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Managed Care Liability

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My talk tonight is about the liability of health care organizations under the official title of "Managed Care Liability." This issue has frayed nerves and raised tempers. It has been the source of a tempestuous debate that has generated more heat than light. But however unsound individual arguments may appear, the debate itself will not have small or insignificant causes. To analyze the question one has to look for key distinctions in order to ferret out fundamental errors. The rival positions cannot be both correct, but they can be internally consistent, such that the identification of one key issue will organize the entire debate that follows.

In searching for that central issue, it is important to recognize that no one writes on a blank page. For every great public policy debate of today, there is some antecedent dispute that offers instructive parallels and perhaps ominous warnings of what may happen in our immediate future. Consequently, to resolve a contemporary dilemma, it is instructive to look back at earlier disputes of equal bitterness and equal futility to extract the wisdom they hold for the present.

Industrial Accidents. Quite frequently workers were injured on the job. Sometimes the loss was a pure accident; sometimes it was attributable to the negligence of the worker himself. On other occasions it was the negligence of a fellow employee, and on still other occasions the fault lay with the employer in the provision of equipment for the workplace. Owing to the high rate of accidents in the railroad, mining and manufacturing sectors, the question of the employer's liability for these accidents was one of the main political issues at the time. In which instances, or rather for which accidents, could the employee sue the employer, and if so, why? Those who sought to hold the employer broadly liable invoked the themes of vicarious liability and supervisory negligence. Those who sought to limit the liability of the employer thought in terms of assumption of risk (by the worker upon taking the job) and contractual freedom. The method of integration of these two themes speaks volumes about the soundness of the modern analysis of managed care liability.

To establish the terminological groundwork for both the historical and modern disputes, vicarious liability refers to a system in which one individual, or one organization is held responsible for the acts of another individual or another organization, solely by virtue of the business or management relationships between them, even if the party that is vicariously liable is guilty of no wrongful act or omission. The standard illustration speaks of a railroad whose engineer runs down a pedestrian

standing by the tracks. Does liability only attach to the individual or does it also run to the firm? In the end, the decisive argument for comprehensive vicarious liability was this: if the law allowed a firm to hide behind the misdeeds of individual employees, then that firm would tend to delegate responsibility to insolvent individuals. As they could not be liable, neither could the firm. Consequently, individual liability only yields an overproduction of certain services *and* an over production of accidents because the people exposed to suit will not be financially answerable for the losses they have inflicted on others. Faced with that specter, the 19th century judges rightly rose up in indignation against the possibility of employers deflecting liability to individual workers who were known to be unable to meet their legal obligations. No one who thinks about the subject regards this evasion as a suitable legal response.

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Yet there is one key variation on this theme. Suppose an employer hires two workers, and one of them, in the course of employment, injures the other. The issue is whether the basic regime of vicarious liability that applies to strangers should carry over to disputes inside the firm. This one issue generated a passionate debate. That debate eventually coalesced around the alleged efficiency of market arrangements on the one hand, as opposed to the metaphors of industrial exploitation on the other. A very strong socialist element lined up on the second side of the issue, and in the end the legal response split.

The classical common law, which was more or less efficiency oriented, reasoned somewhat as follows: When one worker decides to work with a second particular employee in the presence of an employer, then the three can so organize their affairs to require full tort liability (pain and suffering, lost wages, medical expenses, death benefits), no liability, or liability somewhere in between. To the extent that the three parties have made some contractual arrangements amongst themselves, the judiciary should not upset that arrangement on either the choice of liability rule or the measure of damages. The judiciary reasoned that the same bias against judicial oversight of private contracts should apply to liability as it does over contracting for tenure of employment or applicable wages. The "classical" judges were willing therefore to adopt a hands-off posture towards contract over industrial accidents.

Now the standard critics of classical common law insisted that this *laissez-faire* attitude was shocking because it gave employers carte blanche to run and hide from all liability. In short, they posited a world in which firms would unilaterally replicate the worst scenario that one could imagine if they could simply refuse to honor their liability to strangers.

Fortunately, the historical record falsifies that prediction. In practice, firms entered into very sophisticated contractual arrangements—particularly in the mines and on the railroads, the most dangerous forms of employment—in which the employees agreed to assume *greater* liability than the common law imposed upon them in exchange for a lower level of damages. In time these private arrangements became the protocol for the workmen's compensation statutes of the next generation.

The lesson we should take from understanding these situations is that the voluntary structuring of liability arrangements, even for parties of vastly different sizes, works quite differently from liability in stranger arrangements. The reason is that the company that wants to exclude liability after the fact of injury is the identical company that will have a heck of a time in attracting workers or patients before the fact. If so, then market constraint tends to falsify the socialist and labor vision of employer dominance, and to vindicate the classical market oriented understandings of employer's liability law.

Sexual Harassment. Fast forward now to another modern case that raises the same issue in slightly different form: sexual harassment. No one wants to write a brief defending the practice of sexual harassment, but if we are looking for an explanation as to why this topic became such a contentious political issue, it would be on account of the judicial and legislative insistence that any individual worker must have a right of action against the employer when a fellow employee has engaged in acts of harassment.

In the alternative, I would argue that the appropriate response would be to allow them to work out their liability relationship by contract. Why? Since an employer has strong incentives to keep and attract workers, it will offer a mixture of contract terms and job opportunities that minimize the risk of harassment, without creating undue costs and complications. The inability to allow for contractual correction of the collective legal judgment about the right rule of liability is the source of most of our difficulties and public recrimination. The law locks parties into an arrangement that gives rise to opportunities for massive litigation.

On to Managed Care. This basic theme carries to the contentious question of liability for managed care organizations, or medical providers, for the injury that their employees are claimed to have done. It is useful to frame the current disputes with a bit of legal history. When I was first addressed the question of medical liability in the mid '70s the topic of concern was the medical malpractice liability of individual physicians and, to a lesser extent, hospitals as well. What was wrong with malpractice liability in the 1970s? The courts had designed a regime of negligence that they thought was so persuasive, they were prepared to apply it across the board. Their decision was in defiance of the logic of private contracting, which always raised the possibility that some other arrangement for dealing with medical mishaps would prove superior in terms of its long-term sustainability.

Cognizant of that point, my early position was that contracts were better able to deal with medical malpractice than any tort-like rule used to protect strangers from aggression. The explanation is very simple. If the law wants to dictate that physicians and hospitals pay people huge dollar awards at the back end for medical mishaps that may or may not be attributable to negligence—even assuming that judges and juries can draw the line between negligence and innocent mistake—somebody is going to have to fund that treasure chest at the front end. And the only people who can fund prospective liabilities are going to be the patients. Therefore, the only way to bring the system into equilibrium is to raise the charges at the front end so as to cover the liabilities at the back end. The moment that is tried, people will withdraw from medical services by deciding that they'd rather not pay at the front end for services that they don't want and for protection they don't need. They cut back, or do without medical care and spend their money somewhere else.

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Now, the medical malpractice problem of the 1970s has not completely disappeared as of late, but it has to some extent declined. Why? I think the answer has very little to do with the wisdom of the law but rather more to do with two issues whose influence we should never underestimate

The first issue is nothing more than good old-fashioned technology. In thinking about the sources of medical liability that took place in the 1970s, it quickly becomes apparent, for example, that anesthesiology was a comparatively primitive discipline relative to today. The number of mishaps

due to insufficient monitoring was probably far greater than it is presently. Today, we can vary the level of anesthetic after the initial injection to gain much better control over patient welfare. No longer do physicians have to make once and for all, all or nothing, guesses about appropriate dosages that are always open to serious mistakes. Naturally, by reducing the incidence of clinical failure modern science also reduces the incidence of liability. In order for any lawsuit to be brought, there must be an injury. Employer's liability is less of an issue today because the workplace has become far safer. Medical malpractice is somewhat more complicated on this score because advanced medical technology allows for more ambitious, and therefore perhaps also riskier, treatments. However, even after we adjust for this fact, it seems likely that the risk of surgery, globally conceived, has decreased. The frequency of medical malpractice claims, as a result, necessarily falls as well. This would remains true even if there had been no change whatsoever in the applicable legal rules, and of course at some level there has been piecemeal reform of the malpractice system that tends to reduce liability.

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The second explanation for this particular result comes from a change in the legal regime or, better, the business regime, under which various kinds of medical services are provided. One of the dominant features of the 1970's medical regime was that it was dominated by individual fee for service physicians. Whatever one wants to say about their skill and enterprise, these individual physicians did not typically have access to very large databases loaded with relevant information about the desirability of this kind of treatment for that kind of person under these sorts of circumstances. One of the great advantages of amalgamated physician groups, or indeed with managed care organizations that oversee physicians, is the increase in valuable aggregate patient data. That aggregate information helps improve medical protocols; and it allows organizations to check physicians to see that they've retained their competence and stayed abreast of the latest medical advances, notwithstanding the fact that they're getting on in age. Through these two kinds of changes the MCO can reduce the level of malpractice, no matter what the applicable legal rules.

The situation with managed care organizations introduces a third element into this situation that makes things almost more dangerous than they were before. To understand why this is so, I think it's important to understand what it is that distinguishes medical care as a kind of social necessity of our time from other essential services like education or housing. Quite clearly, the decisive feature is that you know basically from the beginning how much you're going to have to pay in each period of your life for housing, food, or education, such that you could either pay for them out of current earnings, out of anticipated savings, or out of borrowings of one form or another. These are relatively smooth expenditures which most people can handle privately from income, savings or loans.

With medical expenditures, however, people do not worry about whether they may have to pay $200 a year to see the doctor twice, but rather they are transfixed with fear regarding the small probability of a catastrophic injury. This low probability/high payoff type situation invites the need for a third-party payer. Yet the moment the third party comes on the scene it raises a new problem, that is, a serious moral hazard of over consumption of medical resources. This risk occurs because the patient and the physician can form an informal alliance that opts, whenever in doubt, to provide more intensive medical services. Both physicians and patients realize that insurance means that others pay for most of the cost while they internalize the benefits in the form of medical payments on the one hand or, at the margin, somewhat better health and security than they might otherwise have.

The introduction of the third party dynamic means that insurance companies are faced with a fateful choice. On the one hand, they could decide to function as an open checkbook that pays bills, however large, that physicians submit to them. Yet if they do that, they will discover that each patient will rejoice in his or her individual short-term successes, but these same patients will be deeply dissatisfied in the long run because the inexorable upward push on rates will, if left unchecked, eventually drive everyone out of business.

Therefore, in response to this relentless financial pressure, insurance companies have tended to retreat from this passive management style by becoming much more aggressive in examining claims and in supervising medical care. Reluctantly but necessarily, the payers had to get themselves involved in decisions over the provision of medical care, which required them to embark on a collision course with a medical profession that has its own paradigm for medical provision; to wit, autonomous medical decisions by physicians acting in the best interests of the individual patient receiving medical care.

But even physicians are not super rational Kantian agents dispensing some universal transcendent good. Anyone who has looked at the complications associated with medical licensing understands that the practice of medicine is not only a learned profession, but also an ordinary business. Like most businessmen, physicians would love to lock up a guaranteed source of payment and protection that cannot be eroded with competition from third parties. That said, the attack on managed care is not solely driven by patient dissatisfaction. Rather, that dissatisfaction is a cloak for the strong physician resentment to the implicit downgrading of their professional services given by that "Big Brother" from the MCO who overlooks their every decision. The ground is thus set for an uneasy alliance between the physicians who staff HMOs and MCOs and health care consumer organizations. Both, for different reasons, would like to neuter the managed care organizations by removing from their management teams the power to control physician practice. Yet by so doing, they do more than remove excessive intervention. They necessarily compromise, perhaps fatally, the critical cost containment functions that these organizations must supply *if they are to survive at all*. Both physicians and consumers would disclaim any grand motive to destroy the MCO. They only wish to improve their operations. But I believe that this disclaimer is just a vain delusion. Once the law restricts and alters the basic contractual structures, it will surely change the willingness of firms to enter this business and thus alter the menu of choices available to patients. The demand for medical services is just as elastic as it is for all other services, and any attempt to alter terms is likely to raise the effective price of patient participation.

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More concretely, how do we anticipate the effect of the contractual changes being called for on the liability frontier? Well, the first point to note is that doctors still can be sued for medical malpractice. Physicians then argue that there will be perfect parity between the their position and that of the MCO. Hence if a patient could sue a physician for medical malpractice, then he or she could sue an MCO for its version of medical malpractice—precisely because it is necessarily involved in something akin to the practice of medicine the moment it decides to approve or deny treatment.

The premise is true enough, but it only invites the further question: ought there to be open season on MCOs on the ground that misery loves company? I start from the proposition that the tort approach to medical malpractice is a mistake. If I am correct, then we must ask ourselves if we care so much for parity that we are prepared to replicate old mistakes in a new area. Or do we hold

fast to the axiom that two wrongs, as it were, do not add up to a right?

That said, we have to see how the system would to play itself out in this brave new world. Here it is instructive to note that state legislation on MCO liability is stunningly broad in its coverage. They affirm that every time an MCO fails to use ordinary care in withholding treatment, it can be subject to liability. All lawyers will instantly recognize that the first question one asks about appropriate liability standards is *not* whether a defendant can be held liable under a rule; for instance, in this case, the relevant question is whether a defendant can get a summary judgment on the standard of care at issue that will avoid the expense of a full-fledged lawsuit. To do that, the defendant will have to persuade the court that the issue is so clear that further litigation is unnecessary, and the chances of that occurring under this "ordinary care" standard will usually be slim to none. Hence even the successful defendant will face massive discovery which will tie up key personnel and documents in litigation to answer the ineffable question of what might have been. A defendant can spend thousands to win a lawsuit, but must find a revenue stream to support that expenditure. And the only place it can turn to for revenue is patient fees.

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Now in reply someone could ask, what's new? After all, the patient could sue the doctor or could sue the MCO. One lawsuit is every bit as good as another, so we should not trouble ourselves in the slightest about the change in the identity of the defendant. Clearly, if this argument were sound, why would physicians and consumer groups make such a hullabaloo? Why would these interest groups push so hard to create managed care liability if its sole consequence is to change the name of the party who signs at the bottom of the check from the physician's group to the MCO.

The answer is that the differences could matter greatly in many cases. Let me explain to you how the game will start to work. The patient will sue both the physician and the MCO. The physician will then settle out cheaply by agreeing to provide the necessary ammunition to allow the suit to go forward against the MCO. The physician will insist that he wanted to do XYZ test or procedure, but the organization decided to pinch pennies and remove the one last, best hope of the patient. By suing the MCO the plaintiff's lawyer has a distant and impersonal target. It is no longer necessary to sue a beloved physician who resides in the community. Instead, to use the favored expression, the recalibrated lawsuit will "send a message" to some distant financial organization whose only connection to the community is a monetary one. The larger target makes for a larger settlement or judgment than could be obtained against the physician who is only a pawn in the larger social structure. I doubt that this scenario will hold true in all cases. I am confident that it will hold true in some.

So what happens next. Well, one obvious response of the MCO is to bring the physician back into the case as a co-defendant. That will have great appeal if the MCO has done little wrong and the physician is primarily responsible. But there are answers to that as well. The recently passed California legislation, for example, anticipates that maneuver by blocking as a matter of positive law any MCO suit for indemnity of contribution, no matter what the equities of the dispute between the MCO and physician providers. The physician that settles out is protected against any reckoning at the hands of the MCO. That holds no matter what the apportionment of responsibility between codefendants. I think we can see that the true aim of the legislation here is to maximize MCO financial liability, rather than accurately apportion responsibility.

In the short run, physicians will love the creation of a system that promises a restoration of their autonomy and insulates them from the costs of

their mistakes after they settle their case out cheaply. But it is ironic that freedom of contract between physicians and MCOs is banned in the name of consumer protection, since eventually it is the consumers who will bear the burden of skyrocketing healthcare costs. If you examine the legislation closely, it is possible to find strong traces of interest group politics at work here.

Now let's just look a little bit further at some of the other protections built into these newly minted proposals to see if the same pattern holds. Let us suppose that an individual patient does not like a particular negative decision from his or her MCO. In what is now something known as utilization review, the new proposals generally require that MCOs refer the case to some independent quasi-judicial bodies composed of professional physicians. Mind you, the key personnel are not business managers who are running the organization, but independent, professional physicians, who are required to deliberate over which expenditures are appropriate and why. That trend to can only result in a shift of influence and control from the MCO back towards the physician.

Yet since these decisions will be made in an atmosphere of distrust, it will spawn an elaborate administrative process with layers of formalities, safeguards against bias, and judicial review. But when all is said and done the underlying problems will still remain. Do these layers of review really protect patients as a class, or do they only protect this particular patient in this particular dispute? I believe that we should never underestimate the conflict *between* patients and the role that a firm has in keeping these conflicts under control. A firm that seeks to monitor access and utilization operates (but only in part) as the agent of those patients who are good actors and thus acts as the opponent of those patients who are bad actors. The MCO acts like the landlord who throws out the lousy tenant and thereby protects the interests of good tenants who don't want to endure the noise or filth generated by the evicted tenant. The risk of administrative review is that it hampers the ability of the good firm to differentiate between responsible and careless actors, and to sanction the latter in order to protect the former.

So it is back to the basic question: if the raison d'être of an MCO organization is ex-ante cost control in the name of scarcity, then it has to be able to limit utilization to screen out futile or experimental procedures and to husband its resources so as to constrain costs. And if it cannot provide that needed cost control, we have to wonder whether the MCO will be able to remain in business. The answer is not clear because MCOs could still provide useful information in the collection and dissemination of information. But in truth a rather different agenda is at work here, which becomes evident from looking at the one exclusion to the proposed Patients Bill of Rights. It seems not to apply to the United States Government in its role as the provider of health care services through Medicare or Medicaid. The proposals therefore are designed to cripple the private programs which compete in the political arena with government-supplied health care.

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Once regulated, can takeover be far behind? Once these policies take full effect, any rational person will look around and will discover that the market has failed because the regulated firms cannot respond to their new challenges. If the market has failed under these circumstances, then perhaps the nation should migrate toward some alternative paradigm—perhaps universal health care provided by the government through general revenues. So my own somber view is that the long-term objective of the Clinton cadre is to hobble private medical providers in order to increase the probability that society will eventually find direct government provision more desirable.

Yet, should we take any comfort when we see how these plans have fared in other countries in which only patient welfare matters? Recent news stories, including some in the New York Times, tell a somber story of stress, and perhaps disintegration, of these programs. The Canadian system has not, cannot, and will not be able to make the capital expenditures necessary to maintain long term care. More and more patients tend to come south to the United States because they choose not to wait on Canadian queues for treatable conditions. Plattsburgh, Vermont; Buffalo, New York; Seattle, Washington; and Detroit, Michigan all have facilities that market to the Canadian trade, often staffed by expatriate Canadians. The blunt truth is that government rationing (dare we call it socialism?) generates queues. Desperate people will do anything to circumvent the queue, including one poor fellow who decided to register as a dog in the unregulated veterinary market for veterinary medicine. Unfortunately, this is no joke; but we can expect this to happen whenever prices are kept artificially low, and this is exactly what occurred in the case of the government-funded Canadian system. Since it cannot raise taxes any more to fund increasing outlays, it is forced to squeeze out the utilization and cut down on capital expenditures. Scarcity matters even if the public sector pretends that it doesn't exist.

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For those of you who want to know why the Canadian system managed to work tolerably well until the last four or five years, here is one answer: it was only in the last four or five years that the rapid depreciation in equipment became evident. The Canadians followed the pattern of so many government programs, which was to spend too much time worrying about cash accounts and not enough time thinking about replacement costs that should have been registered on the books. This common public failure happens less frequently in a corporate setting where shareholders worry about future income streams, and thus monitor the firm's long-term financial health.

The English system reveals the same story: strong government capitation which results in a starvation of capital needs and the long-term deterioration of the overall system. But why should we expect otherwise? In general, socialism has proved incapable of managing the problems of long-term growth. There is no reason to expect that it will do better in the health care remnant where those principles still hold sway. Our domestic choice is this: will MCOs perform so badly under regulation that sentiment builds for state-run programs whose sustainability should be subject to question? Or, will the dismal performance of foreign health care systems so impress the American people that they will demand some return to market mechanisms in health care markets?

I will end with this final irony. In this debate one hidden but mistaken assumption is that the rate of return on investment in health care is highly positive, so that we ought to invest in more of it. But the proper approach to this question is the same as it is for all other kinds of investment. We must remain aware of the law of diminishing marginal returns to additional investment. Health care is expensive, and I suspect that giving people a balanced diet, a simple flu shot, or a warm bed counts for more than a sophisticated bone marrow transplant to an 83 year old patient with a 1.0 chance of success and a $100,000 price tag. That risk/return ratio is simply completely out of synch. The best way to improve longevity and happiness is to keep people from getting sick through good nutrition, healthy air, safe automobiles, decent employment and the like. In many ways, the worst investment in health care is in the ICU.

Until we start to understand these relationships and constraints, we will continue to suffer from a persistent misallocation of resources as the desire for heroic treatment, driven by the joint action of determined high-tech physicians and desperate

patients, dictates our national health-care policy. In thinking about managed care liability, we should worry less about horror stories and more about routine and undramatic ways to improve the human condition. We have to learn, with a little bit of dispassion and some degree of regret, to hew to the ex-ante approach that asks, not do we want treatment in this particular case, but rather, can we sustain the course of treatment and investment over many years and over many thousands of cases? If so, then we should keep the present system with all its warts. But if not, then we better change it before it's too late. Thank you.

Audience: Do you think there is any salvation in shifting from ex ante cost reviews to ex post reviews? For instance, allowing doctors to make treatment decisions and then afterwards evaluating them for efficacy?

Mr. Epstein: My view is that the choice between ex-ante and ex-post review raises one of the single most difficult questions for any legal system or organization. That is, to undertake a comprehensive ex-post review requires extensive monitoring of large patient loads to see whether treatment works in the long run. Sometimes the early indications look poor, and there is a temptation to switch to another program before the original clinical trial has run its course. It may well be that if the organization waits too long to conduct the ex post review, the financial and liability implications become quite negative. And new patients will seek to avoid unpromising treatments. Yet if systematic ex post review is no panacea, it hardly follows that litigation, which looks only at individual cases, will give any sensible insight into overall programmatic success.

So if all ex post review is problematic, do we work harder to prevent certain treatments up front? Again there is no dominant solution. Ex ante supervision can prevent great expenditures, and it can also kill off much needed treatments and therapies. We don't have in the area of medical treatment the kind of bright line rule of thumb which says "don't ever drive through a red light". Once again, the complexity of the issues involved tends to support the insight that private entities are better able to decide on the mix of ex ante and ex post supervision than is government, which has never been able to figure out how to run medical utilization under Medicare or Medicaid. I think we should cut private firms a fair bit of slack and not mandate either system because of the uncertainty as to which is better and why. And it is worth noting that the private plans run all sorts of experiments. They resist having physicians paid in ways that increase their salary a dollar because they have reduced expenditures by two dollars. The moral hazard is too great, and the firms know this. But they also resist divorcing compensation from overall utilization levels. It is one measure of the difficulty of the underlying problem that these protocols in the competitive market are changed and tinkered with quite frequently. Nobody knows with confidence what the optimal strategy should be.

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That said, anyone who claims that every five years the government should review this matter and issue some one-size-fits-all regulation is missing the entire point of competitive innovation and market experimentation. For those who doubt that this experimentation is real, just remember three years or four years ago, fixed rate capitation was all the rage amongst MCO organizations. It didn't work because of consumer resistance and then all of a sudden PPOs became more the norm, again. And now no one is quite sure exactly how much discretion ought to be given to the physicians inside the plan, outside the plan, and so forth.

In the face of that level of heterogeneity and market volatility, no external government program is nimble enough to keep up with the problem at

hand. I think you're right about the medical observation on the necessity for some ex post review, but I think you'd be wrong to draw any implication that the need for ex post review requires the expansion of government regulation.

Audience: At the end of your talk, you touched on some interesting ethical questions that I don't think you quite answered. You said, I think, there's a 1% chance that a bone marrow transplant might help a patient to live from 73 to 75, and you have to make some kind of obvious choice.

The question is, what if there's a 10% chance, or what if there's a 20% chance? And what do you do if there's a 50% chance, and who makes the decision as to whether there's a 50% chance that a bone marrow transplant might extend the life of someone who is 78 to 80?

Of course, human life is riddled with uncertainty. But it hardly follows that the system never works because it sometimes fails.

Now it's a choice that might be easier for a 40-year-old to make than a 78-year-old person, and I think the basic problem is that these are ethical questions that no system of medical care has ever been able to address. These are ethical questions that I think have to be addressed and really can't be answered.

The basic problem is that medical care is extremely expensive. Good medical care is even more expensive. And in some ways it has to be rationed. But no one has solved the problem of how we should ration it in some kind of ethical way.

Mr. Epstein: The moment you recognize that nobody has solved this problem, then the first question to ask is what makes the issue more amenable to government regulation than to the operation of market forces? I'm not asking you alone; this is just a general question.

The question you have formulated can be modeled quite well as follows. You have to imagine that this is a blackboard, and the costs of treatments that you could give are represented in one upward sloping line, and the benefits represent another curve that slopes in the opposite direction, i.e. downward. Alas, the cost of the treatments always rises at some point. We know there's a point at which these two lines cross, producing an "existence theorem." Some medical treatment costs too much for too little benefit.

Why say this? Well, we believe in the general shape of the cost curve; we believe in the general shape of the benefit curve. We know some treatments are obviously too expensive given their benefit to cost ratio. We know that it would be egregious to deny treatment in other cases. That said, our difficulty is not an ethical matter. Everybody agrees that the curves cross somewhere. Our difficulty is that nobody has been able to figure out what these curves look like and where those lines cross.

If benefits go down at a slope of 2, then we get one solution. If they go down at a slope of 1/2, we get another. The same with costs. You ask the empiricist to tell you the slope of the benefit curve and you find that the error term dominates everything: it is so broad that any possible decision may be rational given the uncertainty. You don't know where you are on these curves.

Of course, human life is riddled with uncertainty. But it hardly follows that the system never works because it sometimes fails. Rather, we must recognize that our task is to improve the legitimacy of the system in the eyes of the population it serves, so that on average it's going to make fewer mistakes than some rival approach

That modest goal gets you back to the same question raised about ex-ante and ex-post review. Since there is no uniform analysis, do we expect a better feedback mechanism from a firm that has to continue to sell itself in the market, or from

a government agency which, when it makes a mistake, knows that somebody else is going to have to pay the price? The technical question of what level of medical care is appropriate turns out to generate the insight of the famous economist Friedrich Von Hayek that the variability and fluidity of local knowledge is hard to capture under one large government norm.

So then, just how responsive will private firms be? Here we have to give weight to an important feature of the overall picture that is generally denigrated by current analyses: what's the reputational effect of good or bad performance on the value of an individual firm? It is commonly said today that the feedback mechanisms in MCOs are so weak that reputation doesn't constrain their behavior. So it's government supervision or direct tort liability; nothing else matters.

I think the empirical evidence demonstrates to the contrary. For example, airlines that have the occasional crash, or food companies that occasionally sell contaminated food, will almost invariably, so the event studies show, suffer losses that dwarf their anticipated tort liability or their regulatory fines. Reputation has a tremendous market effect; the loss of future business is a penalty no firm can afford to ignore for long. Medical organizations that seek to develop brand identity against competition could sustain the same types of losses if their behavior continues to alienate consumers.

In addition, today more than ever before we have rapid ways to disseminate information that allow us to separate the provider of health care from the provider of information. Astute consumers can, and do, go to the web to compare firms and treatment policies. Both good and bad news can travel extraordinarily fast. As these alternative checks become more powerful, the case for direct government regulation becomes weaker, especially when we recognize that firms have shorter turnaround times in response to negative feedback than does government.

The second reason why firm adaptation has improved is that most medical consumers now use some sort of intermediation to deal with their health plans. Most thoughtful individuals feel inadequate to choose health coverages. But if they have an employer who knows about the relevant medical issues, consumers could use the employer to run interference in the marketplace, and to run studies to measure the performance of various plans for the firm, or perhaps across the industry. Once key employees start quitting jobs to sign on with competitors that offer better health coverage, which does happen, employer intermediates will become more responsive. It is not just health care analysts who have figured out the difficulties in procuring adequate health care.

Do we expect a better feedback mechanism from a firm that has to continue to sell itself in the market, or from a government agency which, when it makes a mistake, knows that somebody else is going to have to pay the price?

Therefore as we conscientiously seek improvements, and recognize that we shall never obtain perfection, we should ask ourselves what set of incentives and what set of institutions are likely to reduce the error costs of both over and under provision of health care. Government administrators are likely to be wrong for two reasons. First off, government officials largely care about one kind of error, that of under provision. These officials have little, if anything, in their recent mandates that addresses overutilization of medical care. There are no proposals to allow *non*-treated consumers to sue the health plan for giving unwarranted care to somebody else. It's just not part of anybody's program.

Second, we must confront what could be charitably called the dinosaur effect. Government organizations do suffer lousy feedback mechanisms because of sheer size, complex incentives, and procedural snares. They cannot move rapidly

enough to figure out what is needed *now*. They operate on two or five year lag times, and in this market, the world will have fled beyond them before they can respond appropriately.

As to the non-English European medical systems? All too often they start to look like so many socialist systems. Their stated "positive" rights are enormous and expansive, but then the resource constraint comes back in a covert way; huge entitlements and long queues can exist simultaneously, because the budgets just aren't there. And whatever the system in Western Europe, matters are far worse in what remains of the old Soviet Union. You would rather be in the worst charitable hospital in the United States than to receive the standard care offered in these countries. Their results are unspeakable because they live under an illusion. If you really think that what matters are parchment guarantees, then you will accept the deadly embrace of a government monopoly even if it leaves individuals no choice to switch elsewhere. Yet propaganda on rights is a poor substitute for the delivery of needed services.

We need decentralization and competition to survive, and both of these elements are slowly being squeezed out of our system.

The reason why discussion focuses on the English and Canadian systems is that they have been generally regarded as the best of the nonmarket alternatives; yet they too now show signs of failure because they cannot overcome the intractable problems of central planning. Notably, these problems that are even more complex in the United States than in Denmark. We have a larger and more diverse population, coupled with the added complexities of a federal system. What might work for some period of time in a small homogenous country will not work over the long haul here. We do not have the tight-knit communities and informal constraints that are needed as firewalls against excessive consumption. We need decentralization and competition to survive, and both of these elements are slowly being squeezed out of our system. These elements cannot survive if everyone assumes that they have an entitlement to health care, regardless of the costs imposed on others.

So cross-national comparisons are tricky, and the usual lesson that I extract from those comparisons is exactly the opposite of that drawn by our political leaders. I believe that the greater the diversification of the American public by whatever standard—immigrant populations, racial differences, religious differences, ethnic differences, geographical differences, rural/urban differences—the stronger the case for limited government. As those heterogeneities increase, the viability of one-size-fits-all government solutions diminishes. I offer this not as a constitutional argument; it is simply meant to be a prediction. The greater the heterogeneity of the population, the more likely it is that universal solutions will fail. The greater the homogeneity of the population, the easier it is to hit some ideal peak because the error costs in individual cases are likely to be fairly low. So I would be cautious about drawing inferences from any foreign successes, especially for programs that are already frayed at the edges.

Audience: I have two questions regarding two feedback mechanisms, which I believe, would improve the health care system. First, why don't we move away from an employer provided health care system to one where individuals could shop between plans and the costs of health care would be tax-deductible? As it stands now, I have a restrictive health care plan through my employer, and since I can't fire the plan, if I have any problems I am going to be forced to sue.

Second, why is it that my bills are not itemized to show the actual cost to the consumer? That way I could compare the costs of specific items versus the cost of the plan as a whole, and across health care plans, and comparison shop in that manner.

Mr. Epstein: Everybody loves to have individual choice in the abstract, but, systematically, it raises

serious moral hazard and adverse selection problems that are difficult to counteract. Individuals who have good health histories and are feeling just fine will opt for low levels of coverage. Individuals, who sense that there's something wrong with them but don't know what, will invest more heavily in coverage. The insurance firms understand all of this. They know that there's nothing they could do to smoke out these tendencies given the asymmetrical positions: individuals have information about themselves that firms cannot acquire. So in response the firms prefer to write group policies, so that they can rely on the employer to act as a filter that takes out the highest potential risks and allows them as insurers to diversify their risk portfolios. The common sense notion here is that employers are not likely to hire anyone who has one foot in the grave. By piggybacking on employer behavior, insurers can offer lower overall rates.

It is just the risk of individual opportunism that explains the fragility of the market for individual insurance policies in states that have adopted community rating. For example, in New York, the individual part of the market has been gutted by a community rating system that demands that insurers ignore age and pre-existing conditions in writing insurance. In contrast, the group market has been far better able to survive this regulation.

The second question, about itemization, is much harder to answer. I know every time I get a hospital bill, it's itemized in detail and I'm simply horrified at the cost of what I regard as routine tests. More generally, I assume the reason that individual consumers pay little attention to itemization is that they think that they have little control over the outcome given the powerful economic forces at work. The harder question is whether or not the employer who actually pays for much of the cost runs some kind of benefits review to determine whether the coverages received are worth their cost. Until we know (as I do not) the answer to that question, it's not at all clear what counts as a market failure.

What I would caution against would be adopting a mandatory disclosure scheme to counteract any perceived failure. People often champion these by saying that it generates full information without mandating terms. It is therefore a lesser interference that strengthens the operation of markets by moving us to a full information state. But, if you mandate the partial disclosure of information, it could lead to further gaming whereby, for example, insurers disclose the charges for particular kinds of services, but they don't disclose the fact that the extent of these services will be reduced on matters that lie outside the disclosure. Better to have diligence by payers than mandates by government.

The harder question is whether or not the employer who actually pays for much of the cost runs some kind of benefits review to determine whether the coverages received are worth their cost.

Audience: I have a footnote that supports your thesis. I run an insurance company that services half of the fortune 500. Most of these companies have realized that the cost of a sick employee, in terms of productivity, is far more important than the cost of health insurance. Consequently, an organization like mine can act as an ombudsman or manager to proactively get people back to work as quickly as possible. That goes in the opposite direction of limiting health care costs in the short run, even though it is also a market force that supports your thesis.

Mr. Epstein: I've actually seen that too. I've been part of the McClain Clinical Medical Ethics Center at the University of Chicago, and through that organization have participated in meetings with concerned employers who have made that same point. The tricky issue is implementation and the tradeoffs that have to be made to organize that initiative. For example, it is not a wise idea to have the personnel office handle the medical questions, notwithstanding any economies of scale from

putting all employee-related work in a single office. It is not only that regulations may prohibit this practice. It is also bad business, for no employer could expect an employee to come forward with sensitive information if the personnel department could use that for setting salary and determining job responsibilities. It is necessary to create separate lines of authority, to partition information within the business in order to get people to speak candidly about their problems. Accordingly, it could be better for some outside firm to design these programs in order to decide who gets access to what information. It is quite sensible for firms to guarantee confidentiality with respect to use of medical information. No firm is going to post this information on its web site. And this is well understood by employers who know that they can only function in a competitive market if they remember the fundamental truth about all contracts: they only work when they supply mutual gain.

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38	THE ABUSE OF OPENING STATEMENTS AND CLOSING ARGUMENTS IN CIVIL LITIGATION	DAVID E. BERNSTEIN
37	DENTISTS, BARTENDERS, AND LAWYER UNPOPULARITY	WALTER K. OLSON
36	PRODUCTS LIABILITY AND THE THREAT TO CONTRACEPTION	MARC M. ARKIN
35	JOINER, SCHEFFER AND KUMHO: REFINING THE STANDARDS FOR EXPERT EVIDENCE	PETER W. HUBER
34	CREATIVE DEPOSITION	WALTER K. OLSON
33	SCIENCE IN THE COURTS	PETER W. HUBER & KENNETH R. FOSTER
32	BOOKS TO SUE BY: AN EMPLOYMENT-LAW SELF-HELP SHELF	WALTER K. OLSON
31	ABUSIVE EXPERT TESTIMONY: TOWARD PEER REVIEW	L. WILLIAM LURIA, M.D. & DENNIS S. AGLIANO, M.D.
30	CLASS ACTIONS: THE NEW ETHICAL FRONTIER	LAWRENCE W. SCHONBRUN
29	INVESTIGATIVE REPORTS: POLITICS AND THE TRIAL BAR	CAROLYN LOCHHEAD
28	SCIENCE ON TRIAL: MEDICAL EVIDENCE AND THE LAW IN THE BREAST IMPLANT CASE	MARCIA ANGELL, M.D.

Civil Justice Reports

23	THE NEW AMERICAN RULE: A FIRST AMENDMENT TO THE CLIENT'S BILL OF RIGHTS	RICHARD W. PAINTER

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