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NO-FAULT AND THE COURTS

by BENJAMIN S. MACKOFF*

The wide appeal of no-fault insurance legislation is inspired by the belief on the part of the general public that, in some extraordinary way, its adoption will relieve a wide variety of social ailments. Not only will no-fault finally provide automobile accident victims with timely and adequate compensation, but such benefits will be possible at a reduced premium. By providing first-party benefits on a no-fault basis, time-consuming disputes over liability will be obviated. The resulting reduction of the need to pursue relief by filing a lawsuit, will relieve much of the congestion in our nation's courts.

Whether no-fault is as miraculous a panacea as its promoters tell us remains to be seen. While it may be difficult to predict with accuracy the impact of such legislation on compensation and insurance costs, some rather "safe" predictions may be made regarding the impact of no-fault on the courts. To the extent that a particular no-fault scheme precludes or limits access to the courts for the recovery of losses arising out of automobile accidents, the volume of litigation in that jurisdiction will be proportionately reduced. To the extent that such plans remove accident claims from the courts, so also will the shocking number of abuses generated by the fault system be mitigated. The impact of no-fault automobile insurance legislation on the courts will be analyzed in terms of the traditional "fault system" it seeks to reform and the specific provisions of the major no-fault plans proposed to date.

Historically, courts have provided the only available forum for the recovery of damages in automobile accident cases. But unless a claimant could prove an alleged wrongdoer at fault, there was no possibility of recovery. Fault was measured by reference to a standard of negligence used to determine liability in horse and buggy days. The driver had a duty to operate his vehicle in a reasonable and prudent manner. Failure to do so gave the injured party a right to recover in tort for damages against the driver. While a few jurisdictions experimented with alternate forums for determining liability, such as arbitration

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panels, none abandoned the notion of fault. These schemes not only retained fault as a prerequisite to recovery, but also permitted access to the courts on appeal to assure that the standard was correctly applied. Fault was held to be so basic to our system of justice that only a court could be trusted ultimately with such a determination.

The advent of the automobile posed no immediate difficulties for courts. As a matter of convenience, traditional rules of negligence were applied to accident cases involving automobiles just as they had been applied to horses and hansom cabs. But the greater volume of litigation soon made it apparent that accommodating the automobile to the traditional fault system was not quite as simple as it had seemed at first. The automobile was a very much more complex phenomenon which presented new difficulties for the determination of fault and the assessment of damages. Automobiles, by their very nature, were harder to control through the driver's own attentiveness. Further, defective design, irregular maintenance, poorly planned highways and lack of traffic signals contributed as much to causing automobile accidents as simple negligent driving. Moreover, the automobile, unlike the horse and buggy, possessed a tremendous potential for destructiveness. Few individual car owners felt confident of their own ability to bear the financial burden of accidents that statistically would involve nearly all drivers within their lifetimes. As a consequence, most drivers turned to some form of insurance to help them shoulder the financial risk of driving. Insurance carriers soon became the real party at interest in a majority of the automobile accident cases. This development weakened one of the basic tenets of the fault system: namely, that by forcing the wrongdoer to pay for his negligence, the fault system was a deterrent to bad driving.

While some types of insurance coverage — medical, collision and comprehensive health benefits were always on a no-fault basis, recovery for the more substantial bodily injury and property damage was anchored to the third party, fault system. Recovery was not simply a matter to be resolved by applying the terms of the insurance contract; it required proof of liability of the third party satisfactory to a court of law in all but the cases where liability was undisputed. Even where liability was undisputed, the damage question was left to judicial determination. Furthermore, for financial reasons, it was more practical for insurers to leave both the liability and the damage questions to the courts in all but the most obvious cases.

While the volume of litigation generated by the fault sys-

tem was manageable, the system remained unassailed. Courts were able to accommodate automobile accident cases while providing adequate and speedy justice in other areas of the law. But as more and more automobiles crowded the highways,¹ it was inevitable that there would be a substantial increase in the number of accidents with a corresponding increase in automobile accident claims. Soon thereafter, improved methods of reporting court statistics revealed to the general public what judges, court administrators, lawyers, insurers and countless accident victims already knew — namely, that the nation's courts were deluged with automobile accident litigation.

The greater volume of cases placed new pressure on procedures, facilities and personnel accustomed to a slower pace of litigation. Lengthy pre-trial discovery, protracted negotiation and the time-consuming jury selection process contributed to delays even before the case was assigned to a judge. By the mid-1960's, the delay for litigants seeking trial in metropolitan courts was measured in years.² Expanded trial facilities, more judges and streamlined procedures enabled a few of the more flexible court systems to keep up with the rising tide of accident litigation. Other court systems, unable to add judicial manpower to meet the greater volume of litigation, simply shifted judges to personal injury calendars. This was usually accomplished at the expense of other critical areas of litigation, such as criminal or juvenile, matters less amenable to delay in the judgment of the public as well as the professionals.

Some jurisdictions were without even the most basic tools necessary to reduce mounting backlogs. Court appropriations, normally a neglected item, were subordinated to other pressing needs in the formulation of state and local government budgets. In most cases, the forthcoming allocations were insufficient to allow the judiciary to respond to the backlog problem with modern management tools, such as communications systems and data processing, among others. Budget requests of several trial court systems were severely reduced by approving bodies.³ In

¹ 117 CONG. REC. §1835 (daily ed. Feb. 24, 1971). The Federal Highway Administration estimated that by 1970 there were 11,491,705 registered motor vehicles in the United States. The 1970 figure represented an increase of approximately 65 per cent from 1960. 1971 U. S. DEPT. OF COMMERCE, CENSUS BUREAU, 1971 POCKET DATA BOOK 280.

² 117 CONG. REC. §1839 (daily ed. Feb. 24, 1970). The average delay in settling claims over \$2,500 is 19 months. In many cities it takes more than two years for trial of a civil suit. The backlog, or the waiting time for trial is variously calculated from the date of filing the complaint itself, the date of the answer or the date when all parties indicate their readiness to go to trial. The "backlog" is often a misleading statistic since it does not take into consideration the overwhelming majority of cases which are terminated prior to trial.

³ 36 BROOKLYN L. REV. 342, 354, n. 15 (1970).

certain jurisdictions,⁴ the issue of whether the appropriating body had the authority to deny reasonable requests for funds from courts raised serious questions regarding separation of powers.⁵

The inability of the courts to deal with the greater volume of litigation in an expeditious way created not only new delays, but embarrassing abuses of the judicial process which undermined public confidence in the legal system. Delay was fast becoming an embarrassing contradiction to our entire notion of justice.

Delay, seemingly inherent to the litigation process, spawned new abuses unique to the personal injury business. The expense of defending suits over a protracted period made it practical for insurance companies to settle so-called "nuisance claims" where the injuries were minor and the liability dubious. Overpublicized big verdicts encouraged the pursuit of questionable claims where injuries were serious. A litigation-conscious public with exaggerated expectations was easy prey for the unscrupulous attorney adept at building a case.

Undeterred by canons of professional ethics, lawyers solicited cases either personally or through agents popularly known as "ambulance chasers." They signed up accident victims by promising fantastic sums even while the would-be client was stretched out on the street or en route to emergency treatment. These same lawyers induced police officers and firemen, often the first ones to arrive at the scene of the accident, to direct them to the victim for a fee and even color their testimony if it became necessary. "Ambulance chasers" induced some clients and doctors to exaggerate injuries and inflate, or approve inflated bills. Accidents were contrived and injuries were fabricated to defraud the unwary insurance company or the unsuspecting defendant.

In the opinion of many observers, ambulance chasing and related corruptions of the plaintiff's bar were linked to the "contingent fee." Under that system, the victim's lawyer was paid a fee contingent on the amount of money recovered in the case. In certain instances, the plaintiff's attorney supported the accident victim pending settlement of the suit, a practice clearly

⁴ *Id.* at 353.

⁵ In *Carroll v. Tate*, 442 Pa. 45, 274 A.2d 193 (1971), the right of the Philadelphia Court of Common Pleas to mandamus funds was upheld where the items requested were reasonable. The case had dual significance for court administration: (1) The Judiciary has inherent power to determine what funds are reasonably necessary for its efficient operation and (2) it has the power to compel the executive and legislative branches to provide these funds after the reasonable request has been reduced or eliminated.

in violation of the canons of professional ethics. This discriminated in favor of the lawyers who were able to finance their clients. When an award was forthcoming, the lawyer extracted his fee before any compensation was paid to the victim. That fee averaged about 33 per cent of the award nationally.⁶

The personal injury lawyers, who had sound economic reasons for controlling as many of these cases as possible, did not desire an early disposition. If he accumulated a certain number of dispositions, his fees might be greatly diminished by income taxes. Also, the prudent lawyer always wanted an inventory of pending cases for the proverbial rainy day.

Just as the plaintiff with a questionable claim had no reason to hasten the day of reckoning, the culpable defendant counted delay as one of his tools to defer the judgment cost. Frequently, the actual defendant was the insurance company — through a subrogation or indemnification contract in the insurance policy. Delay permitted postponement of claim payments and building interest on reserves.

In some instances, defendants in personal injury cases found themselves liable personally, despite the fact that they carried insurance. Resourceful but unscrupulous investors, eyeing large sums spent each year on casualty insurance premiums, organized insurance companies for the sole purpose of paying themselves high salaries while contesting claims, so as to milk the company until it was insolvent. Instead of being insured against a claim, defendant was obliged to pay the judgment out of his own pocket, or even be assessed an additional one year's premium to pay for claims against others defrauded by the same insurer. Even if the severely injured plaintiff were finally awarded an adequate judgment, he now discovered that it was worthless, since the uninsured defendant had insufficient funds to pay even a portion of the judgment.

The list of abuses that grew up with the fault system was legion, but the more agonizing fact was that the quality of justice rendered to the public was disappointing. As President Nixon pointed out in his speech before the National Conference on the Judiciary convened at Williamsburg, Virginia: "Justice delayed is not only justice denied — it is also justice circumvented, justice mocked and the system of justice undermined."⁷ By the time a case finally went to trial, the delay of up to several years caused a deterioration of evidence, lapsed memories and contributed to

⁶ J. O'CONNELL, *THE INJURY INDUSTRY* 37 (1971).

⁷ *Wall Street Journal*, Apr. 21, 1971 at 22, col. 1.

the unavailability of witnesses. Brittle legal rules, such as the rule of contributory negligence which required the successful plaintiff to prove the wrongdoer's negligence as well as his own freedom from contributory negligence, made proof under tricky rules of evidence, time-consuming and complex. Other than courts prodding lawyers to reach a speedy disposition, there was generally no real effort by any of the participants to speed justice along because there were no real incentives offered by the system. Some courts even refused to hurry matters along, preferring to wait until the lawyers indicated their readiness to proceed to trial.

Furthermore, the social costs of maintaining such a system were great not only to the uncompensated victim but the general public as well. That system not only fostered corruption and abuse in the administration of an often questionable brand of justice, but it did a shockingly inadequate job of fulfilling its principle purpose — compensating the victim.

Various studies sketched the pattern of gross overpayment of small claims and underpayment of large ones. The United States Department of Transportation's study revealed that sixty per cent of those who suffered more than \$10,000 in measurable economic loss received nothing in fault claims. Thirty per cent of that number received less than fifty per cent of their measurable economic loss. In contrast, none of those victims with less than \$1,000 in economic loss received less than half their losses. Fourteen per cent of that number received four times their loss.⁸ Even more startling was the report of the American Insurance Association that victims with under \$100 of economic loss who retained a lawyer received an average of seven times their economic losses.⁹ The fault system was simply failing to provide equitable compensation for automobile accident victims.

Just as the costs of premiums for the automobile owner were high, so were the costs of court administration to the taxpayer. While it is difficult to assign with precision a price for maintaining the courts for auto claims purposes, it has been estimated that it costs \$250 per hour to try a jury case before adding attorneys' fees and other legal expenses. That cost is hardly less for non-jury time. If one considers that many courts throughout the country assign a substantial portion of their trial

⁸ United States Department of Transportation, *Economic Consequences of Automobile Accident Injuries*, Report of the Westat Corporation, vol. 1, table 25fs, p. 235.

⁹ Am. Ins. Assn., Report of the Special Committee to Study and Evaluate the Keeton-O'Connell Basic Protection Plan and Automobile Accident Reparation, Exhibit X (1968).

bench to the processing of automobile accident cases, one may appreciate the handsome contribution which the taxpayer makes.

And what does the taxpayer get in return for his tax dollar? Certainly not an orderly and effective litigation of actual disputes. It is a rather distressing symptom of the abuses now ensnaring the courts that a very low ratio of cases is actually decided by a trial of the issues. In some courts that ratio is as low as two or three per cent. This means that the court is being used merely as a forum for the claims adjusting bargaining process. The judge becomes an umpire between two parties who do not really seek a determination of the legal matters involved. There is little question but that the taxpayer is subsidizing insurance companies to negotiate its own claims within public facilities and on judge time.

All this occurs at a time when new and important matters are being thrust upon the courts for decision. Expanding constitutional requirements of due process have added new aspects to criminal proceedings and demand a more formal trial in juvenile cases. Third party and class actions are now commonplace in many areas of civil litigation. New remedies available for consumer and environmental protection, as well as for welfare recipients and apartment dwellers, represent new demands on court time.

If so many of the inefficiencies and inequities of the present fault system could be traced to reliance on the courts for the settlement of disputed claims, then the solution is to remove the question of liability in automobile accident litigation from the courts. This would leave only the extent of damages for the courts to determine. Many states have attempted to do just this by the introduction of no-fault insurance plans.

What follows is a brief review of the major no-fault legislation both proposed and in effect. They are discussed with a view toward their projected impact on the courts of this nation and assessed in terms of their probable success in ameliorating the persistent problems of court congestion and abuses of the judicial process. The ability of individual plans to provide adequate and timely compensation, as well as reduce mounting insurance costs is a question that is better left to the expertise of others. This is not to say, however, that the compensation and cost problems, while basically economic in nature, do not have an influence on the administration of justice in a significant but albeit indirect way.

State no-fault plans are best treated in the chronological order of their introduction; each successive plan was built on the

basic theory constructed by Professors Keeton and O'Connell in 1965.¹⁰ The original Keeton-O'Connell Plan provided complete reimbursement of the accident victim on a no-fault basis up to a certain specified amount. In the original plan that amount was \$10,000.

As adopted in Massachusetts under that State's Personal Injury Protection Plan, that threshold amount was \$2,000. That is, a total of up to \$2,000 is payable in an injury case for reimbursement of medical expenses and loss of income, regardless of fault.¹¹ If medical expenses stay under \$500, there is no legal recourse for pain and suffering unless one of a specified set of injuries has occurred. This feature was recently upheld by the Supreme Judicial Court of Massachusetts in *Pinnick v. Cleary*.¹² Payment for pain and suffering could be recovered by suit where legal liability was established in court against another person for his negligence. Medical and wage loss payments over \$2,000 also remained under negligence law.

While the Massachusetts bill was a definite improvement over the present fault system, its impact was severely mitigated because the right to pursue fault claims was preserved for so many cases. The danger, according to Professor O'Connell, was:

. . . that sooner or later, they will increase [the number of fault claims] to the point where we will approach that perilous situation of having both fault and no fault applicable to the greater mass of smaller and medium-sized claims, with the corresponding risks of corruption and skyrocketing costs.¹³

The \$500 Massachusetts threshold can be easily reached at today's high medical costs by merely placing the claimant in the hospital for a few days and running him through a battery of tests. The Massachusetts experience in its first year of operation, however, has been hopeful in spite of its limitations. The Commissioner of Insurance in that State reported a drastic reduction in the filings of personal injury claims.¹⁴

The National Association of Independent Insurers (NAII) Plan retains the present liability system, except that it permits first-party payments of the first \$2,000 of medical payments and the first \$6,000 of lost wages.¹⁵ If negligence is a factor in an automobile accident, subrogation is available to the company

¹⁰ R. KEETON & J. O'CONNELL, BASIC PROTECTION FOR THE TRAFFIC VICTIM (1965).

¹¹ MASSACHUSETTS STATUTES OF 1970, ch. 670, §2.

¹² 271 N.E.2d 592 (1971).

¹³ THE INJURY INDUSTRY, note 6 *supra* at 116.

¹⁴ *Id.* at 120.

¹⁵ NO-FAULT: MORE QUESTIONS THAN ANSWERS, 6-7 (2 AIDE No. 3) (1971).

making payments. A claimant who receives first-party payments, were he also to recover from the wrongdoer by suit, would have the amount of the "quick no-fault payment" deducted from such a recovery. Recoveries for pain and suffering are permitted if the other party is at fault, but the amount of such recoveries is limited to a percentage of medical bills.

The American Insurance Association (AIA) Plan eliminates recourse to the current legal liability system entirely, and as such, promises to have the most salutary effect on the problem of court congestion. Insurance coverage is compulsory for measurable economic loss arising out of personal injury, death, or damage to property (other than vehicles). In addition, coverage under this plan includes payments for all loss of earnings and establishes a maximum amount for pain and suffering.

The Hart-Magnuson Bill (S.945) is a compulsory Federal plan requiring minimum state standards for compensation of persons injured in an automobile accident for all medical expenses attributable to that accident. The original proposal introduced in February, 1970, was extensively revised following ten days of hearings before the Senate Sub-committee on Anti-Trust and Monopoly last spring. Subject to revisions, every single automobile owned would be required to purchase a basic policy covering his own losses and those of any other driver or passenger in his vehicle as well as those of any pedestrian injured by his vehicle. Moreover, every insurance company would be required to insure any licensed driver who applied unless he failed to pay premiums or had his license revoked. The basic policy would pay the medical and rehabilitation costs of the driver, his family, his passengers, and his victims other than occupants of the other car, who would receive payments from the other driver's insurance. All lost wages up to \$1,000 a month would be paid until the injured person could return to work. Household services which the victim would have performed were he not injured would also be paid up to a certain limit. Property damage to all but another vehicle in use is included on a first-party basis. Pain and suffering losses suffered by an occupant of the policy-holder's vehicle or a pedestrian struck by it would be paid if that person were not the owner of a vehicle or a member of the owner's family. Optional third-party coverage permits suit for recovery of pain and suffering according to existing state law, if the victim does not feel he has been adequately compensated by his own insurer. Such suits, however, could not be filed until after payment for net economic losses had

been completed, or three years after the injury, whichever occurred first.

Somewhat similar to the Hart-Magnuson Plan is the recent draft bill produced by the National Conference of Commissioners on Uniform State Laws. The measure would provide first-party, no-fault benefits, including all medical rehabilitation expenses and up to \$1,000 per month in lost wages. The proposed bill permits suit if the victim suffered permanent significant loss of body function, including death, permanent serious disfigurement, or an injury resulting in medical expenses exceeding an as yet unagreed upon amount.

The Illinois Extended Personal Injury Protection Plan¹⁶ was to become effective January 1, 1972, but its implementation was enjoined by an adverse ruling in the Circuit Court of Cook County which was upheld on review.¹⁷ The Illinois Plan was to have applied to insurance for private passenger automobiles and certain light utility vehicles.¹⁸ This classification was held to be special legislation under Article IV, Section 13 of the 1970 Illinois Constitution, and therefore void.

The compensation provisions of the Illinois Act provided for the payment of all reasonable medical expenses up to \$2,000, the payment of 85% of all uncompensated lost wages up to \$150 per week or a maximum of \$7,800, and for loss of services at a rate of \$12 per day for one year.¹⁹ The trial court held this section invalid because the general damages recoverable by an injured party were based solely upon his expenses for medical services. The court found that substantial differences existed between the cost of medical services provided for the poor and for the wealthy, and also between different geographical areas of the State.

The plan offered no compensation for pain and suffering, although in damage suits based on tort liability brought to recover sums in excess of \$2,000, recovery was available for pain and suffering, but limited to one-half the amount of the medical expenses up to \$500 and an amount equal to the actual medical expenses above \$500. Recovery in such suits was subject to being reduced by the amount paid to the victim by his own insurance company.

The arbitration provisions of the Illinois Act were of special interest to the reviewing court. Section 609 provided for com-

¹⁶ ILL. REV. STAT. ch. 73, §1065.150-163 (1971).

¹⁷ *Grace v. Howlett*, 51 Ill. 2d 478, 283 N.E.2d 474 (1972).

¹⁸ See note 16 *supra*.

¹⁹ *Id.*

pulsory arbitration of claims in counties with a population in excess of 200,000 persons, where the amount involved was \$3,000 or less. The question of whether such a requirement violated the right to trial by jury was raised but not resolved by the Illinois Supreme Court. However, this provision was found to violate Section 9 of Article VI of the 1970 Illinois Constitution which has been interpreted to prohibit trials de novo, and Section 14 of Article VI which outlawed fee officers in the judicial system.

Although the Illinois No-Fault Act has been declared unconstitutional, Illinois insurers continue to honor their obligations under the quick payment provisions. The rationale for such a course of action is that the no-fault policy is simply a private contract which requires no legislation to effectuate. At present, there still remains complete access to the courts for any type of claim and neither the arbitration provisions nor the limitation on pain and suffering recovery are in effect. Illinois legislators are currently drafting a new bill designed to cure the constitutional defects of the original measure.

Several other states have turned to variants of the no-fault concept recently. Florida has enacted the Automobile Reparation Reform Act, effective January 1, 1972.²⁰ It is somewhat more extensive than the Massachusetts Plan in that it provides a higher threshold of no-fault benefits (\$5,000) and eliminates fault claims for pain and suffering unless medical bills exceed \$1,000, and there is a no-fault provision for property damage. Delaware has recently enacted a no-fault law providing for \$10,000 in first-party benefits, but retaining recourse to the courts for recovery of pain and suffering losses.²¹ Oregon's new law²² provides no-fault benefits of \$3,000 for medical bills and \$6,000 for wage loss, without abolishing fault claims for pain and suffering. Recently, Connecticut²³ and New Jersey²⁴ have passed no-fault laws expected to become operational January 1, 1973. The Connecticut law is nearly identical with the Massachusetts Plan, while the New Jersey law is a weaker version carrying a \$200 threshold amount.

From an overall view of the major trends in so-called no-fault plans, alternative prototypes emerge: The "pure" no-fault, represented by the AIA Plan; the "modified" no-fault exemplified by the Illinois, and to a lesser extent the Massachusetts, Florida,

²⁰ O'Connell, *The Injury Industry* at 121, note. Chicago Tribune, Oct. 5, 1970 at 14, col. 3.

²¹ MASS. GEN. LAWS ANNOT. ch. 90, §34a (1970).

²² ORE. LAWS ch. 523 (1971).

²³ P.A. 273 (1972). (4 Conn. Leg. Serv. at 567-80 (1972)).

²⁴ N.J. LAWS ch. 70 (1972).

Delaware, Oregon, Connecticut and New Jersey Plans. One of the more significant factors insofar as the impact of these plans on the courts is the manner in which pain and suffering is handled. To the extent that recourse to the fault system for the recovery of pain and suffering losses is precluded, the introduction of no-fault legislation will substantially reduce the volume of automobile accident litigation. This is particularly true in those areas where measurable economic loss is negligible but where claims are inflated on the basis of subjective symptoms whose worth is determined by the sheerest of speculations. Under the "pure" no-fault prototype, there is no compensation for such intangible injuries and there can be no recovery by way of a suit for damages. Opponents of no-fault have criticized this aspect of the AIA and the Keeton-O'Connell Plan as being not only inequitable but unconstitutional. The inequity is that the victim may be unable to collect for disabilities which may recur long after he leaves the hospital and returns to work as well as for the anguish and hardship which accompany the injuries. The constitutional argument is that by denying victims recourse to the courts they are being deprived of a vested property right, the right to full recovery in tort. But since most claims are paid for minor injuries rather than to the seriously hurt, the elimination of the lawsuit for pain and suffering will have the effect of holding many claims within the limits set for first-party recovery on a no-fault loss.

The personal injury plaintiff's bar urges that limitation on the recovery of pain and suffering will force many lawyers to refuse cases unless paid in advance, which most clients are unable to do. But the answer to this is that the elimination of petty claims for pain and suffering may allow insurance companies to pay, on a no-fault basis and in addition to out-of-pocket losses, at least some compensation to the permanently disabled. If, however, this type of coverage proves too expensive, there is a strong argument in favor of preserving the right to sue. A sensible compromise embodied in the various "modified no-fault" plans is to eliminate the pain and suffering claim for the smaller suits as measured by the dollar amount of medical expenses and allow recourse to the courts to recover for pain and suffering, limiting that recovery to a percentage or multiple of the out-of-pocket or medical expenses for the larger claims.

Even modified no-fault plans will certainly reduce the number of minor claims filed in our courts. But that still leaves the crux of the problem — those personal injury claims arising out of automobile accidents when the damage is substantial. At present, the bulk of these claim disputes involves the question of

liability. Improved administrative techniques implemented through court rule may be able to screen out the more frivolous claims, but these matters are better settled on a first-party compensation basis which obviates the liability dispute. Any question as to the amount of payment could then be handled by the courts on a contract rather than on a tort basis. The courts would then be relieved of the greatest portion of these lawsuits and the victim would be better compensated on a timely basis and at a reduced cost to insurers, to policy holders and to the tax-paying public.

The time has come for new and bold measures to compensate automobile accident victims which allow the courts to more effectively serve the public. Perhaps, the result of the patchwork state reform labeled "no-fault" will be federal legislation.

Americans are a very mobile people. Interstate highway travel is commonplace on a daily basis. Americans change residences frequently from state to state. Congress has seen fit to legislate certain minimum highway safety standards to minimize the risks of driving. Surely then Congress has the authority to set down minimum standards of no-fault compensation for accident victims to mitigate the harsh consequences of accidents that do occur. In such a way, not only can we replace the present system of compensation which fails to serve the ends for which it was created, but we can also redirect the court's attentions and resources to the disposition of litigation more vital to our liberties.

CBA Proposed "No-Fault" Bill

ARTICLE XXXV

ILLINOIS INSURANCE CODE

An Act to add Article XXXV to the "Illinois Insurance Code," approved June 29, 1937, as amended, and to repeal Section 134a of said Code.

Be it enacted by the People of the State of Illinois as follows:

ARTICLE XXXV: COMPENSATION
OF AUTOMOBILE ACCIDENT VICTIMS

INDEX

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Exhibit "A"

SECTION I. Purposes of the Act.

The purposes of the legislative goals underlying this Article are as follows:

1. To guarantee first and third-party motor vehicle insurance subject to certain limitations and exceptions.
2. To provide medical and hospital benefits promptly without regard to fault subject to certain limitations and exceptions.
3. To reduce congestion and eliminate backlog in the Circuit Court of Illinois.

SECTION II. Definitions

As used in this Act —

1. The term "motor vehicle" means any vehicle driven or drawn by electrical or mechanical power which is manufactured primarily for use on the public streets, roads, or highways except any vehicle operated exclusively on a rail or rails.
2. The term "owner" means a person who holds the legal title to a motor vehicle registered in Illinois; except that in a case of a motor vehicle registered in Illinois which is the subject of a security agreement, or lease with an option to purchase, with the debtor or lessor having the right to possession, such term means the debtor or lessee.
3. The term "insurer" means any person or governmental entity engaged in the business of issuing or delivering motor vehicle insurance policies within the State of Illinois.
4. The term "occupant" means any person situated within a motor vehicle whether as a driver or passenger.
5. The term "pedestrian" means any person not situated within a motor vehicle who is injured as the result of an accident involving a motor vehicle.
6. The term "self-insurer" with respect to any motor vehicle means a person who has satisfied the re-

quirements of Section III of this Act together with the related provisions cited therein.

7. The term "operation, maintenance, and use" when used with respect to a motor vehicle includes loading or unloading the vehicle but does not include conduct within the course of a business of repairing, servicing, or otherwise maintaining vehicles unless such conduct occurs outside the premises of such business.
8. The term "motor vehicle accident" means an accident arising out of the operation, maintenance, or use of a motor vehicle.
9. The term "accidental harm" means bodily injury death, sickness, or disease caused by a motor vehicle accident while in or upon or entering into or alighting from, or through being struck by a motor vehicle or object drawn or propelled by a motor vehicle.
10. The term "death" means accidental harm resulting in death within one year after a motor vehicle accident.
11. The term "injury" means accidental harm not resulting in death.
12. The term "hospital and medical expenses" means all appropriate and reasonable expenses necessarily incurred for medical, hospital, surgical, professional nursing, dental, ambulance, prosthetic services, psychiatric services, and physician and occupational therapy and rehabilitation. The term "hospital and medical expenses" also means all appropriate and reasonable expenses necessarily incurred for any non-medical treatment and care rendered in accordance with a recognized religious method of healing.
13. The term "without regard to fault" means irrespective of fault as a cause of injury or death, and without application of the principle of liability based on negligence.
14. The term "director" means the Illinois Director of Insurance.

SECTION III. Certification of Financial Responsibility

A. After the effective date of this Act, no owner shall register any motor vehicle within this State, nor shall any person knowingly operate or use a motor vehicle registered in Illinois within this State unless and until the owner of such motor vehicle has certified to the Secretary of State that such motor vehicle is insured under a policy of insurance which meets the

requirements of Section IV of this Act, and also complies with such reasonable rules and regulations as the director may promulgate, except that an owner may qualify as a self-insurer provided that such owner offers such security, bond or other evidence of security similar to the insurance provided under Section IV. See Sec. 3-101 and 7-201 of Chapter 95½ and Art. XXIX-IX, XXII - XXX of Chapter 73 and also duties of Secretary of State.

B. No owner or other person shall operate a motor vehicle in this State without carrying with him written evidence that he has the insurance coverage required by Section IV.

C. Any owner or other person who fails to comply with subdivision (A) of this section shall be subject to fine of up to \$500 and to imprisonment for a term up to three months.

SECTION IV. Insurance Requirements

A. Each policy of motor vehicle insurance issued in the State of Illinois must be issued by a company approved by the director to do business in Illinois and in a form approved by him, and each such policy must contain the following provisions:

1. Provide for payment to the owner, occupant, or pedestrian without regard to fault of certain losses which are enumerated below resulting from any motor vehicle accident occurring anywhere within the United States, its possessions and territories, and Canada, and arising out of the operation, maintenance, and use of a motor vehicle.
2. Provide for prompt payment to the owner, occupant, or pedestrian of all his reasonable and necessary hospital and medical expenses up to the sum of \$2,000 per person.
3. Provide for prompt payment to the owner, occupant, or pedestrian of all lost salary, wages, and income up to \$7,500 per person at the rate of no more than \$150 per week, or 85% of such lost salary, wages, and income, whichever is smaller.
4. Provide for prompt payment to the owner for the reasonable and necessary cost of any repair, replacement and loss of use of the registered motor vehicle.
5. If such owner, occupant, or pedestrian dies within one year of the motor vehicle accident, provide for the prompt payment to a surviving spouse, or, in the event there is no surviving spouse, to surviving children depending on the decedent for support, of a

survivor's benefit equal to 85% of the average weekly income the deceased earned during the 52-week period immediately preceding the accident subject to a limit of \$150 per week for a period of 260 weeks. Payments to a surviving spouse may be terminated in the event such surviving spouse dies leaving no surviving children or remarries.

6. Provide for prompt payment to the estate of the owner, occupant, or pedestrian who dies within one year of the accident of funeral expenses in an amount not to exceed \$1,000.

B. Every such policy of insurance shall also contain the following coverages:

1. Bodily injury liability coverage in an amount not less than \$25,000 per person and \$50,000 per accident.
2. Property damage coverage in an amount not less than \$5,000.
3. Uninsured motorists' coverage in an amount not less than \$10,000 per person and \$20,000 per accident.

C. Every such policy of insurance may offer higher limits and additional coverages to such owners of motor vehicles.

D. Every such policy of insurance to be purchased by every owner of a motor vehicle registered in Illinois must provide that it is noncancellable for a period of three years from the date of its issuance providing the policyholder continues to have a valid driving permit and pays his required insurance premiums when due.

E. Any such policy of insurance may provide that no benefits will be payable to any injured person covered under the policy where such injured person's conduct contributed to the injury in any of the following ways:

1. intentionally causing injury to himself;
2. while under the influence of intoxicating liquor or narcotic drugs;
3. operating a motor vehicle while his license is suspended or revoked;
4. operating a motor vehicle upon a bet or wager or in a race;
5. while seeking to elude lawful apprehension or arrest by a police officer;
6. while operating or riding in a vehicle known to him to be stolen;

7. while in the commission of a felony.
8. The company may provide such other exclusions as may be approved by the director as consistent with public policy.

SECTION V. Tort Limitation

No action arising out of the operation, maintenance or use of a motor vehicle within this State may be commenced by a person seeking damages as a result of bodily injury, sickness or disease unless the reasonable and necessary hospital and medical expenses reasonably required to treat such injury, sickness or disease is determined to be in excess of three hundred dollars, said sum of three hundred dollars being measured in terms of the average reasonable cost reasonably required in Illinois to treat an injury, sickness or disease of the type incurred and during the period involved after elimination of any disparity in such costs occasioned by geographical differences and/or by excessive or exorbitant charges; provided, *that if* (1) death ensues or (2) if such injury or disease consists in whole or in part of loss of a body member or bodily function, or in whole or in part of serious disfigurement, then an action for tort damages based on fault will lie.

SECTION VI. Deduction of Certain Collateral Benefits

The amount of any payments received by any person injured in a motor vehicle accident from Workmen's Compensation, as disability payments under social security, or from medicare shall be deducted from any first-party benefits that may be payable to such person under Section IV A and C hereof.

SECTION VII. Fraudulent Claim

In any claim or action arising out of the operation, maintenance or use of a motor vehicle, any person who directly or indirectly (1) obtains or attempts to obtain, from any other person or any insurance company in the State, either as policyholder or a claimant, any money or other thing of value by falsely or fraudulently representing that such person is injured or has sustained an injury or damage to property, for which money may be paid by way of compensation for medical expenses incurred, wage loss sustained, or damages determined to be due as pain, suffering, inconvenience or damages of the same or similar nature or damages to such property, or (2) makes any statement, produces any document or writing or in any other way presents evidence for the purpose of falsely and fraudulently representing any injury or damage to property or exaggerating the nature and extent of such injury or damage, or (3) cooperates, conspires or

otherwise acts in concert with persons seeking to falsely and fraudulently represent an injury or damage to property or exaggerate the nature and extent of such injury or damage to property, may, upon conviction, if the sum so obtained or attempted to be obtained is less than \$100, be fined not more than \$500 or imprisoned in a penal institution other than the penitentiary for not more than three months, or both. If the sum so obtained or attempted to be obtained is \$100 or more, such person may, upon conviction, be fined not less than an amount equal to 3 times the sum or sums so obtained or attempted to be obtained or imprisoned for not more than three months, or both.

SECTION VIII. Prompt Payment of Benefits

A. Payment of the benefits set forth under Section IV of this Article must be made promptly after valid proof of loss has been submitted to the company. The existence of a potential cause of action in tort by any recipient of the benefits prescribed in this Article does not obviate the company's obligation to promptly pay such benefits.

B. Payments under the coverages provided under Section IV of this Article must be made periodically on a monthly basis as expenses are incurred. Benefits for any period are overdue if not paid within 30 days after the company has received reasonable proof of the fact and amount of expenses incurred during that period. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 30 days after such proof is received by the company. Any part or all of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within 30 days after such proof is received by the company. In the event the company fails to pay such benefits when due, the person entitled to such benefits may bring an action in contract to recover them. In the event the company is required by such action to pay any overdue benefits, the company must, in addition to the benefits received, be required to pay the reasonable attorney's fees incurred by the other party. In the event of a willful refusal of the company to pay such benefits, the company must pay to the other party, in addition to other amounts due the other party, an amount which is three times the amount of unpaid benefits in controversy in the action.

SECTION IX. Subrogation and Inter-Company Arbitration

A. If an injured person has received first-party benefits from his insurer as provided aforesaid, he shall promptly repay to such insurer out of any tort recovery for such injuries a sum equal to such first-party benefits paid to him and without any

cost or charge to such insurer. The insurer paying such first-party benefits shall have a lien on any tort recovery to that extent but it shall not have the right to institute litigation in the name of its insured against any alleged wrongdoer on account of such injuries.

B. Every company licensed to write insurance in this State under Class 2 or Class 3 of Section 4 of this Code, is deemed to have agreed, as a condition of doing business in this State or maintaining its license after the effective date of this Article, that (1) where its insured is or would be held legally liable for damages or injuries sustained by any person to whom the benefits provided in Section IV of this Article have been paid by another company, it will reimburse such other company to the extent of such benefits, but not in excess of the amount of damages so recoverable for the types of loss covered by such benefits, or in excess of the limits of its liability under its policy; or (2) where its insured is or would be held legally liable for property damages or destruction sustained by any person to whom payment has been made by another company, it will reimburse such other company to the extent of such payment, but not in excess of the amount of damages so recoverable for the types of loss covered by such insurance or in excess of the limits of its liability under its policy; and (3) that the issue of liability for such reimbursement and the amount thereof must be decided by mandatory, binding inter-company arbitration procedures approved by the director.

C. Any evidence or decision in the arbitration proceedings is privileged and is not admissible in any action at law or in equity by any party.

SECTION X. Medical Disclosure

Any person who claims damages for bodily injury, sickness or disease, arising out of the operation, maintenance or use of a motor vehicle, from another person, or benefits therefrom under an insurance policy must upon request of the defendant or company from whom recovery is sought, submit to physical examination by a physician or physicians selected by the defendant or company as may reasonably be required and must do all things reasonably necessary to enable the defendant or company to obtain medical reports and other needed information to assist in determining the nature and extent of the claimant's injuries and the medical treatment received by him. If the claimant refuses to cooperate in responding to requests for examination and information as authorized by this Section, evidence relevant to such non-cooperation is admissible in any suit filed by the claim-

ant for such damages, or for benefits under any insurance policy. A copy of any medical report made of such physical examination must be forwarded to the person examined.

SECTION XI. Severability

If any provision of this Article or the application thereof to any person or circumstance is held invalid, such invalidity does not affect other provisions or applications of this Article which can be given effect without the invalid application or provision, and to this end the provisions of this Article are declared to be severable.

SECTION XII. Effective Date

This Amendatory Act of 1972 shall become effective on January 1, 1973.

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