increase in premiums resulting from the accident.

generally approved of the right of subrogation of insurers in tort cases on the ground that it prevents overpayment to the tort victim and, thus, moral hazard.[57]

Moral Hazard Arising from Abolition of the Collateral Source Rule

There is another connection between the collateral source rule, subrogation and moral hazard: When the collateral source rule has been abolished, there may be moral hazard, but this time on the part of the tortfeasor rather than the victim. In the last four decades, under the rubric of tort reform, the collateral source rule has been abrogated by statute in many states. These statutes were generally justified on the grounds that they would prevent overpayment to tort victims and moral hazard. Articles in law journals and economics journals that commend statutes abolishing the collateral source rule either do not consider the possibility of subrogation, or contend that insurers generally do not exercise the right of subrogation.[58] This objection is undercut by the recent rapid increase in the use of subrogation shown in Figure 1 and Figure 2.

Two types of statutes have modified the collateral source rule. In four jurisdictions, evidence of the collateral sources is admissible during the trial itself so that the verdict may well reflect a reduction of collateral source amounts.[59] In many other jurisdictions, evidence of collateral benefits is barred during the trial, but they are, or may be, subtracted in a post-verdict proceeding.[60] Some of these jurisdictions do not allow the plaintiff to receive a cumulative recovery even if the insurer fails to, or is unable to, exercise its right of subrogation against the defendant.[61] Some courts have interpreted statutes ruling that collateral benefits must be subtracted from the plaintiff's recovery to mean that health insurers, who

57. Kimball and Davis (1962), at 869; Reinker and Rosenberg (2007); and Polinsky and Shavell (2017).

58. See Jacobsen (1991), who does not mention the possibility of subrogation. Wershbale (2008) states that "the main reasons subrogation rights are unenforced include difficulty in establishing that a damage award encompasses the particular collateral benefits paid out by the insurer, high administrative costs associated with seeking subrogation, and potential damage to the insurer's reputation resulting from subrogation actions." [Citing Congressional Budget Office (2004).]

59. Alabama Code § 12-21-45(c) (1975). In Alabama, the insurer is able to exercise its right of subrogation by suing the defendant directly. *Melvin v. Loats*, 23 So. 3rd 666 (Alabama Civ. App. 2009). In Alabama, evidence of collateral benefits is admissible at trial in all personal injury actions. In Arizona and California, evidence of collateral benefits is admissible only in medical malpractice actions, and in South Dakota, only in health care malpractice actions Arizona Revised Statute 12-565; California Civil Code Sec. 3333.1; South Dakota Codified Laws Sec. 21-3-12.

60. Todd (2012), at 993, and cases cited in n. 207.

61. Id.

stand in the shoes of the plaintiffs, cannot recover from the defendant the amounts they paid the plaintiff for medical expenses.[62] Thus, with either type of abrogation of the collateral source rule, there is potential for the defendant to avoid paying the full measure of damages.

Suppose again that an insured person has been injured by a negligent driver and obtains a judgment against the negligent driver in the amount of $500,000, representing $300,000 in medical bills and $200,000 in pain and suffering. A first-party insurer has paid the insured's medical bills in the amount of $300,000. If the judge reduces the defendant's liability by $300,000, and the insurer cannot or does not recover that amount through a direct action or by subrogation, there is a serious problem of moral hazard in that the defendant has not paid the full social cost of his or her actions. The abolition of the collateral source rule transfers liability from the defendant to the plaintiff's health insurer (and thereby to the plaintiff in the form of higher health insurance premiums), thereby creating a problem of moral hazard and inadequate deterrence to tortfeasors.[63] A number of empirical studies have found that tort liability has been reduced by statutes modifying or abolishing the collateral source rule.[64]

62. See. e.g., *Humbach v. Goldstein*, 229 A.D. 2nd 64, 653 N.Y.S. 2nd 950, 952 (2nd Dept. 1997): "However, since Oxford paid the plaintiff's medical costs, CPLR 4545 [the statute abrogating the collateral benefits rule] would be applicable to any verdict in the instant action. Oxford could not recover, by verdict after trial, the cost of the plaintiff's medical care which was reimbursed by Oxford, without running afoul of the rule that Oxford's rights of recovery under subrogation cannot be any more than the plaintiff's rights of recovery, or without running afoul of CPLR 4545. The purpose of CPLR 4545 is not only to prevent double recovery by plaintiffs, but also to keep down the liability insurance costs of policyholders."

63. Reinker and Rosenberg (2007), 264 at n. 4.

64. One line of research involves motor vehicle accidents. Browne and Puelz (1999), analyzing closed automobile bodily injury insurance claims from 1992, found that reform of the collateral source rule was associated with a decrease in value of non-economic claims of 14.4%, in economic claims of 15.3% and overall claim value of 13.7%. They concluded, "These results suggest that courts do adjust awards to plaintiffs to account for evidence that they have received compensation for their injuries from other sources." Rubin and Shepherd (2005) found that weakened versions of the collateral source rule were associated with more vehicle accident deaths, as drivers exercise less care when they face less than the full costs of accidents they cause.

Other researchers have investigated the effect of collateral source rule modification on medical malpractice. Danzon (1986) found that collateral source offset reduced the frequency of medical malpractice claims by 14%. Klick and Stratmann (2005) found increased infant mortality (concentrated in the black population) as physicians exercised less care when accountability for the full costs of malpractice was reduced. In another study of medical malpractice, Iizuka (2013), analyzing data from 1994 to 2007, found that collateral source rule reform significantly increased preventable medical errors associated with four specific ob-gyn procedures.

Conclusion: Policy Implications

The thrust of the economic analysis summarized above is that clauses in insurance contracts providing for subrogation should not be prohibited. The gain to insurers from subrogation will be reflected in lower premiums, and risk-averse consumers will be better off. There is an unmistakable trend toward increasing use of subrogation by health and disability insurers, including private firms, Medicare and Medicaid. As previously noted, some states have helped the process along by requiring plaintiffs to send notice of their action to all parties who may be entitled to subrogation. This means that the recovery of personal injury claims is increasingly divided among multiple parties, rather than a single victim. When part of the plaintiff's recovery will be taken by someone who has a right of subrogation, the plaintiff has no incentive to sue for this component of damages, and in some cases not enough incentive to sue at all.

We found that the Medicare statutes are carefully designed to preserve the incentives of plaintiffs' lawyers to pursue personal injury actions. However in some states, the expanding use of subrogation by Medicaid and private health insurers without measures taken to bolster the incentives of plaintiffs may substantially erode the real return to suing in tort. These trends are likely to reduce settlement payments and the filing of lawsuits by tort victims, and thus the deterrence of tortious behavior, unless subrogation arrangements adapt to preserve plaintiffs' incentives. Some states require (by judicial decision or statute) that insurers pay a proportionate amount of the plaintiff's legal expenses that make the personal injury award possible, while others do not. We believe that insurers should be required to pay an appropriate share of the legal expenses to prevent insurers from free-riding on the legal expenditures of the insured plaintiff and to preserve the incentives of the plaintiff and the plaintiff's lawyer to pursue valid tort claims.

Another problem arises in many states that have abolished the collateral source rule, if there is no subrogation by the insurer. If there is no subrogation, either because the insurer has not included the right in its insurance policy or because the insurer does not exercise that right, then there is a tradeoff: Either the insured obtains a recovery beyond his or her damages, or the tortfeasor pays less than the social cost of his actions. Suppose that an insured person, Smith, has been injured by negligent driver Jones. Smith's medical expenses in the amount of $300,000 were paid by his own health insurer, X Co. Smith sues Jones and obtains a judgment in the amount of $500,000, representing $300,000 in medical bills and $200,000 in pain and suffering. X Co., which paid Smith's medical bills, could obtain subrogation of its outlay of $300,000 from Jones, the injurer who was primarily responsible, leaving Smith with only $200,000 in damages. But suppose X Co. does not have, or does not enforce, its right of subrogation. Then, if the state has repealed the collateral benefits rule, the Court might have to decide whether: 1) Jones must pay Smith only $200,000, so that Jones pays less than the social cost of his actions; or 2) Smith collects full damages, resulting in an

overcompensation of $300,000. The answer should turn on which kind of moral hazard is more serious: that of the tortfeasor, who may take less precautions to avoid injuring others, or that of the victim, who may take less precautions to avoid being injured. This is a question that must be settled by empirical research. If, for example, the moral hazard of the tortfeasor is determined to be a more serious problem than the moral hazard of the victim, then the collateral benefits rule should be preserved.

Appendix: A Comparison of the Incentives of the Tort Victim and His Lawyer

We would expect that victims of tortious injuries who are not otherwise opposed to filing a lawsuit will be willing to do so if they can expect at least a small recovery. Normally, the real filter that would determine whether a lawsuit is pursued will be the plaintiff's lawyer, not the plaintiff. This is easy to see by comparing the respective cost-benefit problems faced by the tort victim and the lawyer, assuming that it is strictly a financial decision for each of them (admittedly a strong assumption). The lawyer will normally be on a contingent fee, typically for one-third of the recovery. A major empirical study of civil litigation[65] found that for lawyers on a contingent fee in 1978, the average predicted number of hours spent by the lawyer on a case was 50.7 hours, and that the average estimated recovery was $14,390 in 1978 dollars, or about $52,971 in 2016 dollars.[66] The median hourly wage of a U.S. lawyer in 2016 is estimated to be $56.81.[67] Assuming the average time spent on a case has not changed from 1978 to 2016, this suggests that the average case would involve a time cost for the lawyer in 2016 of $2,880.27. The lawyer's expected fee, one-third of the expected recovery, would be $17,657. Of course there would be additional expenses for taxes, rent, utilities, nonlegal staff, photocopying, court fees, expert witnesses and the like.

With regard to the cost-benefit calculation of the potential plaintiff, the median wage of U.S. workers in 2016 was $17.81 per hour,[68] but plaintiffs in personal injury cases often have lower-than-average income. Kritzer et al.[69] estimated that about 16% of the lawyer's time was spent conferring with the client and 16.7% in discovery, part of which often involves depositions of his or her client or the client's family. If we assume the client spends on average 32.7% of the time spent by the lawyer, and that the client's wage is $17.81, we obtain a time cost for the client in 2016 of $295.27. If the client obtained two-thirds of the recovery, he or she would have $35,314. Clearly, there is a much wider margin of profit for the client than the lawyer, and if the tort victim is willing to consider a lawsuit, the marginal decision of the lawyer will almost always determine whether the case is filed.

65. The Civil Litigation Research Project. See Kritzer et al. (1985).

66. Id. at 266, 258.

67. May 2016 National Occupational Employment and Wage Estimates, Bureau of Labor Statistics.

68. Id.

69. Trubek et al. (1983), at 91.

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