

*Comments on Jost “Legal and Regulatory Issues Presented by Health Care Reform” and Noll
“The Regulatory Component of Health Care Reform”*

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Both of these papers aim to address a basic panglossian bias in most policy making and that is the idea that the hard question is what policy you want, the easy part is implementing that policy through legal mechanisms: legislation, regulations, rights. People in law are sometimes the worst offenders in this regard. With a view of law as transparent and costless, the basic model of rule-making in legislatures or courts is: if you want the world to look like X, put in place a rule that says “world is to look like X.” If you want custody decisions in family law to be based on the best interests of the child, pass a statute that says “custody determination to be based on the best interests of the child.” If you want equal speed of internet service for all content providers enact a rule that says “internet service providers will deliver content at the same speed for all content providers.” If you want all citizens to hold health insurance, pass a law that says “all citizens must hold health insurance.” These models of legal and regulatory processes, however, assume all the cost, strategic behavior, and institutional dynamics that the law is attempting to channel and control exist outside the legal process and of course they don’t. Roger Noll reminds us that we should be pessimistic that the process of rule-making in agencies will overcome the interests of powerful constituencies such as providers and insurers. But even if we get the right target X in the rules, the outcomes actually produced by the rules are likely to deviate from X. I don’t play golf but I’ve seen enough airport concourse ads of Tiger Woods staring thoughtfully off at the putting green to know that if you want to sink the ball you don’t

just aim straight for the flagstick; it's a complex process of weighing all the factors that will influence the trajectory of what you put in motion. Legal and regulatory elements to achieve desired health policy goals should be thought of as systems of frictions and diversions, contours and hazards that will influence the outcome actually produced. Aiming straight for the target is unlikely to work well.

Roger Noll makes this point nicely with his observations about the significant impact that can come from a piece of legal/regulatory design that few pay attention to: the allocation of burden of proof and thus the selection of the default result. And Tim Jost's suggestion, at the end of his helpful review of the complex state-federal regulatory terrain, that addressing physician concerns about medical malpractice—concededly a minor determinant of health care costs in fact—could help secure provider support for more important reforms focuses necessary attention on the process of achieving desired results in practice. Aim at malpractice and one might hit the target of greater cost control.

My response to Roger's and Tim's papers takes aim not at the cost of healthcare but at the cost of the legal system. Let me start out with a few simplifying points of reference.

First, a principal problem in controlling the costs of health care and providing more widespread access to the health insurance pool is the difficulty of aligning ex post care and payment incentives with ex ante optimal decisions. Roger calls these moral hazard problems (suggesting a knowing bad faith cheating by doctors, patients or insurers,) but I think it could be helpful to think of them more generally as time inconsistency of preferences (including opportunism and cheating but also changed preferences and sunk-cost auction dynamics.) Expenditure limits that rationally rule out low-value procedures before illness appears are easy to

agree to but hard to stick by when a sick person is lying in front of you. There is a similar problem in law: although we could easily identify what would be rational limits on the complexity and cost of dispute resolution before we get into a dispute, once we're in one, the incentives to expend in an arms race of dollars and rarified arguments take over. (In litigation, it doesn't matter that you've already spent a million bucks on litigating a million dollar claim if the case is not over; if you quit you get nothing, if you put the next few bucks in the meter, you stay in the game for a potential payoff of a million. I suspect medical expenditures are subject to a similar dynamic.) The importance of this observation is that some key problems in the design of legal/regulatory mechanisms in health care look a lot like contracting problems (which invoke the basic legal apparatus integral to structuring private markets) not regulatory problems (which call for external interference with market interactions.¹)

Second, as Roger emphasizes with respect to agency regulation in particular, legal enforcement mechanisms are costly, complex and subject to strategic distortion. The cost of converting aspirations (mandatory benefits, coverage entitlements, differential tax treatments, adherence to quality of care standards) into actual outcomes through legal rules has to be factored into the potential to achieve those outcomes. This is especially true if litigation to enforce rights—whether before an administrative agency or a court—is contemplated in the enforcement mechanism. Most litigation is simply too expensive and takes too long for ordinary individuals to make any use of it. This has the capacity to make any purported legal constraints ineffective. In addition, litigation outcomes in the health care area are likely to be badly distorted by asymmetries in resources and repeat-play incentives between the parties to any dispute (individuals versus organizations/commercial entities.) Last, under the control of the

¹ I'm taking Roger's definition here of regulation which is the production of non-legislative, non-judicial (agency) mandates that control prices, entry, product characteristics or disclosure.

legal profession (which includes judges and asserts exclusive, constitutional, authority to regulate the markets for legal products and services) law with an individual plaintiff is bottom of the barrel in terms of resources and expertise. This segment of the market attracts lower quality judges (relegated to family or traffic court, or passed over for the federal bench, for example) and lawyers who are uncompetitive in the more lucrative corporate services market and who practice in solo and small firm settings with little of the organizational capital available in larger firms. Law serving even well-funded and sophisticated corporate demand has also grown hideously expensive and complex under lawyers' heavy regulation of the market (which interferes with most avenues of innovation in legal products and services); the law serving lay individuals with sporadic, poorly funded legal needs just grows more out of reach over time. The solutions that are now bandied about for resolving the crisis in the legal system, however, largely involve reducing or eliminating the use of law, rather than fixing it. It seems unlikely that a broken legal system can fix a broken health care system.

Third, any legal apparatus that plays a role in achieving the goals of wider access and cost containment has to be thought of not in static terms of what rules to enact but rather dynamic terms of what institutions to turn to develop and adapt rules over time in response to complex changing and local conditions. All rules are incomplete and need to be interpreted, filled in and adapted over time. Tim suggests we might need a relatively independent federal commission to make decisions about entitlements and some entity (I wasn't clear if this was also to fall to the federal commission) to ensure that cost-sharing in insurance policies is tailored appropriately to income. Roger focuses his analysis (and pessimism) on the capacity for a (federal?) regulatory agency to control prices, set benefit levels and so on. In either case it will be important to pay close attention not only to the agency problem of ensuring that a regulatory

body is motivated to serve the goals of health care reform but also to the competence problem of ensuring that the regulator is well-informed about the problems it is solving.

The competence problem is not a straightforward issue of expertise; rather it is a problem of how information is developed and makes its way into the system. This is affected by procedural considerations as Roger suggests, including who bears the cost of collecting and presenting information to a decision maker and what alternative mechanisms exist to potentially bias the sample of information reaching the decision maker. In litigation, for example, rule-making (or rule-interpretation, which is much the same thing) is influenced by the incentives of parties to take matters to court, incentives that are influenced systematically by resources, repeat-play incentives, the costs of public disclosure of confidential information, and so on. Litigated cases are a highly selected and non-random sample of disputes and the information relevant to adapting rules and standards to changing conditions. In theory, regulatory bodies with the capacity to choose their samples more representatively and structure proceedings to give equal opportunity to all sources of information may overcome these limitations of litigation-based methods of rule-determination. But regulatory processes don't—and I think this is Roger's major point—work like this in practice; resources and interests will affect regulatory outcomes. Moreover, regulation relies on public expenditure to fund the process whereas litigation relies on private expenditure, suggesting that the former is likely to see less investment in the process of making rules 'smarter' than the latter.

This brings me to my principal observation about Roger's and Tim's papers. Both limit the set of institutions that might play a role in effectuating health care reform to conventional regulatory mechanisms. Roger does this explicitly—defining regulation to be non-legislative

and non-judicial control of market outcomes. He suggests towards the end that there may be a role for courts and rights-based litigation by patients (against HMOs, insurers) etc. but, perhaps because this would require legislative changes he thinks are very unlikely to come about, he focuses most of the paper on the reasons regulators are unlikely to implement effective reform: industry capture and the extraordinary cost and complexity of the task facing a bureaucracy that is expected to make transaction-level interventions in a massive byzantine sector of the economy. Tim contemplates a much wider range of institutional participants sharing (and no doubt fighting over) regulatory powers, including federal and state legislatures, executive agencies, independent commissions, professional bodies and courts, but the list is still the usual suspects. Which, I suspect, is why Roger is so suspicious any of this can work.

Neither paper contemplates any innovation in the mechanisms that might deliver the rule creation, adaptation and dispute resolution inputs—which are also economic inputs—that health care reform requires. In particular, neither paper considers the potential role for private, even competitive profit-making, entities to supply these inputs. But particularly because a very large share of the “regulation” that is needed is not external constraint on market transactions but rather internal contractual structure for market transactions, I think this makes the focus too narrow. Moreover, even where the necessary regulation is market-controlling rather than structuring (such as requiring patients to hold insurance or providers to provide care to those without adequate insurance) the institutions that might contribute to the achievement of these goals may not look like the unwieldy bureaucracies or inaccessible and slow courts we know and hate. Let me suggest two possible examples.

First, an example of how a private contract enforcement mechanism might work: Both Roger and Tim recognize that the market for health plans, like most markets, works better if the terms of plans—contracts—are enforced: if coverage is delivered as promised and limited as agreed. This is not, of course, a simple matter of reading unambiguous language on a piece of paper and making orders that effectuate the intent of that language. Any contract for health care will have to be written in highly incomplete terms with respect to standards of care; even coverage limits are likely to be incomplete and stated in terms of reasonable costs of appropriate (possibly limited levels) of care and not ex ante fixed dollar amounts. But the mundane problem of translating those incomplete terms into concrete outcomes in particularized circumstances is the bread and butter of the contracts cases that make up a significant share of all litigation and dispute resolution. The important observation is that this is fundamentally an economic problem—of determining cost-effective methods for implementing agreements and achieving the goals the contracting parties have of aligning ex ante and ex post incentives and adapting obligations to particular circumstances as they evolve. Unfortunately this basic mechanism is disabled in health care by limitations on ‘suing’ HMOs, employers providing benefit plans etc., restrictions that are reflective of (and, other than for class actions, largely redundant of) the extraordinary cost, delay and unpredictability of the modern court system.

But there is no *a priori* reason why contract enforcement mechanisms could not be offered in a market by private firms, firms that would compete to provide better systems for the drafting, interpretation, ongoing dispute resolution and adjudication if necessary of health care contracts. Most of the law in this area—since the obligations themselves are defined by the contracting parties—have to do with systemic procedural considerations: how language will be interpreted, what evidence will be relevant, how much ‘process’ will be ‘due’ in order to reach a

determination, what remedies are available, what excuses or limitations on obligations will be found. All of these factors affect the cost, time and uncertainty of contract performance and dispute resolution. And all could be determined by private rather than public actors. “Health Contracts Inc.,” for example, could invest in designing an attractive system that balances the costs of the process against its benefits and contracting parties could decide whether they want to contract under the ‘law’ of Health Contracts Inc. rather than California or New York.

Health Contracts Inc. is likely, with competition, to offer a product that operates very differently from conventional legal dispute resolution. It might provide standard terms with a pre-determined and narrow scope of interpretation. It might use data-mining techniques (which lawyers eschew) to assess how effective terms and procedures are in achieving intended results. It might limit the number of days or documents that can be gobbled up in dispute resolution. It might fold the cost of ‘legal representation’ into the package price for individual parties (as automobile insurers now try to do, for example, by providing the services of staff attorneys for policyholders who are sued.²) It might employ ongoing safety valves or checks, expert input and monitoring, to reduce the likelihood of a dispute in the first place. It might provide what many individuals who litigate want most which is information and explanation. It might separate dispute resolution from rule formation by strictly and mechanically applying rules and using the feedback from multiple disputes to update rules in a separate process. It might combine ‘legal’ constraints with other mechanisms designed to improve the alignment between ex ante and ex post incentives such as technology that automates decision-making or routes information so as to change incentives or the set of feasible actions, organizational structures that delegate decisions to actors with better ex post incentives, information distribution networks that harness reputation

² The regulators who control legal markets—lawyers themselves—work hard to prevent such mechanisms from being adopted.

incentives, and so on. Private contracting systems now operate extensively in trade association settings—cotton traders or diamond merchants, for example, agree to have their transactions governed under the dispute resolution terms and institutions of the association; Lisa Bernstein has shown how these private systems have diverged from conventional state-run contract enforcement processes (such as by using stark simple rules which are not modified in the context of dispute resolution but only in response to proposals from dispute resolvers, and using publication of information about contract defaults to harness reputation incentives.) And in standard contracting settings, there is increasing use of privately-designed arbitration systems which can modify state law of evidence and procedure to resolve disputes, although all of these systems, to my knowledge, continue to apply the substantive law of contracts from some state jurisdiction; this may explain why they have become so lawyer dominated and largely regressed from the early hope that they would provide much lower-cost higher quality litigation alternatives.

The question for health care reform in this context would then be whether or not this market, for private contract enforcement, could be made tolerably competitive. This would depend in part of whether those exercising choice across competing suppliers included parties who are equally likely to be ‘plaintiffs’ as ‘defendants’ in health contract disputes and relatively balanced in their importance to the supplier. A system where large repeat players who are only going to be defendants in disputes to enforce obligations of coverage (e.g., insurers) chose the enforcement supplier (by including it in the standard contract—as many now control the use of particular arbitration providers) would, for example, not produce efficient solutions. Suppliers would develop a product to meet the ex post interests of insurers, not the joint interest in aligning ex ante and ex post incentives. But if the choice of enforcement provider was determined

through relatively equal bargaining between insurers and reasonably sized employers, or if insurers had to submit to the same provider in their efforts to enforce the premiums in their policies, private competition could potentially do at least a better job than public courts and the lawyer-controlled legal profession.

As a second example of how innovative legal institutions might play a role in providing the legal and regulatory structure needed to achieve health care objectives, consider the proposal for 'health courts' to resolve medical malpractice claims. As Tim and Roger both note, there's little evidence malpractice is a serious source of health care costs but the proposal for health courts contains some of the more innovative thinking about legal structure that might be needed both to promote provider interest and participation in reformed institutions and to develop models that go beyond malpractice litigation. The important attribute of malpractice disputes is that they involve elements of both contract (subject to private ex ante bargaining) and external politically determined constraints on behavior (tort and other regulated care standards.) They thus seem to pose a challenge that goes beyond developing effective private contract enforcement mechanisms, where cost-effective alignment of ex and ex post incentives is primary, to addressing political relational concerns about doctor autonomy and reputation, respectful patient treatment, compliance with professional and community care norms and information entitlements.

Health courts, as I understand the proposals, would seek to shift medical injury dispute resolution into expert tribunals (rather than the general jurisdiction tribunals that characterize most of the American legal system) that would separate patient compensation from individualized negligence-based assessments of quality of care and produce written (rather than

jury) determinations that are keyed into professional systems for monitoring and implementing best practices. Although the proposals I've seen (from Harvard School of Public Health and Common Good) are seriously lacking in legal design, the principle of separating different functions of dispute resolution as much as possible (compensation from deterrence) is a good one. So too is the goal of integrating the dispute resolution system with the provider system, and the attention paid to how standards develop over time and on the basis of what expertise. But one of the most interesting features of the proposal is the recognition that the costs of medical injury dispute resolution are in part driven by the relational injuries suffered by both patient and provider and that a mechanism that seeks to control these costs has to serve this 'market demand' in order to be effective. This is Tim Jost's observation too that even if malpractice is a tiny piece of the problem from a health economics point of view, it dominates the vision of doctors because of the emotionally and psychologically draining experience of litigation.

Although this has been rarely studied systematically it seems fairly clear that what drives many individuals who suffer medical injury to litigation (the few that do resort to the courts) is not the search for dollars (though they may need these to pay both their doctors and their lawyers) but the search for information, accountability and responsive change.³ I would not be surprised if similar dynamics did not also underlie many health coverage disputes—that is, that patients seek not merely maximum coverage and financial benefit but rather rational, respectful explanations of coverage that comply with the terms of the policy or plan they chose to purchase or were granted. Dispute systems that provide a venue for explanation, apology, accountability and professionalism may provide a double benefit: addressing the issues that otherwise emerge

³ I've done a study of another group of tort claimants, those injured in 9/11, and these are the major themes to which they appeal in explaining why accepting a dollar payout from the Victims Compensation Fund was not an easy alternative to pursuing civil litigation.

in other costly ways and allowing a rational limitation of the amount of time and energy expended to keep costs, of all kinds, in check. Most deliberative institutions, for example (legislatures, agencies,) have no trouble operating under strict guidelines of how long one may speak, how many witnesses one may call, or how many documents may be reviewed; if ultimate determinations of high-stakes reputational liability and financial obligation are not on the line, it may be easier to cabin a process focused on information and accounting.

Ultimately, however, the flaw in the health courts proposals comes back to the problem that, by remaining within the basic framework of the adjudication system provided by the state⁴ it fails to come to grips with what drives the entropy of complexity and cost in modern legal systems. It is all well and fine to say ‘a clear body of standards would be developed by judges’ written opinions’ and ‘lawyers won’t be necessary,’ ‘experts will be neutral’ and ‘compensability recommendations would be based on best available scientific evidence.’ Except for the ‘no lawyers’ bit, most courts would describe their goals in similar ways. But as organic institutions operating as monopoly providers, courts have in fact faced enormous difficulty reigning in the cost and complexity of adjudication and rule adaptation. And without serious reductions in those costs, the effectiveness of legal mechanisms to implement health care objectives will remain illusory. Achieving those objectives likely requires innovative approaches to delivering legal inputs.

⁴ As I understand the Harvard/Common Good proposal, these would be Article I courts, that is operating within the executive branch of government, but there is an ultimate connection back in the proposals I have seen to Article III general jurisdiction courts through appellate review. Other courts within administrative agencies or with specialized Article I jurisdiction—such as social security appeals tribunals or tax and bankruptcy courts—tend to be heavily influenced by the dynamics that govern the courts to which there is ultimate appeal in terms of the cost and complexity of adjudication.