

ESSAY

FEDERALIZATION SNOWBALLS: THE NEED FOR NATIONAL ACTION IN MEDICAL MALPRACTICE REFORM

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Because tort law and healthcare regulation are traditional state functions and because medical, legal, and insurance practices are localized, legal scholars have long believed that medical malpractice falls within the states' exclusive jurisdiction and sovereignty. This conventional view fails to consider the impact that federal healthcare programs have on the states' incentives to regulate. As a result of federal financing, each state externalizes some of the costs of its malpractice policy onto the federal government. The federal government therefore needs to take charge of medical malpractice in order to fix the spillover problem created by existing federal healthcare programs.

Importantly, the need for federal intervention in medical malpractice arises solely from the federal government's prior decisions to pay a portion of healthcare spending. Unlike traditional spillover stories, the story here is not that the states are inevitably ill-suited to govern medical malpractice; rather, the federal government has made them so. The federal government's prior interventions in healthcare spending have snowballed into a need for federalization of medical malpractice. This causal distinction between spillover and "snowball" stories bears theoretical and practical significance for functional models of federalism, and it could explain and justify federalization decisions in a range of regulatory regimes.

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INTRODUCTION

We are told that our medical malpractice system is broken.¹ Doctors are sloppy without punishment; patients are injured without compensation; juries seek revenge without proof; and lawyers get rich without justification.² Meanwhile, the price of liability insurance rises; the practice of defensive medicine increases; and the rate of healthcare inflation dramatically outpaces the rate of inflation in every other industry.³

1. See Note, Fixing Medical Malpractice Through Health Insurer Enterprise Liability, 121 Harv. L. Rev. 1192, 1192 & n.3 (2008) (noting and collecting multitude of scholarly calls for reform of malpractice system).

2. See Paul C. Weiler et al., A Measure of Malpractice 16–19 (1993) (reporting results of Harvard Medical Practice Study and arguing that malpractice system simultaneously undercompensates patients and overdeters negligence, resulting in defensive medicine without accomplishing compensation).

3. Ceci Connolly, Malpractice Situation Not Dire, Study Finds, Wash. Post, Mar. 10, 2005, at A8 (quoting then-President George W. Bush as citing increasing malpractice insurance premiums and increasing healthcare costs as justifications for federal legislation that would have capped damages in malpractice litigation).

Since at least the mid-1970s (when the United States suffered the first medical malpractice “crisis” of the modern era⁴), scholars and politicians have debated the causes and the extent of the malpractice problem, proposing a variety of systemic solutions. Although there has been much disagreement as to both the true extent of and the proper solution to the problem, there has been at least one solid academic consensus throughout the debate: To whatever extent medical malpractice matters, it is solely a matter of state concern.⁵ That is, although scholars have not fully agreed on whether there is a genuine problem to solve⁶ or whether any given proposal would work to solve it, they have agreed that the federal government is not the right institution to implement malpractice reforms.⁷ Because tort law generally and healthcare regulation specifically are traditional state functions and because medical, legal, and insurance

4. Academic writings from the 1970s noted the “crisis.” See, e.g., Martin H. Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 *Tex. L. Rev.* 759 (1977); Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 *Duke L.J.* 1417; see also Neal C. Hogan, *Unhealed Wounds: Medical Malpractice in the Twentieth Century* 129 (2003) (recounting emergence of malpractice crisis and dating it back to the 1950s); Cecilia Loh, *An Overview of Medical Malpractice and the Tort Reform Debate*, April 23, 2003, at <http://www.case.edu/med/epidbio/mphp439/Malpractice.htm> (on file with the *Columbia Law Review*) (dating first medical malpractice “crisis” to 1840).

5. This generalization has one notable exception: Bill Sage and Eleanor Kinney have argued recently that the Medicare program should implement a comprehensive federal system for enforcing quality controls against doctors and for compensating Medicare and Medicaid beneficiaries who have suffered from negligent care. This proposal is a limited version of my suggestions here because it represents a federal attempt to control doctor quality and patient safety. See generally Eleanor D. Kinney & William M. Sage, *Dances with Elephants: Administrative Resolution of Medical Injury Claims by Medicare Beneficiaries*, 5 *Ind. Health L. Rev.* 1 (2008) [hereinafter Kinney & Sage, *Dances with Elephants*] (arguing in favor of administrative resolution of malpractice claims through Medicare); Eleanor D. Kinney & William M. Sage, *Resolving Medical Malpractice Claims in the Medicare Program: Can It Be Done?*, 12 *Conn. Ins. L.J.* 77 (2005) [hereinafter Kinney & Sage, *Resolving Medical Malpractice Claims*] (assessing legal and practical feasibility of Medicare-led malpractice reform); William M. Sage, *The Role of Medicare in Medical Malpractice Reform*, 9 *J. Health Care L. & Pol’y* 217 (2006) [hereinafter Sage, *Role of Medicare*] (arguing real malpractice crisis is lack of connection between malpractice system and healthcare system).

6. There is a scholarly consensus emerging that the core problem is one of patient safety rather than malpractice litigation. See, e.g., Tom Baker, *The Medical Malpractice Myth* 3 (2005) [hereinafter Baker, *Malpractice Myth*] (arguing “the real problem is too much medical malpractice, not too much litigation”).

7. Cf. James F. Blumstein, *A Perspective on Federalism and Medical Malpractice*, 14 *Yale L. & Pol’y Rev.* 411, 14 *Yale J.* on Reg. 411, 427–28 (1996) (Joint Symposium Issue) (noting few limited roles that federal government might properly play in medical malpractice reform but also concluding that it should not take charge of comprehensive reforms).

practices are highly localized, legal scholars have long believed that medical malpractice falls within the states' jurisdiction and sovereignty.⁸

Indeed, this view is so widely held that modern legal scholarship takes it for granted.⁹ Articles that address general federalism issues use medical malpractice as an easy example of a localized policy in which federal intervention lacks functional justification,¹⁰ and articles that focus on federalization of other tort reforms (particularly products liability reform) use medical malpractice as an easy foil, pointing out that the uniformity interest that justifies federalized products liability law does not apply to medical malpractice law.¹¹

This Essay challenges that scholarly consensus. Although I do not dispute that both tort law and medical regulation are traditional state concerns or that all of the relevant industries are localized, I nevertheless argue that federalization of medical malpractice reform is functionally justified—and ultimately necessary.¹²

The justification arises from the political economy of medical malpractice, which suffers from a spillover problem. While a given state fully internalizes the benefits of inefficient malpractice laws, that state does not bear the full cost of the inefficiencies. Instead, it externalizes a significant (and ever-growing) portion of those costs onto the federal government and, by extension, onto the other forty-nine states.

8. For the most forceful and robust presentation of this view, see Gary T. Schwartz, *Considering the Proper Federal Role in American Tort Law*, 38 *Ariz. L. Rev.* 917, 922 (1996) [hereinafter Schwartz, *Proper Federal Role*].

9. I distinguish here between theoretical scholarship and scholarly commentary on political debates. Because the 2008 presidential candidates proposed and debated federal malpractice reform, some scholars have recently addressed the federalism argument in popular media, including the blogosphere. See, e.g., Rick Hills, *Caps Off for Obama? Med Mal and the '08 Election*, *Prawfs Blawg*, Mar. 27, 2008, at <http://prawfsblawg.blogs.com/prawfsblawg/2008/03/caps-off-for-ob.html> (on file with the *Columbia Law Review*). There has not, however, been a serious scholarly consideration of the question since the mid-1990s.

10. See, e.g., Betsy J. Grey, *The New Federalism Jurisprudence and National Tort Reform*, 59 *Wash. & Lee L. Rev.* 475, 534 (2002) (using medical malpractice reform as example of federal reform that is less likely to pass constitutional muster because such reform is directed at “individual” rather than “economic” activity); Samuel Issacharoff & Catherine M. Sharkey, *Backdoor Federalization*, 53 *UCLA L. Rev.* 1353, 1383–84 (2006) (using medical malpractice as example of matter that is “quite localized in [its] impact” and therefore does not need to be federalized).

11. See, e.g., Robert M. Ackerman, *Tort Law and Federalism: Whatever Happened to Devolution?*, 14 *Yale L. & Pol'y Rev.* 429, 456 (1996) (Joint Symposium Issue) (“Beyond products liability, the case for federal tort legislation is not nearly as clear Despite the growth of tertiary care facilities, medical practice remains largely local.”); Robert L. Rabin, *Federalism and the Tort System*, 50 *Rutgers L. Rev.* 1, 29 (1997) (“[M]ost cases of accidental harm arising in the course of everyday life retain a distinctly local character; motor vehicle accidents, premises-related mishaps and medical malpractice injuries account for a very substantial part of the tort docket.”); Schwartz, *Proper Federal Role*, *supra* note 8, at 922 (arguing that medical malpractice is localized concern appropriate for state regulation).

12. This argument is not a constitutional one; my focus here is purely functional.

What is the mechanism for externalization of costs? It is the federal government's large and growing role in financing Americans' healthcare utilization. As of 2006, the federal government was directly responsible, through Medicare, Medicaid, and a handful of other programs, for about thirty percent of nationwide healthcare spending.¹³ The federal government thus pays directly for about one-third of a state's healthcare consumption, including one-third of malpractice-induced inefficient utilization (both "defensive medicine" and follow-up care after injury).¹⁴ Additionally, because the federal tax code subsidizes private healthcare spending, an additional ten percent of healthcare costs—the subsidized private costs—are borne by the federal government.¹⁵ Those subsidized private costs are ultimately federal public costs in the form of lost tax revenue. In total, the federal government bears forty percent of the costs of U.S. healthcare spending.

Because this significant portion of utilization costs, including those associated with a state's malpractice laws, will be borne by the federal government, it is the only institution that internalizes the full cost-benefit tradeoff of malpractice policy. The federal government, thus, is best positioned to choose the optimal cost-benefit balance in medical malpractice policy, and it should therefore intervene in malpractice reform.¹⁶

This externalization story, of course, will ring familiar to federalism scholars. My argument here is an ordinary functional federalism argument, falling comfortably with traditional spillover stories that have justified federalization of, for example, environmental and antitrust law.¹⁷

13. See Ctrs. for Medicare & Medicaid Servs., National Health Expenditure Web Tables, at tbl.1, at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf> (last visited Feb. 18, 2009) (on file with the *Columbia Law Review*) [hereinafter CMS, NHE Web Tables] (depicting that federal government spending accounted for \$707.6 billion of more than \$2.1 trillion spent on healthcare in United States in 2006).

14. Federal spending is limited to certain patient groups, so the distribution of malpractice costs among payers depends on the distribution of malpractice costs among patient groups. It seems likely, though, that the distribution of general expenditures among patient groups is about the same as the distribution of malpractice-induced expenditures among patient groups, such that the payment distribution will be roughly the same for malpractice-induced costs. For more discussion on this point, see *infra* Part II.A.3.

15. For the derivation of this percentage, see *infra* Part II.A.2.

16. Under an uncontroversial representation theory, the federal government must internalize all national costs and benefits. As a whole, the federal government represents the interests of all parties in the nation, possibly including the states. This internalization account often fails in practice—just as the rational actor model I use to analyze state-based decisionmaking often fails in practice—but that practical failure does not defeat the empirical and theoretical point that federal healthcare spending systematically skews states' incentives. The point here is only that if the current political system worked perfectly as theorized, we would want the federal government rather than the state governments to set malpractice policy.

17. The original argument to this effect is Charles Tiebout's. Charles M. Tiebout, A Pure Theory of Local Expenditures, 64 *J. Pol. Econ.* 416 (1956) (demonstrating that competition among local governments will allow those governments to set appropriate

But there is an important causal difference between the traditional spillover story and the spillover story at issue here: The externalization effect that justifies federalization of malpractice reform would not exist but for a prior decision to federalize a significant portion (but only a portion) of U.S. healthcare spending. The functional need for federal intervention in this case arises solely from the federal government's prior interventions in financing some healthcare (through Medicare and Medicaid) and in subsidizing some medical expenses (through tax breaks). The partial federalization of healthcare spending has thus snowballed into a functional need for federalization of medical malpractice law.¹⁸

This snowball effect is both theoretically and practically significant. First, it is theoretically significant because federal intervention in a snowball scenario may be offensive to certain federalism values, especially state sovereignty. The states are not inevitably ill-suited to govern medical malpractice; the federal government has made them so. Federal intervention in malpractice, thus, could be seen as a greater insult to state sovereignty than federal intervention in a traditional spillover field like environmental law.

Furthermore, the snowball effect is practically significant because the need for federal intervention in a snowball scenario could be eliminated by choosing to dismantle existing federal programs and because future snowball scenarios can be avoided by deciding not to create limited federal programs. We ought therefore to recognize that we are now facing a choice between, on the one hand, federalizing medical malpractice and, on the other, repealing federal programs and tax breaks. And in the fu-

levels of expenditure on public goods). Tiebout's general insight has been fleshed out in the theoretical literature. See Bruce H. Kobayashi & Larry E. Ribstein, Introduction to *Economics of Federalism*, at xi, xi–xx (Bruce H. Kobayashi & Larry E. Ribstein eds., 2007) (summarizing Tiebout's theory and surveying literature developing that theory); John D. Donahue, Tiebout? Or Not Tiebout? The Market Metaphor and America's Devolution Debate, *J. Econ. Persp.*, Fall 1997, at 73, 74–77 (describing Tiebout's "market metaphor" for interjurisdictional competition and limits thereto); Robert P. Inman & Daniel L. Rubinfeld, Rethinking Federalism, *J. Econ. Persp.*, Fall 1997, at 43, 45–52 [hereinafter Inman & Rubinfeld, Rethinking] (noting that three main theories of federalism allow central governments to intervene, at least to some extent, to fix spillover problems among states). For specific considerations of spillovers in the areas of antitrust and environmental law, see Frank H. Easterbrook, Antitrust and the Economics of Federalism, 26 *J.L. & Econ.* 23, 38–40 (1983) (discussing effect of "monopoly overcharges" by industries based primarily in one state); Richard B. Stewart, Pyramids of Sacrifice? Problems of Federalism in Mandating State Implementation of National Environmental Policy, 86 *Yale L.J.* 1196, 1215–16 (1977) (discussing spillover of physical pollution).

18. Critically, my point here is not the oft-made point that the federal government tends to grow; I am not making a claim about bureaucratic power grabbing or "centralization creep." See *infra* Part III.B. My point is that by federalizing some healthcare regulation, we created an actual *need* and *justification* for further federalization. Even if federal bureaucrats were perfect agents of the people who fully internalized and fully appreciated values of state sovereignty, they would want and need to take some control of medical malpractice law.

ture, we ought to consider the possibility that new federal programs could create a need for further federalization of traditionally state-based regulations.

Given these theoretical and practical considerations, what precise role should the federal government play in medical malpractice reform? The right answer certainly is not that Congress should dismantle Medicare and Medicaid and repeal the tax subsidies so that the states' incentives will realign. But the necessary alternative, given the snowball story, is some degree of federal intervention.

Because the discrete problem identified here is purely financial—the federal government's large portion of current regulatory costs—it is tempting to propose a purely financial solution, such as block grants or categorical grants to states that enact robust malpractice reforms. Such grants, however, would be nearly impossible to administer because the necessary level of federal participation would be nearly impossible to calculate.¹⁹ I therefore propose substantive federalization, which seems necessary to fix the externality. Of course, given the lack of uniformity concerns in medical malpractice, federalization here need not be fully preemptive or comprehensive. In order to preserve federalism values such as competition and experimentation, the federal government could, for example, allow waivers or run demonstration projects, two approaches that I endorse in Part IV below.

This Essay proceeds as follows. Part I describes the theoretical and empirical tie between malpractice reform and healthcare spending, identifying sources of inefficient spending that the current malpractice environment creates and describing academic and political proposals for reducing those inefficiencies. Part II presents the externalization story, explaining the need for federal involvement in future malpractice reform efforts. Part III draws out the causal distinction between the snowball effect and the ordinary spillover effect, discussing the theoretical and practical importance of the distinction. Part IV outlines a range of federalism values that are important in designing malpractice reform and proposes a form of substantive federalization that balances those federalism values. Finally, Part V explores the possibility that the snowball story could be used to justify prior federalization decisions in other regimes and notes the likelihood that other snowball scenarios have existed and currently exist.

I. THE CALL FOR MEDICAL MALPRACTICE REFORM

There are two categories of inefficiency that might arise from our current medical malpractice system, one of which has been the primary focus of political argument while the other has become the primary focus

19. See *infra* Parts IV.B.3–4.

of academic writing. The first is defensive medicine²⁰—politicians argue that malpractice litigation overincentivizes provision of diagnostic tests. The second is patient injury—scholars contend that the malpractice system underincentivizes effective precautions.²¹

Despite having produced voluminous empirical and theoretical literatures on medical malpractice reform, academics and politicians have continued to disagree—both between and among themselves—on the significance of malpractice-related inefficiencies to healthcare costs and on the causal relationship between those inefficiencies and malpractice litigation. That is, they have disagreed on whether defensive medicine or patient injury adds significantly to healthcare inflation, and they have disagreed on the extent to which any alteration to the malpractice system could reduce defensive practices or iatrogenic (i.e., physician-caused) injury. They have also disagreed on how best to fix the inefficiencies that exist. While politicians emphasize “first-generation” reforms such as caps on damages, scholars emphasize “second-generation” reforms such as alternative dispute resolution; and while politicians continue to push for federal-level reforms, scholars continue to insist that state-level reforms are more appropriate.²²

For present purposes, we need not tangle much with the unanswered empirical and causal questions. Only two aspects of the voluminous malpractice literature are centrally relevant to this Essay: first, the theoretical ties between malpractice incentives and healthcare costs, and second, the

20. See Daniel Kessler & Mark McClellan, Do Doctors Practice Defensive Medicine?, 111 Q.J. Econ. 353, 354–55 (1996) [hereinafter Kessler & McClellan, Do Doctors] (finding that malpractice reforms that decrease liability pressure on doctors result in decreased utilization but not increased mortality or morbidity and therefore concluding that defensive medicine occurs and may be decreased by changes in litigation environment); see also Cong. Budget Office, Medical Malpractice Tort Limits and Health Care Spending 2 (2006), available at <http://www.cbo.gov/ftpdocs/71xx/doc7174/04-28-MedicalMalpractice.pdf> (on file with the *Columbia Law Review*) [hereinafter CBO, Medical Malpractice Tort Limits] (noting that tort reform might affect utilization by decreasing defensive medicine); Patricia M. Danzon, Liability for Medical Malpractice, in *Handbook of Health Economics* 1339, 1343 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (noting that liability might induce “either cost-justified injury prevention that the system is intended to encourage or defensive practices that are not cost-justified”); Daniel P. Kessler, Evaluating the US Malpractice System and Paths to Its Reform 4–5 (Dec. 2006) (unpublished manuscript, on file with the *Columbia Law Review*) [hereinafter Kessler, Evaluating US Malpractice] (summarizing theory of defensive medicine).

21. Baker, Malpractice Myth, *supra* note 6, at 3 (“[T]he real costs of medical malpractice have little to do with litigation. [They] are the lost lives, extra medical expenses, time out of work, and pain and suffering of tens of thousands of people every year [who are injured by physicians], the vast majority of whom do not sue.”); Inst. of Med., To Err Is Human 1 (2000) [hereinafter IOM, To Err] (concluding, based on empirical work, that between 44,000 and 98,000 “Americans die each year as a result of medical errors”).

22. For an overview of government attempts at tort reform, see Rogan Kersh, Medical Malpractice and the New Politics of Health Care, in *Medical Malpractice and the U.S. Health Care System* 43, 46–49 (William M. Sage & Rogan Kersh eds., 2006).

substantive and federalism debates surrounding proposals for malpractice reform.

This Part briefly reviews both. Part I.A presents the cost-saving goals of malpractice reform by describing two kinds of inefficient healthcare utilization that might arise from the current malpractice environment: defensive medicine and post-injury care. Part I.B briefly describes academic and political debates over reform options, highlighting not only the necessity of choosing among substantive reform proposals but also the necessity of choosing between state and federal governments for implementation.

A. *Medical Malpractice and Healthcare Utilization*

Throughout modern debates on medical malpractice, the primary goal of reform-minded politicians and scholars has been the reduction of healthcare costs.²³ Since the malpractice crisis of the 1970s, calls for reform have centered on the promise of decreasing costs associated with medical malpractice litigation and thereby reducing U.S. healthcare spending.

Importantly, the direct cost of litigation is not the only or even the primary source of malpractice-induced healthcare costs; litigation costs amount to only one or two percent of total U.S. healthcare spending.²⁴ And that figure includes the cost to doctors of carrying liability insurance, meaning that even the premium spikes of the 1970s, 1980s, and early 2000s had relatively small effects on national health expenditures (at least in percentage terms).²⁵

But there are also indirect costs associated with malpractice policy, which are likely more substantial in themselves and which add to the

23. See Connolly, *supra* note 3 (quoting then-President Bush as saying, “If you’re a patient, [the malpractice problem] means you’re paying a higher cost to go see your doctor”).

24. Cong. Budget Office, *Economic and Budget Issue Brief, Limiting Tort Liability for Medical Malpractice 1* (2004), available at <http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf> (on file with the *Columbia Law Review*) (“But even large savings in premiums can have only a small direct impact on health care spending—private or governmental—because malpractice costs account for less than 2 percent of that spending.”); Danzon, *supra* note 20, at 1343 (“Malpractice premiums account for roughly one percent of total health care spending, hence are not a significant contributor to the level or growth of health care costs.”).

25. It is important to understand that the one percent figure still represents a significant expenditure in dollar terms. National health expenditures in 2006 were \$2.1 trillion, CMS, NHE Web Tables, *supra* note 13, at tbl.1, meaning that the malpractice system costs about \$21 billion per year in litigation costs alone. Furthermore, these costs are passed on to healthcare consumers, so even doctors’ and hospitals’ litigation costs become consumers’ healthcare costs in the U.S. system. See Mark V. Pauly, *Who Pays When Malpractice Premiums Rise?*, in *Medical Malpractice and the U.S. Health Care System*, *supra* note 22, at 71, 77–80 (noting evidence that when malpractice premiums increased, doctors’ fees increased “with an elasticity sufficiently large to imply 100 percent forward shifting”).

more tangible litigation costs. The indirect costs arise from two categories of inefficient utilization that the malpractice system simultaneously incentivizes (defensive medicine) and fails to deter (post-injury care). Although these indirect costs are notoriously difficult to measure,²⁶ their empirical existence is widely accepted, and their theoretical underpinnings are well developed.²⁷

The theory behind defensive medicine is that doctors will overprovide diagnostic tests and other precautionary procedures in order to create an appearance of *legally* adequate care (to avoid an appearance of negligence). Motivated by a fear of litigation and a fear of adverse judgments, doctors provide more blood work, more MRIs, more biopsies than are cost-justified, hoping to demonstrate to their patients and perhaps jurors that they are being duly cautious. Some “defensive” utilization provides at least some medical benefit to the patient, so the inefficiency associated with it is only the difference between social cost and social benefit. Other defensive utilization may be medically useless or even harmful to the patient, making the inefficiency the full cost of the service plus the cost of any resulting harm.²⁸ Based on survey results²⁹ and some other empirical testing,³⁰ scholars generally agree that doctors practice defensive medicine, though the extent of the problem has been impossible to measure with precision. The important point for present purposes is only that the current malpractice system creates pressure for doctors to overprovide precautionary services, and the aggregate cost of any resulting overprovision constitutes an inefficient inflation of U.S. healthcare spending.

Of course, there are also nonmedical benefits to defensive medicine that may weaken states’ motivation to eliminate the practice. For exam-

26. See Baker, *Malpractice Myth*, supra note 6, at 24–25 (describing most common approaches to measuring rates of negligent injury and noting approaches’ weaknesses); CBO, *Medical Malpractice Tort Limits*, supra note 20, at 35 (noting “the difficulty of disentangling any effects of tort limits from other factors that affect levels of spending for health care”); Danzon, supra note 20, at 1343 (noting that “there remain no good empirical measures of the changes in medical care that are induced by liability” and that those changes “are alleged to contribute significantly to total healthcare costs”); id. at 1366–68 (surveying empirical studies); Michelle Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*, in *Medical Malpractice and the U.S. Health Care System*, supra note 22, at 11, 23–25 (noting difficulties in measuring rates and kinds of defensive medicine).

27. Danzon, supra note 20, at 1364–69 (reviewing empirical sources and theoretical underpinnings of defensive medicine and iatrogenic injury).

28. See id. at 1343 (noting that liability might induce extra care that might constitute “either cost-justified injury prevention that the system is intended to encourage or defensive practices that are not cost-justified”); Kessler & McClellan, *Do Doctors*, supra note 20, at 354 (noting that defensive medicine “may even have adverse effects on patient health outcomes, if liability induces providers either to administer harmful treatments or to forgo risky but beneficial ones”); Mello & Studdert, supra note 26, at 25 (noting examples of medically useless and harmful defensive medicine).

29. Kessler, *Evaluating US Malpractice*, supra note 20, at 6–7 (collecting sources).

30. Id. at 8–9 (collecting sources).

ple, patients might like defensive medicine if it reassures them of diagnostic accuracy or generally makes them feel better cared for. Doctors might also like defensive medicine if it provides a demonstration of adequate care, which might be useful to the doctor-patient relationship for reasons independent of the liability system. The practice of defensive medicine thus gives rise to inefficient medical and monetary costs but also provides nonmedical and nonmonetary benefits.

The second source of inefficiency—patient injury—results from an opposing effect of the current malpractice environment: the underdeterrence of negligence. Because so few injured patients sue, doctors and hospitals lack a full incentive to invest in cost-justified safety measures that would reduce probabilities of injury.³¹ Negligent iatrogenic injuries thus continue to occur with alarming frequency.³² Those injuries then give rise to a host of avoidable costs, including most significantly the cost of additional healthcare to treat the injuries. As should be apparent, those additional healthcare costs are purely inefficient since negligent injuries are, by definition, avoidable through cost-justified precautions. As with costs arising from defensive medicine, the healthcare costs of malpractice-related injuries are difficult or even impossible to measure with precision.³³ Nevertheless, there is no doubt that such injuries occur regularly and that they give rise to avoidable healthcare spending.³⁴

As with defensive medicine, there are benefits to allowing patient injury to occur. In order to decrease rates of patient injury, doctors and hospitals might need to make dramatic reforms to their structures (including both physical and relational structures). To take one straightforward example, the medical community might need to change doctors' and nurses' work hours and training systems, which would require changes to contractual relationships and basic educational programs that have been standard for decades. Changing those structures could be quite costly, at least in the short term. Although patient injury gives rise to inefficient healthcare costs for affected patients and their payers, maintenance of the current injury rate also provides a benefit to hospitals and doctors in the form of avoided systemic costs of necessary reforms.

In sum, the current medical malpractice system gives rise not only to direct litigation costs but also to indirect utilization costs. All of those utilization costs, although providing some benefits to affected parties,

31. See David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 *Vand. L. Rev.* 1085, 1088–92 (2006) (reviewing empirical literature on frequency of suits and concluding that too few injured patients file claims).

32. See IOM, *To Err*, *supra* note 21, at 1–2 (finding high rates of injury and death, resulting in high systemic costs associated with iatrogenic injury).

33. See Baker, *Malpractice Myth*, *supra* note 6, at 24–25 (describing most common approaches to measuring rates of negligent injury and noting weaknesses of each).

34. IOM, *To Err*, *supra* note 21, at 40–41 (giving \$17 billion per year as best estimate of total costs, only part of which constitutes healthcare costs).

also inefficiently increase our national health expenditures, contributing to the healthcare industry's alarming inflation rate.

B. *Reform Debates: Scholars and Politicians, Substance and Federalism*

How should we change the malpractice system to reduce—or even eliminate—these inefficiencies? And which governmental institution (or institutions) should take responsibility for implementing malpractice reforms? Scholars and politicians have debated these questions for decades, but their conclusions have diverged, particularly in recent years. On the substantive question, politicians have focused on amendments to the litigation system while scholars have urged alternatives to that system. On the federalism question, scholars have generally agreed that state policymaking is more appropriate while politicians have increasingly pushed for federal implementation of policy solutions.

1. *Substantive: Which Reform?* — The first relevant question is the substantive one: Which reform option or options should we implement? Throughout the decades-long malpractice debate, politicians have focused on first-generation reforms, proposing and passing amendments to the litigation process. In recent years, however, academics have largely disparaged such first-generation proposals, instead urging wholesale alternatives to traditional tort litigation—or second-generation reforms.³⁵

Starting in the 1970s, state legislatures have implemented a variety of first-generation reforms, including caps on damages, caps on attorneys' fees, modification or elimination of joint and several liability rules, elimination of collateral source restrictions, and amendments to statutes of limitations.³⁶ Empirical studies of those reforms show that they have had, at best, minimal impacts on healthcare spending and healthcare quality.³⁷ But despite the apparent ineffectiveness of first-generation reforms

35. See, e.g., Kersh, *supra* note 22, at 43 (drawing and defining distinction between “first-generation” and “second-generation” reforms); see also William M. Sage, *Medical Malpractice Insurance and the Emperor's Clothes*, 54 *DePaul L. Rev.* 463, 463–64 (2005) (noting that politicians have the wrong end of the stick by focusing on first-generation reforms, especially damages caps, and that academics are on the better track).

36. See generally Henry Cohen, Cong. Research Serv., *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages*, available at <http://shelby.senate.gov/legislation/MedicalMalpractice.pdf> (last updated Apr. 11, 2005) (on file with the *Columbia Law Review*) [hereinafter Cohen, *Medical Malpractice Liability Reform*] (outlining individual states' tort reform proposals and discussing their costs and benefits from legal perspective); Ronen Avraham, *Database of State Tort Law Reforms* (Oct. 2006) (unpublished manuscript, on file with the *Columbia Law Review*), available at <http://ssrn.com/abstract=902711> (providing comprehensive data regarding state tort reform laws).

37. For surveys of the empirical literature, see CBO, *Medical Malpractice Tort Limits*, *supra* note 20, at 1–3, 20–27 (summarizing existing empirical estimates and reporting inconclusive empirical estimates from new analyses of Medicare spending); Danzon, *supra* note 20, at 1371–78 (cataloging “traditional” tort reforms and concluding that most “result, at best, in simply shifting costs from medical providers to patients and taxpayers; at worst, total social costs may actually increase if, for example, deterrence incentives are

at reducing costs or improving quality, members of Congress and former President George W. Bush have urged federal adoption of the same basic package, particularly emphasizing damage caps.³⁸

Unlike political actors, many normative legal and economics scholars have shifted their focus from these mere modifications to malpractice litigation to the adoption of wholesale alternatives to it. They have proposed replacing traditional litigation with, for example, no-fault insurance, enterprise liability, private contracting, independent health courts, uniform practice standards, and alternative dispute resolution.³⁹ Within the academic community, scholars continue to debate the theoretical virtues of and difficulties with these proposals, and there has been little agreement on whether any of the academic proposals could accomplish its goals. No single second-generation reform, thus, has emerged from

weakened"); Kessler, *Evaluating US Malpractice*, supra note 20, at 12 (finding approximately three to four percent reduction in healthcare spending in jurisdictions that have passed statutory tort reforms, but questioning causal link). For studies completed after those surveys were published, see, e.g., David A. Hyman et al., *Estimating the Effect of Damage Caps in Medical Malpractice Cases: Evidence from Texas*, 1 *J. Legal Analysis* (forthcoming 2009) (analyzing effect of 2003 Texas cap of noneconomic damages on verdicts, payouts, and settlements); Nancy L. Zisk, *The Limitations of Legislatively Imposed Damages Caps: Proposing a Better Way to Control the Costs of Medical Malpractice*, 30 *Seattle U. L. Rev.* 119, 122–23 (2006) (noting “the mounting evidence against the effectiveness of damages caps”); Ronen Avraham & Max Schanzenbach, *The Impact of Tort Reform on Private Health Insurance Coverage* (Northwestern Univ. Sch. of Law, Public Law and Legal Theory Series No. 07-16, 2007), available at <http://ssrn.com/abstract=995270> (on file with the *Columbia Law Review*) (using empirical data to assess tort reform’s effect on health insurance coverage).

38. Allison H. Eid, *Tort Reform and Federalism: The Supreme Court Talks, Bush Listens*, *Hum. Rts.*, Fall 2002, at 10, 11 (describing President Bush’s arguments in favor of “federal limitations on medical malpractice suits”).

39. For summaries of arguments for and against all of these proposals, see Danzon, supra note 20, at 1376–82; Note, supra note 1, at 1197–1203. For examples of papers proposing or refuting these ideas, see Kenneth Abraham, *The Forms and Functions of Tort Law* 261 (3d ed. 2007) (describing no-fault insurance); Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 *N.Y.U. L. Rev.* 1929 (2003) (discussing enterprise liability); Paul J. Barringer, III, *A New Prescription for America’s Medical Liability System*, 9 *J. Health Care L. & Pol’y* 235 (2006) (proposing creation of health courts); Richard A. Epstein, *Contractual Principle Versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice*, 54 *DePaul L. Rev.* 503 (2005) (proposing private contracting); Timothy Stoltzfus Jost, *Health Courts and Malpractice Claims Adjudication Through Medicare: Some Questions*, 9 *J. Health Care L. & Pol’y* 280 (2006) (discussing Sage’s proposal of health courts run through Medicare); Kinney & Sage, *Resolving Medical Malpractice Claims*, supra note 5 (proposing health courts run through Medicare); Sage, *Role of Medicare*, supra note 5 (same); Kathryn Zeiler, *Turning from Damage Caps to Information Disclosure: An Alternative to Tort Reform*, 5 *Yale J. Health Pol’y L. & Ethics* 385 (2005) (proposing information disclosure); Emily Chow, Note, *Health Courts: An Extreme Makeover of Medical Malpractice with Potentially Fatal Complications*, 7 *Yale J. Health Pol’y L. & Ethics* 387 (2007) (arguing against health courts); Jennifer Arlen, *Contracting over Malpractice Liability* (N.Y. Univ. Sch. of Law, Law & Econ. Research Paper No. 08-12, 2008), available at <http://ssrn.com/abstract=1105368> (on file with the *Columbia Law Review*) (refuting private contracting).

the theoretical literature as the best option for implementation.⁴⁰ Perhaps as a result of this internal scholarly disagreement, the state legislatures have shown little interest in adopting any of these ideas, and Congress has never considered national adoption of any such proposal. That said, Congress has considered bills that would fund limited demonstration projects for some of the academy's more dramatic proposals.⁴¹

In sum, politicians as a group seem to agree that first-generation reforms are the best option, while scholars as a group seem to agree that such reforms are insufficient. But scholars have continued to disagree as to which second-generation reforms should be tried, and politicians have shown only minimal interest in testing second-generation proposals.

2. *Federalism: Which Government?* — Even if there were broad agreement that a single reform option was the best, we still would need to confront the federalism question of whether the state governments or the federal government should implement that reform. On that question, national politicians are moving towards a consensus that the federal government should take over malpractice, while academics have long believed that the state governments should retain that responsibility.

a. *Politicians.* — Although the federal government has actively considered malpractice reforms throughout the modern debate, the states have been the only active players in implementing such reforms. The state legislatures were the first movers on malpractice policy in the mid-1970s as several states enacted statutory reforms,⁴² including most famously California's Medical Injury Compensation Reform Act of 1975 (MICRA).⁴³ In waves that tracked the malpractice insurance crises of the 1970s, 1980s, and 2000s, all state legislatures eventually followed suit so that by 2007, every state had implemented at least one of the first-generation reforms listed above.⁴⁴

Throughout that time, however, the federal government has participated actively in the malpractice debate. The Senate started holding hearings on medical malpractice in the late 1960s, and President Nixon convened a commission to study the issue in the early 1970s.⁴⁵ Impor-

40. See generally Danzon, *supra* note 20, at 1376–82 (noting theoretical advantages and disadvantages of all proposals without settling on any option as best theoretically).

41. See, e.g., Better HEALTH Act of 2003, S. 1374, 108th Cong. § 603 (2003) (proposing “National Patient Safety Research Demonstration System” to collect data on patient safety and to test improvements).

42. See Comment, *supra* note 4, at 1419 n.6 (listing state statutes limiting liability of healthcare providers).

43. 1975 Cal. Stat. 3949.

44. See Am. Tort Reform Ass'n, Medical Liability Reform, at <http://www.atra.org/issues/index.php?issue=7338> (last visited Apr. 2, 2009) (on file with the *Columbia Law Review*) (describing medical liability laws of each state); Comm. on Law & Criminal Justice, Nat'l Conference of State Legislatures, Medical Malpractice: State Medical Liability Laws 2007, at <http://www.ncsl.org/standcomm/sclaw/StateMedliablitylaws2007.htm> (last visited Apr. 2, 2009) (on file with the *Columbia Law Review*) (same).

45. William J. Curran, Public Health and the Law: A National Commission on Medical Malpractice, 61 Am. J. Pub. Health 2313, 2313 (1971); Kersh, *supra* note 22, at 45.

tantly, as states' efforts have proven ineffective, both the seriousness and the robustness of federal proposals have steadily increased. Whereas the congressional proposals of the 1970s and 1980s never passed either chamber and would have simply funded the states' efforts,⁴⁶ two modern proposals have passed the House of Representatives,⁴⁷ and most bills introduced today are comprehensive reforms that would preempt state efforts.⁴⁸ Even opponents of first-generation reforms in Congress have proposed federal alternatives that still would preempt state efforts. For example, former Senators Hillary Clinton and Barack Obama cosponsored a bill in 2005 that would have shielded physicians from state-level liability if they admitted to their mistakes and entered into settlement negotiations.⁴⁹

Of course, opponents of malpractice reform still invoke state sovereignty as an argument against federal bills, but that argument seems to be losing traction as national politicians on both sides of the aisle push federal adoption of the legislative approach that best captures their preferences. Preemptive federal legislation, thus, seems increasingly likely to reach the President's desk in the coming years.⁵⁰

46. See, e.g., Health Care Quality Improvement Act of 1986, H.R. 5110, 99th Cong. (1986); Federal Incentives for State Health Care Professional Liability Reform Act of 1985, S. 1804, 99th Cong. (1985); Alternative Medical Liability Act, H.R. 5400, 98th Cong. (1984); National Medical Malpractice Insurance and Arbitration Act of 1975, S. 482, 94th Cong. (1975); National Medical Injury Compensation Insurance Act of 1975, S. 215, 94th Cong. (1975); Federal Medical Malpractice Insurance Act, S. 188, 94th Cong. (1975); S. 1211, 94th Cong. (1975); Medical Malpractice: Hearing Before the Subcomm. on Health and the Env't of the H. Comm. on Energy and Commerce, 99th Cong. (1986); Alternative Medical Liability Act: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 98th Cong. (1984).

47. Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003); Health Coverage Availability and Affordability Act, H.R. 3160, 104th Cong. §§ 271–283 (1996).

48. See H.R. 5; H.R. 3160; see also Cohen, Medical Malpractice Liability Reform, *supra* note 36, at 3–4 (summarizing preemption provisions of HEALTH Act of 2003).

49. National Medical Error Disclosure and Compensation Act, S. 1784, 109th Cong. (2005); see also Robert A. Clifford, *The Candidates and Tort Reform*, *Chi. Law.*, Feb. 1, 2008, at 42 (reporting records of Senators Clinton and Obama on tort reform, including medical malpractice reform).

50. Cf. Clifford, *supra* note 49, at 42 (“Regardless of who becomes president in November, our government should not make it more difficult for people who have been injured to receive compensation It remains to be seen whether November’s election will bring more hardship for those injured by wrongdoers.”); Joseph Curl, McCain Vows Tax, Spending Restraint; Calls Democratic Foes ‘Liberal,’ *Wash. Times*, Feb. 18, 2008, at A06 (quoting Republican candidate Senator John McCain as calling for malpractice reform); Deb Price & Kim Kozlowski, Market-Based Solutions Touted: GOP Contenders Push Plans in Financially Unhealthy Mich., *Detroit News*, Jan. 10, 2008, at 1B (reporting that both Senator McCain and his primary rival, Governor Mitt Romney, support medical malpractice reform). But see Kersh, *supra* note 22, at 66–67 (arguing that federal politicians may be deadlocked and malpractice reform might instead be implemented through judicial decision).

b. *Scholars.* — Meanwhile, scholars remain firmly convinced that medical malpractice is a state issue, such that any federal legislation would be inappropriate.⁵¹ In making this argument, academics consider two traditional justifications for federalization: uniformity needs and spillover problems. They almost universally conclude that those justifications are inapposite to medical malpractice policy.

The foundations for this view are, first, that the relevant industries are localized and, second, that jurisdictional rules are settled.⁵² Doctors typically practice in only one state; liability insurers write state-specific (or even locality-specific) policies for actuarial reasons; and jurisdictional rules limit plaintiffs to the forum in which they were injured. As a result, neither doctors nor insurance companies need to conform to multiple states' liability rules. Doctors can conform their standards of care to the legal minimum in the state in which they practice, without worrying that they will be subject to liability in a more stringent state; and insurance companies can conform their policy limits and coverable events to the legal standards in the state for which the policy is drafted, without worrying that the insured will be subject to liability elsewhere. There is, therefore, no need to create uniformity of medical malpractice standards across state lines.⁵³

For the same underlying reasons, there is little risk that one state can externalize litigation costs onto another state. Because medical malpractice defendants get sued in the state in which they practice, the damages that a jury awards against those defendants will come out of the jurors'

51. Again, Bill Sage and Eleanor Kinney represent a notable exception to this generalization, having proposed a comprehensive federal system for Medicare and Medicaid beneficiaries. See *supra* note 5. Sage and Kinney, however, write from the perspective of substantive institutional competence rather than the perspective of federalism theory, arguing only that the Medicare agency would bring a substantive expertise to the malpractice problem that generalist state legislatures lack. They do not argue, as I do, that there is any functional need for federal intervention in malpractice reform efforts.

52. See Hills, *supra* note 9 (noting regional nature of tort laws and well-settled choice of law rules for medical malpractice cases); see also Ackerman, *supra* note 11, at 456 ("Beyond products liability, the case for federal tort legislation is not nearly as clear. . . . Despite the growth of tertiary care facilities, medical practice remains largely local."); Schwartz, *Proper Federal Role*, *supra* note 8, at 922–24 (critiquing federalism interest in malpractice and pointing out logic of tort law developed and administered at state level).

53. Although "medical tourism"—or travel across state or national lines for medical care—has become more common, it remains the case that doctors serving out-of-state patients can be sued only in their home forum. Out-of-state courts lack personal jurisdiction over a doctor that practiced only at home, even if the injured patient is not a resident of the doctor's home state. See, e.g., *Wright v. Yackley*, 459 F.2d 287, 288–89 (9th Cir. 1972) (finding no jurisdiction in Idaho over South Dakota doctor who treated Idaho citizen in South Dakota). But see *Cabbage v. Merchant*, 744 F.2d 665, 671–72 (9th Cir. 1984) (allowing jurisdiction over nonresident doctor who intentionally solicited business from state). An exception might arise if the doctor owns property or has other significant ties in the patient's home state such that she could be sued there, but such a situation would be too rare to justify uniformity of malpractice standards.

home economy. The forum state, thus, has adequate incentives to avoid excessive damage awards.

These points distinguish medical malpractice from another area of tort law that has been subject to both state and federal legislative reform: products liability. Unlike doctors, product manufacturers do not typically confine their business to a particular state; most sell their products nationwide or even worldwide. They would therefore benefit, perhaps substantially, from uniform safety and liability standards across state lines. Furthermore, jurisdictional rules allow manufacturers to be sued in any state in which their products cause injury. An Ohio-based firm, thus, could be sued in Texas, and the damages awarded against that firm in the Texas court would come out of Ohio's economy. In a products liability suit, therefore, there is a greater possibility that the jury could externalize a portion of litigation costs (especially damages costs) onto another state.⁵⁴

Under a straightforward application of functional federalism arguments, medical malpractice and products liability seem to be perfect foils. In products liability, because firms operate nationwide and can be sued in any state, we see both a uniformity need arising from liability standards and a spillover problem arising from damage awards. Both of those problems justify federal action in products liability law. But neither the need for uniformity associated with liability rules nor the spillover problem associated with damages justifies federal action in medical malpractice law. Doctors almost always get sued in the state in which they practice.⁵⁵

This account of federal tort reform—this apparent division between products liability and medical malpractice—is the one that is so widely accepted, that is taken for granted, in the legal literature. While scholars do not seem ardently opposed to Congress's efforts in medical malpractice and although many accept that congressional action would pass constitutional muster,⁵⁶ they have long believed that a federal

54. See Issacharoff & Sharkey, *supra* note 10, at 1386–89 (“Products liability law raises the specter of spillover effects, whereby a state . . . exports the cost of its regulation to out-of-state manufacturers and product consumers”); Schwartz, *Proper Federal Role*, *supra* note 8, at 932–37 (discussing structural bias theory that when states increase products liability, costs are exported out-of-state and benefits remain in-state).

55. See *supra* note 53.

56. Ackerman, *supra* note 11, at 443 (noting that “current federal funding of Medicare and Medicaid” could “serve as a [constitutional] rationale for federal intervention in the law of medical malpractice” under spending power); Blumstein, *supra* note 7, at 425 (“The Supreme Court has construed the Commerce Clause so broadly that large-scale federal intervention in the medical malpractice area is almost certainly constitutionally valid.”); E. Donald Elliott, Sanjay A. Narayan & Moneen S. Nasmith, *Administrative “Health Courts” for Medical Injury Claims: The Federal Constitutional Issues*, 33 *J. Health Pol. Pol’y & L.* 761, 765 (2008) (concluding that health courts legislation would be constitutional if properly drafted); Nim Razook, *A National Medical Malpractice Reform Act (and Why the Supreme Court May Prefer to Avoid It)*, 28 *Seton Hall Legis. J.* 99, 125–26 (2003) (using HEALTH Act of 2003 to demonstrate difficulties in

incursion on the states' sovereignty over medical malpractice would be unjustified.⁵⁷

II. MALPRACTICE AND SPILLOVERS: THE PROBLEM OF UTILIZATION COSTS

Although federalism scholars correctly note that a given state cannot externalize its malpractice-related litigation costs onto another state, they wrongly conclude on that basis that malpractice policy is free of spillover problems. The failure in the scholars' logic is that it focuses only on the direct litigation costs of the tort system, ignoring the utilization costs associated with malpractice policy choices. In fact, the states not only can but must externalize a significant portion of the utilization costs associated with their malpractice policies, giving rise to a serious spillover problem that justifies federal intervention.

Why must the states externalize those costs? Because for a large and growing percentage of American healthcare consumption, the federal government foots the bill. Through several spending programs, including most famously Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), the federal government directly pays a portion of enrollees' healthcare expenses. For those patients, the states externalize the full federal portion of inefficient utilization costs. Additionally, through a series of targeted tax breaks, the federal government subsidizes private healthcare spending. Some of the costs of inefficient utilization, thus, are externalized to the federal government in the form of lost tax revenue; inefficient utilization raises the cost of private healthcare and thereby reduces privately insured patients' taxable income.

commerce clause jurisprudence); Victor E. Schwartz, Mark A. Behrens & Leavy Mathews III, *Federalism and Federal Liability Reform: The United States Constitution Supports Reform*, 36 *Harv. J. on Legis.* 269, 272 (1999) (analyzing several tort reform bills, including some related to medical injury, and concluding that such reforms have "ample basis for support in the Constitution"); Eid, *supra* note 38, at 11 (noting that Supreme Court would uphold medical malpractice reform if regulated activity were understood to be economic activity of purchasing healthcare services rather than arguably noneconomic activity of injuring patients); see also Henry Cohen & Vanessa K. Burrows, *Cong. Research Serv., Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes* (2003) (concluding that both federal products liability reform and federal medical malpractice reform would be constitutional). But see Perry H. Apelbaum & Samara T. Ryder, *The Third Wave of Federal Tort Reform: Protecting the Public or Pushing the Constitutional Envelope?*, 8 *Cornell J.L. & Pub. Pol'y* 591, 593 (1999) (noting that so-called "third-wave" tort reforms, including medical malpractice reform, raise new and harder constitutional issues); Grey, *supra* note 10, at 534 (concluding that federal tort reform "that regulates a commercial area with direct economic impact—such as the airline industry—will fare better than legislation directed at individual activity—such as medical malpractice"); Collin Sult, *Note, Questionable Medicine—Why Federal Medical Malpractice Reform May Be Unconstitutional*, 47 *Ariz. L. Rev.* 195, 198 (2005) (expressing skepticism about HEALTH Act's constitutionality under "Supreme Court's more recent pronouncements defining the scope of congressional power under the Commerce Clause").

57. See *supra* notes 5–8 and accompanying text.

These externalization effects are significant. Direct federal spending (including spending on Medicare, Medicaid, and SCHIP) amounted to about \$707.6 billion in 2006, or about thirty percent of total national health expenditures.⁵⁸ The value of the federal tax subsidies in 2006 was about \$225.8 billion,⁵⁹ taking the federal government's share to about forty percent. The federal government thus paid for about forty cents of the average dollar spent on U.S. healthcare in 2006. Because malpractice-related inefficient utilization is probably evenly distributed among patient populations,⁶⁰ the federal government likely pays for that same forty percent share—or almost half—of the inefficient utilization that results from a state's malpractice system, allowing the states to internalize the benefits of inefficient malpractice rules⁶¹ while externalizing a significant portion of associated costs.

Part II.A fleshes out the externalization effects that result from federal spending programs and tax subsidies. Part II.B explains the spillover problem that arises from that externalization and situates malpractice's spillover problem within the functional federalism literature.

A. *Externalization Effects*

This subsection details the mechanisms and magnitudes of the externalization that arises from federal spending programs and tax subsidies. Part II.A.1 provides further details on healthcare spending programs, focusing particularly on Medicare, Medicaid, and SCHIP. Part II.A.2 provides further details on federal tax breaks, focusing particularly on the exemption for employer-sponsored insurance (ESI). Part II.A.3 discusses the specifically malpractice-related externalization that occurs through those general expenditures, demonstrating that the federal government probably foots the bill for forty percent of specifically malpractice-induced utilization costs.

1. *Direct Spending: Medicare, Medicaid, and SCHIP.* — The first externalization mechanism for medical malpractice is a group of federal spending programs that includes most significantly Medicare, Medicaid,

58. CMS, NHE Web Tables, *supra* note 13, at tbl.1.

59. The total estimate of \$225.8 billion is the sum of the Joint Committee on Taxation's estimates for lost income taxes (\$152.5 billion) and Selden and Gray's estimate for lost payroll taxes (\$73.3 billion). See Joint Comm. on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2006–2010*, at 38–40 (2006), available at <http://www.house.gov/jct/s-2-06.pdf> (on file with the *Columbia Law Review*) [hereinafter Joint Comm., *Estimates of Federal Tax Expenditures*] (estimating aggregate value of all individual and corporate exemptions related to healthcare as \$152.5 billion in 2006, which includes only foregone income taxes); Thomas M. Selden & Bradley M. Gray, *Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006*, 25 *Health Aff.* 1568, 1570–71 & tbl.1 (2006) (estimating value of federal employer-sponsored insurance exemption in 2006 as \$185.2 billion, which includes \$73.3 billion in foregone income and payroll (or "FICA") taxes).

60. See *infra* Part II.A.3.

61. See *infra* Part II.B.2.

and SCHIP. These programs fund their enrollees' healthcare expenses through complicated and variable systems that are beyond the scope of this Essay, but the common and relevant characteristic of all such programs is that they provide their enrollees with public health insurance that is financed at least in part by federal revenues. Under Medicare, the federal government provides those revenues directly to healthcare providers that serve Medicare patients. Under Medicaid and SCHIP, the federal government financially participates in state-administered and partially state-funded public insurance programs.

When a Medicare enrollee consumes healthcare services, almost all of the resulting monetary burden falls on the federal government. Although Medicare enrollees are responsible for an out-of-pocket premium, copay, or deductible for some services and although healthcare providers might shift some of the cost of Medicare consumption to private payers (if Medicare under-reimburses for certain services), the federal government picks up the bulk of Medicare enrollees' costs. As a result, if a state enacts a law that causes Medicare enrollees to increase their consumption of healthcare services, the consequent increase in healthcare costs will fall largely on the federal government.

Under Medicaid and SCHIP, the federal government provides grants to the states, which then administer the programs. When a Medicaid enrollee consumes healthcare services, thus, a state agency writes the check, but in every state, at least half of the Medicaid program's budget comes from federal revenue. (The level of "federal financial participation" in Medicaid varies by state, but the lowest level is fifty percent. The average in 2006 was 59.28%.⁶²) Importantly, because the federal government's share in a state's Medicaid program is determined on a percentage basis, increases in the states' Medicaid costs necessarily increase the federal government's Medicaid costs. As a result, if a state enacts a law that causes Medicaid enrollees to increase their consumption of healthcare services, at least half of the consequent increase in healthcare costs will fall on the federal government.

Medicare, Medicaid, and similar federal programs accounted for about thirty percent of total U.S. healthcare spending in 2006.⁶³ But be-

62. Federal Financial Participation in State Assistance Expenditures, FY 2006, 69 Fed. Reg. 68,370, 68,370-73 (Nov. 24, 2004) (listing "federal financial participation" (or "FFP") levels for all fifty states for fiscal year 2006).

63. The breakdown of health expenditures is as follows: Of the \$2.1 trillion in health expenditures nationwide, \$707.6 billion represent federal expenditures. CMS, NHE Web Tables, *supra* note 13, at tbl.3. That federal total includes Medicare expenditures of \$402.3 billion, Medicaid expenditures of \$174.9 billion, SCHIP expenditures of \$5.4 billion, and other expenditures amounting to \$125 billion. *Id.* (listing federal Medicare and Medicaid expenditures); Statehealthfacts.org, Federal SCHIP Expenditures, FY 1998-2007, at <http://www.statehealthfacts.org/comparetable.jsp?ind=234&cat=4> (last visited Apr. 18, 2009) (on file with the *Columbia Law Review*) (listing federal SCHIP spending). The federal expenditure total does not include the cost of tax breaks or the cost of the Federal Employee Health Benefit Plan (FEHBP).

cause these federal programs are restricted to certain patient populations, this figure does not mean that the federal government paid thirty cents of every marginal dollar spent on U.S. healthcare. The federal government pays for more than thirty percent of the utilization it finances, but it finances less than one hundred percent of total utilization. I will return to this point in Part II.A.3.

For now, I mean to highlight only two aspects of direct federal healthcare spending: that its absolute magnitude increases and decreases as relevant patients' healthcare utilization increases and decreases and that the direct federal portion of total healthcare spending is substantial.

2. *Tax Breaks: Employer-Sponsored Insurance.* — The second externalization mechanism is a group of federal tax exemptions, deductions, and credits for healthcare spending, which includes most significantly the exemption for employer-sponsored insurance (ESI). Under these tax breaks, income spent on healthcare is excluded or deducted from taxable income. The tax breaks, thus, constitute federal spending in the form of foregone revenue, intended to subsidize private healthcare consumption. In effect, the federal government gives up income in order to decrease the private cost of healthcare goods and services.

Of these tax breaks, the ESI exemption is the most significant. It affects more than ninety percent of privately insured patients (the percentage of such patients that receive insurance through employment), and it allows almost the full cost of the insurance premium to be excluded from both the employee's and the employer's taxable income. Importantly, even though employers pay insurance premiums directly, the cost of the insurance ultimately comes out of employees' wages.⁶⁴ Employees who receive health benefits at work are simply receiving part of their wages in health insurance rather than cash. The effect on federal tax revenues results from the fact that cash wages are taxable but insurance wages are not. Thus, as the absolute cost of health insurance fluctuates, so does the employees' ratio of cash-to-insurance wages and, with it, the federal government's revenue.

Consider first the scenario in which the price of insurance decreases, such that insurance wages decrease. Here, cash wages will increase. Employees' taxable income will therefore increase, and the federal government's revenue from income and payroll taxes will increase as well. On the other hand, if the price of private insurance increases due to, say, increases in defensive medicine or post-injury utilization rates, then employees' insurance wages will increase; cash wages will decrease; and federal revenues will decrease.

For the 2006 fiscal year, the Joint Committee on Taxation estimated the cost of all healthcare-related income tax breaks to be about \$152.5

64. See Mark V. Pauly, *Health Benefits at Work* 33 (1997) ("The economic viewpoint argues that anything that affects health insurance impacts workers, not their employers.").

billion,⁶⁵ and of that \$152.5 billion, the Joint Committee attributed \$90.6 billion (or nearly sixty percent) to the ESI exemption.⁶⁶ These figures, however, include only foregone income taxes; they do not include foregone payroll (or “FICA”) taxes.⁶⁷ Researchers at the Department of Health and Human Services Agency for Healthcare Research and Quality estimated foregone payroll taxes resulting from the ESI exemption in 2006 to be an additional \$73.3 billion.⁶⁸ The combined cost to the federal government of these healthcare-related tax breaks, thus, was approximately \$225.8 billion in 2006.

Because of these tax expenditures, the United States actually spent more than \$2.1 trillion on healthcare in 2006, and the federal government actually paid for more than 30% of 2006 health expenditures; the \$225.8 billion to subsidize private healthcare spending needs to be added to both numerator and denominator, taking the federal government’s 2006 portion to about 39.9%.⁶⁹ Of that nearly 40%, the portion attributed to tax subsidies alone was about 9.6% of total 2006 spending.

As with the 30% figure, this 9.6% figure does not necessarily prove that the federal government’s tax policies financed 9.6% of malpractice-induced utilization. The tax breaks apply only to private spending and most significantly to spending on employer-sponsored insurance, so the effect of malpractice policies on federal taxes depends on the distribution of malpractice-related utilization among patient populations. The federal government lost revenues amounting to 9.6% of inefficient costs only if the distribution of those costs was the same on average as the distribution of ordinary healthcare costs. I return to this point in Part II.A.3.

The important point to take from this subsection is simply that tax breaks, once included in the national health expenditure data, raise the federal portion of U.S. healthcare costs to about forty percent.⁷⁰

65. Joint Comm., Estimates of Federal Tax Expenditures, *supra* note 59, at 39–40.

66. *Id.* at 39. The other healthcare tax breaks are: exclusion of medical care and TRICARE insurance for military dependents, retirees, and retiree dependents; deduction for health insurance and long-term care insurance for the self-employed; deduction for medical expenses and long-term care expenses; exclusion for medical benefits included in workers’ compensation benefits; health savings accounts; exclusion of interest on state and local government qualified private activity bonds for private nonprofit hospital facilities; deduction for charitable contributions to health organizations; tax credit for orphan drug research; and tax credit for purchase of health insurance by certain displaced persons. *Id.*

67. *Id.* at 3.

68. Selden & Gray, *supra* note 59, at 1570–71.

69. The CMS data incorrectly exclude the federal tax breaks from both federal public and total national health expenditures. See CMS, NHE Web Tables, *supra* note 13, at tbl.1. This 39.9% figure is the fraction that results from adding \$225.8 billion to both the numerator and denominator; the federal public portion of total national health expenditures in 2006 was $(707.6 + 225.8)/(2112.7 + 225.8) = 0.399145$. Including the tax expenditure as a health expenditure reduces the *direct* federal percentage from 33.5%, or $707.6/2112.7$, to 30.2%, or $707.6/(2112.7 + 225.8)$.

70. This figure is the best estimate discernible from available data, but it excludes two important categories of federal spending. First, the direct spending data from CMS exclude public spending on federal employees’ insurance benefits, provided through the

3. *Externalization: Federal Spending on Malpractice-Related Utilization.* — Bearing in mind that the two categories of malpractice-related inefficiency are defensive medicine and post-injury care and given that the federal portion of all healthcare spending is approximately forty percent, what can we now say about the states' ability to externalize malpractice-related costs onto the federal government? Although difficult to establish with certainty, it seems likely that the states externalize something close to the full federal portion—the full forty percent—of their malpractice-induced healthcare costs. In other words, it seems likely that malpractice-induced utilization costs are ordinarily distributed among patient populations (or might, in fact, be slightly more likely than average to be borne by federally funded patients).

First, the federal government probably bears at least its average share of inefficient costs associated with defensive medicine. Although Medicare and Medicaid patients are less likely than other patients to sue when injured,⁷¹ doctors probably do not discriminate among patients when deciding whether to provide defensive services. Studies indicate that physicians engage in unified treatment practices, failing to differentiate treatment patterns for different patient populations.⁷² For example, when Medicare changed its pay structure to incentivize certain treatment behaviors, physicians changed their behavior toward all patients, not just Medicare patients, even though they could have profited from continuing to treat non-Medicare patients under prior patterns.⁷³ Based on this evidence, it seems likely that doctors provide the same rates and kinds of defensive services to federally funded patients as to non-federally funded patients, even though the federally funded patients are less likely to sue.

Federal Employee Health Benefits Program (FEHBP). That spending is incorrectly included in private spending. Second, the tax data exclude expenditures related to nonprofit treatment of hospitals and nursing homes. The federal government has granted favorable tax status to several healthcare organizations and has thereby foregone revenue from those organizations.

71. U.S. Gen. Accounting Office, *Medical Malpractice: Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses 2* (1993), available at <http://archive.gao.gov/t2pbat5/149700.pdf> (on file with the *Columbia Law Review*) (summarizing studies on incidence of malpractice claims and reporting that “Medicare and Medicaid patients . . . are less likely than other patients to file malpractice claims”).

72. See Laurence C. Baker, *Association of Managed Care Market Share and Health Expenditures for Fee-for-Service Medicare Patients*, 281 *J. Am. Med. Ass'n* 432, 435–36 (1999) (finding managed care activity influences expenditures for nonmanaged care patients and suggesting “physicians . . . may adopt managed care practice patterns for all their patients”); Uwe E. Reinhardt, *Editorial, The Economist’s Model of Physician Behavior*, 281 *J. Am. Med. Ass'n* 462, 464 (1999) (arguing Baker’s findings support hypothesis that physicians apply same practice style to all patients); cf. Judith Feder et al., *How Did Medicare’s Prospective Payment System Affect Hospitals?*, 317 *New Eng. J. Med.* 867, 870 (1987) (finding that introduction of Medicare’s prospective payment system reduced average length of stay for both Medicare and non-Medicare patients, although reductions for non-Medicare patients were “much smaller”).

73. Feder et al., *supra* note 72, at 870–72.

It therefore seems likely that defensive utilization is evenly distributed among patient populations and, as a result, that the federal government bears its forty percent share of total defensive utilization costs.

Second, the federal government might bear slightly more than its average share of inefficient costs associated with post-injury care. The seminal Harvard Medical Practice Study found that patients over the age of sixty-five are more likely than average to suffer injury from negligent care in hospitals.⁷⁴ For the elderly population, Medicare is overwhelmingly likely to pay more than forty percent of healthcare costs, including many of the costs of post-injury utilization.⁷⁵ All patients over the age of sixty-five are eligible for Medicare coverage; about ninety-seven percent of eligible patients are enrolled;⁷⁶ and Medicare pays a high percentage (approaching one hundred percent) of total costs for its enrollees, in-

74. Weiler et al., *supra* note 2, at 46–47, 49 tbl.3.5.

75. As of January 1, 2009, Medicare Part A (which covers hospital inpatient reimbursements) refuses reimbursement for treatment of twenty-nine specified “never events” (certain preventable injuries) and for treatment of three identified hospital-acquired conditions, but it continues to reimburse for treatment of iatrogenic injuries that are not on the lists of twenty-nine never events and three conditions. See Press Release, Ctrs. for Medicare & Medicaid Servs., Medicare and Medicaid Move Aggressively to Encourage Greater Patient Safety in Hospitals and Reduce Never Events (July 31, 2008), available at http://www.cms.hhs.gov/apps/media/press_releases.asp (on file with the *Columbia Law Review*) (describing new rules meant to “improve the quality of care in hospitals and reduce the number of ‘never events’”); see also Centers for Medicare and Medicaid Services, 73 Fed. Reg. 23,528 (Apr. 30, 2008) (codified at 42 C.F.R. §§ 411–413, 422, 489 (2008)) (proposing new regulations). Medicare Parts B and C (which cover outpatient and managed care) continue to pay for all post-injury care. The Medicaid programs in some states have also stopped reimbursing providers for some or all of the never events that Medicare has identified. See, e.g., Rick Valliere, Medical Errors: Massachusetts Programs Will Not Pay for Costs Attributable to Medical Errors, 17 BNA Health L. Rep. 877, 877 (2008) (reporting that Massachusetts stopped reimbursing for all never events that Medicare refuses to reimburse and that Minnesota refuses payment for some such never events); Jean DerGurahian, N.Y. Medicaid Ups the Ante, Mod. Healthcare, June 16, 2008, at 6 (reporting that New York’s Medicaid program refuses to pay for fourteen never events).

76. Medicare Part A covers inpatient services, Part B covers outpatient services, Part C provides private coverage such as HMO coverage, and Part D covers prescription drugs. Enrollment statistics vary by part, but approximately ninety-seven percent of the population over sixty-five is enrolled in at least one Medicare plan. See Ctrs. for Medicare & Medicaid Servs., Medicare Enrollment: National Trends 1966–2007 (2007), at <http://www.cms.hhs.gov/MedicareEnRpts/Downloads/HISMI07.pdf> (on file with the *Columbia Law Review*) (reporting 36.25 million aged persons enrolled in Medicare in 2006); U.S. Census Bureau, Table 2: Annual Estimates of the Population by Sex and Selected Age Groups for the United States: April 1, 2000 to July 1, 2007 (NC-EST2007-02) (2008), at <http://www.census.gov/popest/national/asrh/NC-EST2007-sa.html> (on file with the *Columbia Law Review*) (estimating 37.25 million Americans over sixty-five as of 2006). For a breakdown of over-sixty-five enrollment in Medicare Part A and Medicare Part B, see Ctrs. for Medicare & Medicaid Servs., Medicare Enrollment-Aged Beneficiaries (2006), at <http://www.cms.hhs.gov/MedicareEnRpts/Downloads/06Aged.pdf> (on file with the *Columbia Law Review*).

cluding much of the post-injury cost arising from negligent care.⁷⁷ Because Medicare enrollees suffer a higher than average share of post-injury costs and because the federal government pays more than forty percent of Medicare enrollees' costs, the federal government might pay more than its average (forty percent) share of total post-injury costs. Aside from the high risk for the over-sixty-five population, risk of negligent injury in the Harvard study's sample group did not depend on age, income, or payer group.⁷⁸ The over-sixty-five effect, thus, is the only demonstrated distortion of injury rates and resulting spending on post-injury care.⁷⁹

Because the costs of both post-injury care and defensive utilization seem to follow an average distribution among patients and payers, the states can count on the federal government to pick up about forty cents of the average dollar spent on malpractice-induced utilization. As a result, although each state internalizes the benefit to patients of defensive utilization (such as actual and perceived increases in diagnostic accuracy) and the benefit to hospitals of lax safety standards (such as avoided costs of systemic precautions), the state externalizes forty percent of associated monetary costs onto the federal government and, by extension, onto the other forty-nine states. Put another way, if a state were to implement malpractice reforms that decreased utilization costs by one dollar, that state could expect to gain only sixty cents; the remaining forty cents would become federal revenue and would be dispersed among the states.

B. *The Spillover Problem*

What does this externalization story tell us about federal intervention in medical malpractice policy? As in traditional spillover stories, the federalism lesson that emerges here is that the state governments will not realize the correct (that is, the optimal) cost-benefit balance in their malpractice choices—but the federal government might. Because the states internalize the benefits of excessive utilization but externalize a significant portion of consequent costs, the states will systematically underprovide patient safety regulations. The federal government, by contrast, internalizes the full benefit and the full cost of malpractice-related utilization and might therefore be better positioned to choose optimal policy outcomes.

77. See *supra* note 75.

78. See Weiler et al., *supra* note 2, at 49 tbl.3.5 (depicting effect of age on injury rates and post-injury care spending).

79. There was evidence that self-pay patients in the Harvard study's sample also bore a higher than average risk of negligent injury, but the study concluded the effect was not practically significant because it appeared to be caused not by self-paying status itself, but by higher rates of negligence at hospitals with a higher proportion of minority patients, who were more likely to self-pay. Harvard Med. Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, at 6-2 (1990), available at <http://biotech.law.lsu.edu/cases/medmal/index.htm> (on file with the *Columbia Law Review*).

To support this claim, Part II.B.1 briefly outlines a foundational economic theory of federalism: Tiebout's model of interjurisdictional competition. Part II.B.2 then returns to medical malpractice policy, demonstrating the similarities between the externalization story presented here and the more traditional spillover stories—those that have justified federalization of environmental and antitrust laws.

1. *Interjurisdictional Competition and Externalities.* — The spillover justification for federalization is founded in economic theories of federalism, starting most famously with Charles Tiebout's model of interjurisdictional competition. In his brief essay, Tiebout outlined the conditions under which local governments would provide optimal levels of public goods.⁸⁰ Put simply, he argued that competition among jurisdictions for resident taxpayers (or, to use his term, "consumer-voters") would force local governments to provide the bundle of taxes and goods that would attract the best residents.⁸¹ In other words, Tiebout argued that interjurisdictional competition, like perfect competition in the private market, would lead to optimality through a kind of invisible hand mechanism.

Just as the perfect competition model for private market behavior depends on a set of restrictive assumptions, so too does Tiebout's model for interjurisdictional competition. As Tiebout outlined in his essay, such competition will create optimality only if: (1) taxpayers are mobile, and mobility is costless; (2) taxpayers have full information about goods provided and taxes paid in competing jurisdictions; (3) there are several jurisdictions available; (4) taxpayers face no restrictions due to employment opportunities; and (5) the public goods provided in one jurisdiction do not impose externalities on other jurisdictions.⁸²

As the economics and legal literatures have long recognized, Tiebout's fifth assumption may be the least likely to hold: Almost every local regulation creates some externality, whether positive or negative, for neighboring jurisdictions.⁸³ Tiebout's invisible hand is therefore unlikely to work perfectly for any given public good or regulation. That point, however, does not fully defeat Tiebout's arguments in favor of decentrali-

80. Tiebout, *supra* note 17, at 419–21.

81. *Id.* at 422–23.

82. *Id.* at 419.

83. See Robert P. Inman & Daniel L. Rubinfeld, Making Sense of the Antitrust State-Action Doctrine: Balancing Political Participation and Economic Efficiency in Regulatory Federalism, 75 *Tex. L. Rev.* 1203, 1221–22 (1997) [hereinafter Inman & Rubinfeld, Making Sense] ("Interjurisdictional externalities are common in the local public economy."); Kobayashi & Ribstein, *supra* note 17, at 6 (discussing public goods spillover from one jurisdiction to another); Mark V. Pauly, Optimality, "Public" Goods, and Local Governments: A General Theoretical Analysis, 78 *J. Pol. Econ.* 572, 574–77 (1970) (describing purely public goods between communities); Alan Williams, The Optimal Provision of Public Goods in a System of Local Government, 74 *J. Pol. Econ.* 18, 18 (1966) (arguing interdependence of local communities is essential to understanding consequences of public goods); Inman & Rubinfeld, Rethinking, *supra* note 17, at 46 (asserting "significant intercommunity interdependencies" weaken Tiebout's assumption).

zation, just as the regular failures of Adam Smith's invisible hand do not fully defeat arguments in favor of free private markets. Although regular externalities might prevent decentralized authority from working as theorized, decentralization might still provide many of the advantages that Tiebout initially identified.

That said, Tiebout also recognized that some interjurisdictional externalities (or "spillovers") are sufficiently significant to necessitate integration of local governments.⁸⁴ He offered law enforcement as an example, noting that sheriff departments and the FBI are necessary, in addition to local police, to address criminal activity that harms multiple localities.⁸⁵

Since Tiebout wrote, scholars have identified several other policy areas that suffer from sufficiently significant spillover problems to require greater centralization of regulatory authority. Indeed, since Tiebout wrote, the existence of significant spillovers has become a mainstream justification for federalization. The most frequently cited examples of federalized regimes that arose to address such spillover problems are environmental law and antitrust law.

2. *Pollution, Collusion, and Utilization.* — The externalities inherent in environmental and antitrust regulation are closely analogous to the externalities associated with medical malpractice policy. In all three regimes, individual states internalize benefits but externalize costs associated with their specific policy choices, and in all three regimes, the predictable result is systematic underprovision of desirable regulations.

In environmental law, the problem is that a state can implement lax environmental regulations to attract industry to the state without suffering the full environmental cost of those lax regulations; some of the resulting pollution will travel to neighboring states' water and air supplies. Of course, the polluting state does not externalize all costs of its regulations; some of the pollution will stay at home, and some of the state's citizens might suffer utility losses from environmental degradation that occurs entirely abroad.⁸⁶ The material point, though, is that the state's cost-benefit calculation will be systematically skewed. If a state can export a significant portion of its pollution costs while retaining all of the associated economic benefits, then that state will systematically undersupply environmental regulation.

In antitrust law, the problem is that a state will benefit from allowing anticompetitive behavior among businesses that produce at home but that sell both at home and abroad. If those businesses are allowed to

84. Tiebout, *supra* note 17, at 423 ("In cases in which the external economies and diseconomies are of sufficient importance, some form of integration may be indicated.")

85. *Id.*

86. This utility loss could be based on purely altruistic or hedonic motivations if citizens abstractly value environmental quality, or it could be based on more concrete motivations if citizens are likely to travel to neighboring states and are likely to prefer a clean environment at their travel destination.

inflate prices artificially through anticompetitive practices, the resulting producer surplus will stay in the producing state, but the cost of the surplus will be distributed among consumers throughout the nation. As in the case of environmental regulation, it is unlikely that a state could externalize all costs of its businesses' anticompetitive practices; some of those businesses' consumers are almost certainly residents of the same state, and they, too, will be forced to pay the inflated price. But, again, the material point is that the state's cost-benefit calculation is systematically skewed, and the state will therefore predictably undersupply antitrust regulation.

The externalization story in medical malpractice follows the same basic pattern. With respect to defensive medicine, the governing state keeps all of the benefits to doctors and patients of allowing defensive practices to continue. Doctors feel better shielded from liability when they practice defensive medicine, and patients feel better cared for when they receive defensive tests. But as discussed above, that state externalizes forty percent of associated costs onto taxpayers throughout the nation because the federal government picks up forty percent of the bill when Americans overconsume defensive tests.

With respect to post-injury care, the governing state keeps all of the benefits of lax safety standards. Hospitals and doctors save money by failing to take cost-justified precautions, especially by failing to implement the expensive systemic precautions that would likely do the most good, and those savings remain in the home state. But as discussed above, the governing state externalizes the federal portion of resulting injury costs.

Of course, as in the environmental and antitrust cases, the point is not that a state can maintain bad malpractice policies at no cost. The state internalizes the full nonmonetary costs of causing iatrogenic injuries and of providing unnecessary or inadequate care, such as the cost of citizens' lost confidence in the medical system. And, of course, the state internalizes the nonfederal share of monetary costs as well as the state's share of federal monetary costs. The state's citizens pay into federal programs through federal taxes, such that some portion of the federal spending (approximately 1/50th or two percent) comes out of each state. But as in the other cases, the material point here is that the states are able to externalize the portion of federal monetary costs that comes from other states, meaning that their cost-benefit calculations are predictably and systematically skewed. Because the states externalize costs while internalizing benefits, they will systematically underprovide patient safety regulations.

In sum, in environmental law, antitrust law, and medical malpractice law, the states' regulatory choices will be predictably suboptimal. Because of significant spillover problems in the relevant fields, individual states will systematically underprovide environmental regulation, antitrust regulation, and patient safety regulation. As has been the case in environmental and antitrust law, some degree of federalization of or interstate coop-

eration in medical malpractice policy may be necessary to correct these problems.

III. MALPRACTICE AND SNOWBALLS: THE PROBLEM OF CAUSATION

Despite the similarities among the spillover stories in environmental, antitrust, and medical malpractice law, there is one important difference among them, which bears theoretical and practical significance for functional theories of federalism: Whereas the externalization of pollution costs occurs naturally and the externalization of anticompetitive costs occurs through market forces, the externalization of healthcare costs occurs only through preexisting federal programs—through a series of prior decisions to federalize certain kinds of healthcare spending. Medical malpractice, thus, is not a simple spillover story; it is a “snowball” story, in which partial federalization of healthcare regulation has snowballed into a need for further federalization of healthcare regulation.

From this causal distinction between spillover stories and snowball stories, we can extract an important theoretical point and two practical lessons for functional federalism. The theoretical point is that full federalization of medical malpractice regulation would present a greater threat to federalism values, especially including the value of state sovereignty, than full federalization of environmental or antitrust regulation, despite the three regimes’ shared instrumental justification for federal intervention. The practical lessons are, first, that we could (but should not, as I will explain in Part IV) eliminate the spillover problem in medical malpractice by dismantling relevant tax subsidies and spending programs and, second, that we can avoid similar snowball problems in the future by choosing not to create limited federal programs.

Part III.A fleshes out the causal distinction between, on the one hand, the spillover stories in environmental and antitrust law and, on the other hand, the snowball story in medical malpractice law. Part III.B distinguishes the snowball story from two more common explanations for the federal government’s continual growth: centralization creep and empire building. Part III.C considers the theoretical and practical significance of the distinction between spillovers and snowballs.

A. *Spillovers Versus Snowballs*

The critical distinction between the spillover stories and the snowball story rests in the differing externalization mechanisms. In environmental law, that mechanism is the natural reality that pollution travels. In antitrust law, the externalization mechanism is less natural (in the denotative sense) but equally unavoidable; it is the flow of goods across state lines. Because local specialization and trade are mutually beneficial and ultimately inevitable, no state will internalize all the costs of its residents’ anticompetitive behavior; some of those costs will travel to and be borne by out-of-state consumers. As a result, the states are naturally and inevita-

bly ill-suited to regulate anticompetitive conduct, just as they are naturally and inevitably ill-suited to regulate pollution.

But in medical malpractice, the externalization mechanism is neither inevitable nor unavoidable. Externalization of malpractice-related costs occurs only through preexisting, partial federal programs—which arose and remained more by sticky historical accident than by coherent federalist justification. The need for federalization of medical malpractice arises solely from prior decisions (and historically accidental decisions) to federalize portions of healthcare spending.

The most significant healthcare tax break—the ESI exemption⁸⁷—was enacted during World War II as a means of curbing wage inflation during a time of labor scarcity.⁸⁸ The intention of the tax exemption was to incentivize employers to use benefits rather than wages to attract employees. In that rarified labor market, the risk of wage inflation justified federal regulation since interjurisdictional competition for scarce labor could have harmed the national economy in a typical “race to the bottom”; in the wartime economy, each state would have had an incentive to underprovide inflation controls since higher wages would attract scarce employees. But once the labor market restabilized after the war, the need for benefits-based (as opposed to cash-based) wages disappeared, as did the need for federal regulation of private wage packaging decisions. But by the time the labor market had restabilized, the habit of providing private health insurance as an employee benefit and the presence of federal tax breaks to subsidize that habit had taken over U.S. healthcare.⁸⁹ And they stuck. It was thus mere historical accident that employer-sponsored insurance became the primary model for private health insurance in the United States—and sticky historical accident that the federal government became a major contributor to the private market through federal tax subsidies.

Similarly, the Medicare and Medicaid programs—at least in their current form as partial programs rather than full public insurance programs—lack coherent justification under functional theories of federalism; like the ESI subsidy, those programs arose by political and historical accident and simply stuck. When passed in 1965, Medicare and Medicaid were intended to be the first steps in an incremental climb to national health insurance.⁹⁰ Although full nationalization of public health insurance would be functionally justified, there is no reason that insurance for the poor, the elderly, and the disabled should be regulated at the federal level while insurance for everyone else should be regulated at the state

87. See *supra* Part II.A.2.

88. David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 *New Eng. J. Med.* 82, 83 (2006).

89. *Id.*

90. Lawrence R. Jacobs, *The Medicare Approach: Political Choice and American Institutions*, 32 *J. Health Pol. Pol’y & L.* 159, 160 (2007).

level.⁹¹ Rather, those patient groups became the starting point in an agenda for national public insurance simply because they were the most sympathetic. But national insurance still has not passed. Medicare and Medicaid have simply stuck in their original form as limited federal programs, which are good and popular programs but which still—and arbitrarily from a federalism point of view—assist only the discrete populations that first enrolled. As a result, the federal government lacks a comprehensive regulatory scheme for healthcare, leaving large chunks of regulatory authority in the hands of the states.

Of course, I do not mean to imply that the 1965 federal government was entirely misguided in tackling the problem of public health insurance. If we want health insurance to be provided publicly rather than privately, then federal control of such a program might well be better than state control since the federal government benefits from economies of scale and since the states might engage in a race to the bottom, attempting to avoid sick residents by underproviding public insurance.⁹² The basic federalism logic behind Medicare and Medicaid, thus, is sound, and the programs themselves are generally beneficial and popular. The problem with the programs—the characteristic of Medicare and Medicaid that arose and remained by historical accident and the characteristic that is responsible for the malpractice spillover—is that they limit federal power to the provision and regulation of public insurance for a few discrete patient groups, leaving significant power over healthcare regulation (including full power over medical malpractice regulation) in the hands of the states. That division of labor between state and federal governments was not well planned when Congress passed Medicare and Medicaid; it arose from political compromises. And it is that division of labor—that disjuncture between financial and regulatory control over malpractice-induced utilization—that creates the malpractice spillover. Without the historically accidental partialness of the federal programs, we would not have the snowball problem identified here.

B. *Snowballing Versus Creeping and Conquering*

It is important to distinguish here between the federalization snowball effect and the “centralization creep” and “empire building”⁹³ effects. Scholars have long noted that the federal government (like many other

91. Federal rather than state regulation of public insurance might be functionally justified. In a Tiebout competition, the states might underprovide public insurance if they believe that robust state-sponsored healthcare would attract sick residents.

92. See Alice M. Rivlin, *Reviving the American Dream: The Economy, the States, and the Federal Government* 177–82 (1992) (discussing which tasks and responsibilities are appropriate for federal and state undertaking).

93. See Daryl J. Levinson, *Empire-Building Government in Constitutional Law*, 118 *Harv. L. Rev.* 915, 940 (2005) (discussing whether empire building behavior of federal and state governments is main problem of federalism).

institutions) simply tends to grow rather than shrink.⁹⁴ Our national history is one of steady motion towards greater centralization, with very few moments of devolving power to the states. Some scholars attribute this tendency to federal agents' active desire to expand their power at the expense of state power (empire building),⁹⁵ while others hypothesize that agents simply have a psychological aversion to shrinkage (centralization creep).⁹⁶ An important assumption underlying both of these theories of federal growth is that the relevant expansions of federal power are not functionally justified. Scholars have long assumed that the federal government expands because the relevant decisionmakers simply have some personal preference for greater federalization.

The snowball effect is somewhat similar in that creeping, conquering, and snowballing all begin with an initial—and presumably innocent—decision to federalize, and that initial decision eventually spirals into greater federalization. In all three scenarios, the federal government starts small and then gradually takes over more policy space from the states.

But the snowball effect is importantly different in terms of functional justification. Indeed, the most significant scholarly payoff of identifying the snowball effect is not the recognition that partial federalization leads to greater federalization; it is the recognition that partial federalization creates a concrete need for greater federalization. When responding to a snowball scenario, the federal government expands not to build an empire or to avoid the embarrassment of shrinkage but to fix a concrete problem of state governance that prior federal programs have created.⁹⁷

C. *Snowballs and Federalism*

The causal distinction between the spillover story and the snowball story is important to both federalism theory and federalism practice. The

94. See, e.g., Saul Levmore, *Irreversibility and the Law: The Size of Firms and Other Organizations*, 18 *J. Corp. L.* 333, 334 (1993) (“[T]here is a kind of ratcheting, or irreversibility, in the evolution of a firm such that it is easier to expand than to contract.”).

95. Lynn A. Baker & Ernest A. Young, *Federalism and the Double Standard of Judicial Review*, 51 *Duke L.J.* 75, 112–17 (2001).

96. Levmore, *supra* note 94, at 337.

97. Of course, if the federal programs that give rise to the snowball problem themselves arise from empire building, then a federal response to the snowball could be considered part of that same attempt to build an empire. That is, if we imagine that the 1965 Congress simply wanted to grab state power when it passed Medicare and Medicaid, then federalization of malpractice regulation to fix the snowball could be considered a further empire build—another mere grab of state power—even though the snowball provides a solid functional justification for federalization; if that were the case, then we should prefer dismantling Medicare and Medicaid to federalization of malpractice as a response to the snowball problem. As I noted *supra* Part III.A and as I will discuss further *infra* Part IV.B.1, however, Medicare and Medicaid were not mere power grabs; they were based (at least in part) on sound federalist logic. As a result, federalization of malpractice is not an entrenchment of power grabbing or a further power grab; it is a reasonable response to the mistaken partialness of federal regulatory control.

distinction matters in theory because it indicates that federalization of medical malpractice poses a greater threat to state sovereignty than federalization of environmental law and antitrust law. In theory, the federal government should take over a regulatory regime only if the states, as sovereigns, would collectively agree that federalization is in their best interest. And when a snowball creates the functional need for federalization, it is not clear that federalization is the solution that independent sovereigns would prefer.

From a practical perspective, the distinction matters for two reasons. First, it illuminates a different solution—other than federalization—to the externalization problem in medical malpractice. Rather than federalizing patient safety regulation, we could devolve authority over healthcare financing to the states in order to realign their incentives to regulate malpractice. Second, the causal distinction serves as a cautionary tale. In the future, we could avoid these federalization snowballs by choosing not to create limited federal programs like Medicare and Medicaid.

1. *Theoretical Lesson: State Sovereignty.* — The Tiebout line of scholarship illuminates the functional benefits of decentralization and a functional justification for federalization,⁹⁸ but it does not fully take account of noninstrumental federalism values that matter in law and legal theory, especially the values of state sovereignty and political participation. When considering federalization of a regulatory power that has traditionally resided in the states, we must remember that federal power is, constitutionally, a delegated power; the states, as sovereigns, voluntarily relinquished some of their authority—some of their sovereignty—to a central government when they entered the union. But they did not give up their sovereign status. Functional expediency, thus, does not suffice to justify federalization.⁹⁹ Rather, we must also consider whether the states as sovereigns have agreed or would agree to delegate the relevant authority to the central government.

In a traditional spillover scenario, the answer to that question should be a straightforward “yes.” If the relevant regulatory regime is one that the states will not govern effectively on their own because their individual cost-benefit calculations are significantly skewed, then centralization is straightforwardly in the states’ collective best interest. In environmental and antitrust regulation, for example, the states collectively are better off when law reflects the national cost-benefit balance. Because of the inherent externalization problems in those two regimes, interstate coordination is simply necessary to achieve the right balance. And, of course, the established constitutional structure for that interstate coordination is fed-

98. For discussion of Tiebout’s scholarship, see *supra* Part II.B.1.

99. See, e.g., Richard A. Posner, *Toward an Economic Theory of Federal Jurisdiction*, 6 *Harv. J.L. & Pub. Pol’y* 41, 41–42 (1982) (“[T]he relationship between the states and the federal government cannot be regarded solely as an expedient one, designed to promote efficiency and hence alterable from time to time . . .”).

eralization.¹⁰⁰ The sovereign states agreed, through the constitutional compact, to delegate power to the federal government when individual retention of that power would make them collectively worse off, and the spillover scenarios are straightforward examples of regimes that require such delegations.

But in a snowball scenario, it is much less clear that the sovereign states, if actually acting as independent sovereigns at a bargaining table, would or should agree to delegate the relevant power to the federal government. At this point, of course, the states are just as incapable of effectively regulating medical malpractice as they are of effectively regulating pollution, but that deficiency is not inherent: The reason that the states are bad at governing patient safety is that the federal government has made them so. And the prior federalization decisions were not clearly good or necessary from the perspective of either functional federalism or state sovereignty; rather, Medicare, Medicaid, and the ESI exemption were somewhat arbitrary federalization decisions that simply stuck. Further federalization, thus, would not be a solution to a natural federalism problem; it would be a further entrenchment of a prior federalism mistake—namely, the federal subsidization of private insurance and the partialness of federal control over public insurance.

In short, the theoretical lesson is that federalization could be seen as a greater threat to state sovereignty when the states are not naturally or inherently ill-suited to perform the relevant regulatory function. The states might rationally prefer to fix their incentive and coordination problems without relinquishing their sovereign powers if such a fix is available.

2. *Practical Payoffs: Solving and Avoiding Snowballs.*

a. *Solving the Snowball.* — In a snowball scenario, of course, an alternative to federalization is available for solving the states' externalization and coordination problems. Rather than federalizing another chunk of healthcare regulation, we could return currently federalized funding responsibilities to the states, fixing rather than entrenching the sticky federalization decisions of the past. If the states were paying for all healthcare utilization, then their incentives to govern medical malpractice would no longer be skewed, and interstate coordination or integration would no longer be necessary.

The first practical payoff of the snowball story, thus, is the recognition that we now face a decision between federalizing medical malpractice and devolving healthcare spending. Instead of giving the federal government the power to govern malpractice standards, we could dismantle the Medicare and Medicaid programs and eliminate the healthcare tax subsidies at the federal level. The result would be that state-created healthcare savings arising from malpractice reforms would no longer flow

100. In Part IV, I discuss the possibility of interstate coordination through mechanisms other than the federal legislature.

into federal coffers. The externalization problem would thus disappear, as would any need for federalization of malpractice regulation. (Of course, this solution has its own impracticalities and federalism problems—and might even be impossible to accomplish—as I will discuss in Part IV.)

b. *Avoiding Future Snowballs.* — The second practical payoff of the snowball story is the recognition that federalization snowballs are avoidable. Snowball scenarios arise solely from decisions to federalize parts—and only parts—of regulatory regimes. If federalization decisions were all or nothing, then we would never see snowball-style externalization problems. The federal government would never pick up mere portions of the states' regulatory costs and would therefore never motivate the states to underprovide cost-saving regulations.

The point here is not that full-fledged national health insurance would have prevented a need for federalization of medical malpractice standards—quite the opposite. The point is that we should have known, when creating Medicare and Medicaid, that even those *partial* programs would eventually give rise to a need for federalization of malpractice.¹⁰¹ If we had recognized that eventuality at the time and had either federalized the whole healthcare system (including medical malpractice) or none of it, then we could have avoided thirty years of costly but ineffectual malpractice reform efforts in the states—costly efforts that eventually need to be replicated at the federal level anyway. Additionally, if federalization decisions were all or nothing, then the political fallout of federalizing malpractice standards would have affected the Congress that was actually responsible for that decision—the 1965 Congress—rather than affecting Congresses decades later.

Of course, the decision between federalizing *all* or federalizing *nothing* should itself be based on solid functional federalism logic, so the 1965 Congress should have passed national health insurance only if there had been federalist justification for such a move. As noted in Part III.A and later in Part IV.B.1, though, such justification existed then and exists still today since federal control of public insurance would benefit from economies of scale and would avoid a race to the bottom. The federal

101. This point is clear enough when Congress considers national health insurance today. For example, when Congress debated national health insurance in 1993, the relevant bill included comprehensive medical malpractice standards. Health Security Act, H.R. 3600, 103d Cong. (1994); see also Henry Cohen, Cong. Research Serv., *Medical Malpractice Provisions of the President's Proposed Health Security Act: A Legal Analysis* 5–14 (1994) (describing provisions of proposed Health Security Act with pilot program establishing practice guidelines). Congress and President Clinton recognized that *full* federalization of healthcare funding would require federalization of medical malpractice as well. See Schwartz, *Proper Federal Role*, *supra* note 8, at 924 (“In short, a federal takeover of the system of delivering medical services would carry with it a justification for federal control of malpractice rules. But the Clinton bill, proposing such a federal plan, went down to a resounding political defeat.”).

government, thus, ought to have taken—and ought now to take—full control over healthcare regulation, including malpractice regulation.

IV. FIXING MEDICAL MALPRACTICE

What, then, should we do to resolve the snowball problem in medical malpractice? The right answer surely is not that we should dismantle federal programs and subsidies in order to put financial control and financial incentives back in the hands of the states. Also, a more positive financial solution such as a grants-based attempt to realign the states' financial incentives does not seem possible here since the necessary level of the federal grant would be impossible to determine. Substantive federalization therefore seems necessary to correct the snowball problem in medical malpractice. That said, such a federalized regime can and should be structured to promote benefits of decentralization, such as competition and experimentation, by allowing waivers to states¹⁰² and by funding demonstration projects.¹⁰³ This approach would allow the federal government to try a variety of the academy's second-generation reform ideas.

To support this proposal, Part IV.A briefly outlines a continuum of federalism values, including the economic, political, and legal values that trade off of one another as we move from decentralized to centralized decisionmaking. Part IV.B then considers five options for interstate cooperation in medical malpractice policy—program repeals, interstate bargaining, block grants, categorical grants, and full federalization—settling on federalization as the necessary solution here but endorsing waivers and demonstration projects as means of maintaining some decentralization values.

A. *Federalism Values*

Federalism scholars have long acknowledged a set of core values that will be served either by state-based or by federal-level decisionmaking in a particular regulatory regime—values that trade off as the degree of centralization changes. The set includes virtues of decentralization, such as state sovereignty, and virtues of centralization, such as uniformity.

1. *Virtues of Decentralization.* — On one hand, there are theoretical and instrumental virtues of state-based decisionmaking that counsel in favor of decentralization. As discussed above in Part III.C.1, state sovereignty is one such virtue, guiding both the formal constitutionality and

102. Waivers would allow individual states to deviate from federal substantive requirements and systems in order to try alternatives. The Medicaid Program, for example, includes a waiver provision that allows the states to deviate from federal substantive requirements of the Medicaid Act in order to try alternative approaches to public health insurance. See Medicaid Act, 42 U.S.C. § 1315 (2000).

103. Demonstration projects would be federally funded and centrally administered experiments with various approaches to medical malpractice. The Medicare Program, for example, occasionally runs temporary demonstration projects to try different payment structures.

political appropriateness of congressional action. Interstate competition (as Tiebout identified) is another virtue, possibly allowing an “invisible hand” mechanism to play a role in the optimization of public goods and taxes. A decentralized system might be more likely than a centralized system to achieve optimal allocation of resources for citizens’ welfare.¹⁰⁴ Other virtues of decentralization include political participation, experimentation, and (perhaps) tradition.

Decentralization allows for greater political participation by putting decisionmaking power in the hands of a smaller government.¹⁰⁵ Because smaller governments represent fewer people, they give their citizens greater voice in determining policy outcomes. In the case of medical malpractice, we might favor state-based decisionmaking as a means of ensuring that patients, for example—who are dispersed and unorganized—have the strongest chance to represent their interests against those of organized doctors and lawyers. Such unorganized interests have a better chance of getting the attention of state representatives than federal representatives. Relatedly, decentralization allows differing interests and preferences to be represented differently across jurisdictions. Citizens of Alabama can choose one approach to malpractice reform while citizens of Vermont choose another.

State-based decisionmaking also allows for experimentation with a variety of policy solutions. If Alabama tries caps on damages while Vermont tries enterprise liability, we might gain valuable information about the successes and failures of each approach. Justice Brandeis provided the most famous acknowledgement of this virtue, referring to the states as laboratories for social and economic experimentation.¹⁰⁶ Without such experimentation, it might be difficult, if not impossible, to determine whether alternative dispute resolution, for example, would be an improvement over traditional malpractice litigation for deterring negligence and compensating victims.

Finally, we might consider the value of tradition. As noted above, tort litigation has long been the province of state courts—a traditional common law field. Centralized, statutory medical malpractice reform would be a dramatic departure from our legal system’s history. Although tradition does not, in itself, provide any instrumental justification for one approach or another, the existence of a long tradition often correlates with reliance interests and institutional experience, both of which might be worth preserving for instrumental reasons. We might not want to change the malpractice system in a way that puts large numbers of lawyers

104. See *supra* Part II.B.1.

105. See Inman & Rubinfeld, *Making Sense*, *supra* note 83, at 1215–17 (noting evidence supporting theory that smaller government increases citizen influence and participation).

106. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory . . .”).

out of work, for example, and we might not want to change it in a way that requires creation of new institutions that serve essentially (or exactly) the same functions as existing institutions. By giving regulatory authority to the federal government instead of the state governments, we risk these kinds of costly departures from tradition.

2. *Virtues of Centralization.* — On the other hand, centralization has virtues that need to be considered. As noted above, uniformity of legal standards is one such virtue for some regulatory regimes.¹⁰⁷ While variability across state lines allows different political preferences to be represented in different jurisdictions and allows experimentation with multiple regulatory approaches, that variability also requires individuals and businesses that operate across state lines to conform their behavior to several legal standards, which can be costly. As noted in Part I.B.2, however, uniformity does not seem to be a necessary or important goal for medical malpractice policy. Because the relevant industries are localized, there is no need to create uniformity of medical malpractice standards; doctors, insurance writers, and lawyers tend to run state-specific businesses.

Correction of interstate externalities is, of course, another virtue of centralization¹⁰⁸—and the one that motivates this Essay's call for federalization of medical malpractice reform. Because the federal government represents every state and every citizen, it internalizes both the full national cost and the full national benefit of policy choices. In medical malpractice policy, the federal government internalizes the full cost of excessive utilization not solely because it pays for some such utilization itself but also because it represents all of the people who pay for the rest.

The virtues of centralization for political participation are simply mirror images of the identified political participation virtues of decentralization. Because the federal government represents more people and because federal officials are harder to contact than state officials, they will be less accessible not only to disorganized interests like patients but also to organized interests like doctors and lawyers.¹⁰⁹ Federal officials might therefore be less susceptible than state officials to lobbying pressures and might, as a result, be more likely to represent the public interest.¹¹⁰

Finally, there is an administrative advantage to centralization. Decision costs are lower if there is only one governmental unit in charge of

107. See *supra* Part I.B.2.b; see also David L. Shapiro, *Federalism: A Dialogue* 48–49 (1995) (noting taxes, emergency relief, and professional activities as ideal areas to have uniformity).

108. See Shapiro, *supra* note 107, at 40–41 (exposing extreme externalities in areas where states independently regulate private activity).

109. See, e.g., *id.* at 45 (positing expansive singular government prevents any one party or interest from exercising completely selfish power); see also *The Federalist* No. 10 (James Madison) (arguing broad democracy is best means to guard against small powerful factions and special interests).

110. The balance here is still debated among public choice theorists. See Daniel A. Farber & Philip P. Frickey, *Law and Public Choice: A Critical Introduction* 13–17 (1991) (explaining possible impact of interest groups in state and federal settings).

the regulatory regime. If the federal government takes charge, then communication and bargaining among the states become unnecessary, and communication and bargaining between the state and federal governments become less necessary.¹¹¹ Particularly in a spillover regime, the administrative costs of interstate bargaining can be high, and in a snowball regime, the administrative costs of bargaining between the state and federal governments can be high.

B. *Regulatory Options*

Given this set of federalism values, the next question is how to approach medical malpractice regulation in a way that best balances the competing virtues of centralization and decentralization. One option, as previously noted, would be to dismantle existing federal programs in order to eliminate the externalization effects that motivate my call for federalization. But there is also a range of alternative options—involving varying degrees of centralized authority—for fixing the externalization problems without eliminating existing programs.

In order of least centralization to greatest:

- States could decide among themselves how to set malpractice standards, allowing the states to fix their own externalization problems without bestowing any additional authority on the federal government.
- The federal government could provide block grants to the states, financing medical malpractice reform without issuing any substantive requirements for reform implementation.
- The federal government could provide categorical grants to the states, financing medical malpractice reform while imposing certain statutory requirements on the substance of the states' reforms.
- The federal government could take full control of medical malpractice law, implementing preemptive patient safety standards and taking power entirely out of the hands of the states.

Although a grants approach is tempting because it is a financial solution to a financial problem, the right level of such grants would be impossible to calculate.¹¹² I therefore propose full federalization as the necessary approach to solving the snowball in this case. In order to preserve some of the competition and experimentation benefits of decentralization, however, I also endorse federally granted waivers and federally funded demonstration projects.

1. *Dismantling Federal Programs.* — The first option for eliminating the snowball would be to dismantle the federal programs through which the states externalize malpractice-related costs: Medicare, Medicaid,

111. Shapiro, *supra* note 107, at 46–48 (discussing specific instances of emergency relief and revenue raising where federal government's unilateral actions led to more effective outcomes).

112. See *infra* Part IV.B.3.

SCHIP, the ESI subsidy, and many others. In some ways, this option might seem to be the one that is most consistent with federalism's decentralization values, identified above. Given that the federal programs—at least in their current form—arose and remained largely by historical accident,¹¹³ it is not obvious that they currently serve any federalism values at all.

But there are at least two reasons to disfavor this approach even in the absence of federalism justifications, and there is at least one federalism justification for keeping the spending programs. The first non-federalism reason for maintaining existing federal programs is the need to preserve reliance interests. Millions of Americans count on Medicare, Medicaid, and the ESI subsidy for their health insurance or even for their employment. Although it might be possible to wean the country from that reliance over time, the medical malpractice snowball problem is probably not significant enough to justify that kind and degree of disruption, especially if the snowball can be fixed by less disruptive means.

Second and relatedly, dismantling Medicare would be politically impossible. Although Medicaid is not particularly well liked and although employers are tiring of their role in U.S. health insurance such that the ESI subsidy could perhaps be repealed, the Medicare program is wildly popular.¹¹⁴ And its constituency—the over-sixty-five population—is well organized and politically powerful. A repeal of Medicare, thus, would be simply impossible to pass. Given that Medicare is the largest federal healthcare program, we could not fix the snowball problem without repealing Medicare, and there does not seem to be any politically feasible way to do so.

The federalism justification for maintaining federal spending programs is based on the federalism logic for national public insurance, discussed in Part III.A. Because public health insurance would benefit from economies of scale and might suffer from a race to the bottom if governed by the states, the federal government should be the one in charge of any public health insurance program we create. Although the current division of labor—with the federal government running public insurance only for the poor and the elderly and the states maintaining control over private insurance for the rest of the population—was accidental and remains nonsensical under federalism logic, the idea of federal control over public health insurance is generally sound. One reason for maintaining Medicare and Medicaid, thus, might be the hope that they will one day fulfill their intended purpose as incremental steps on the path to a comprehensive national regime (a “Medicare for All”). Medicare and Medicaid today do not serve federalism values at all, but if they could be expanded, they would.

113. See *supra* notes 88–90 and accompanying text.

114. Jonathan Oberlander, *The Politics of Medicare Reform*, 60 *Wash. & Lee L. Rev.* 1095, 1100 (2003) (noting that Medicare is considered the most successful innovation of the welfare state).

In sum, dismantling federal programs would be costly if not impossible, and that approach might not lead us to the best final result for healthcare federalism in the United States. Repeal of existing tax and spending programs seems unnecessary, difficult, and unwise. It is surely not the best option.

2. *Interstate Bargaining*. — Among options for fixing the snowball problem *without* dismantling existing programs, the one that requires the smallest degree of centralization is interstate bargaining. This option is premised on a Coasean retort to the entire federalism debate. The Coasean tautology teaches us that, if transaction costs are zero, then parties will bargain to the most efficient result.¹¹⁵ Legal rules and entitlements will not, therefore, affect the ultimate state of the world as long as parties can bargain freely. Well, the federal and state governments are parties that are capable of bargaining, so why should we expect rules governing the relative powers of the state and federal governments to affect the ultimate division of labor between and among them? If a particular regulatory result or division of labor is optimal and if transaction costs are zero, then the federal and state governments will bargain their way to that result regardless of any legal attempts to sway them.¹¹⁶

In the case of medical malpractice, this approach theoretically could work because the states *collectively* internalize the full cost-benefit balance of malpractice policy choices. The federal revenues that pay for states' malpractice costs, of course, start in the states' pockets. The federal government is not separate from the state governments; it is the collection of all fifty state governments. And federal healthcare spending is not separate from state healthcare spending; the citizens of Alaska (along with the citizens of the other forty-nine states) pay for Medicare and Medicaid just like they pay for state-funded healthcare and private healthcare. The states collectively, thus, should want to enact robust malpractice reforms in order to minimize their citizens' federal taxes. The problem that prevents them from enacting optimal reforms in the present climate is, in important respects, nothing more than a collective action problem. If the states could gather and bargain, they could pass optimal regulations.

The problem with this approach, of course, is that transaction costs are *not* zero. Bargaining is not free. Indeed, bargains among the fifty states, without federalized coordination, could be extremely costly. The primary problem is not that the states lack a forum for communication; state legislators and governors regularly come together in, for example, the National Conference of State Legislatures and the National Governors Association, and those organizations probably could facilitate bargaining among the states.

115. See generally R.H. Coase, *The Problem of Social Cost*, 3 *J.L. & Econ.* 1 (1960).

116. Daniel A. Farber, *The Coase Theorem and the Eleventh Amendment*, 13 *Const. Comment.* 141, 142 (1996) (explaining legal rules, including rules governing state sovereignty and federal power, are unimportant when cost of bargaining is negligible).

But the problems would begin once the fifty sovereigns sat down at a table. Most significantly, the problem with bargaining is that without formalized mechanisms for discussion and voting—like those that are institutionalized in the national legislature—it would be difficult for the states to find and agree to a solution to the snowball problem.¹¹⁷ By definition, an efficient bargain creates an economic surplus, and for a voluntary bargain to work, the parties must be able to agree on a division of that surplus. Such agreements are hard enough to reach when two parties try to divide a single pie; it might be impossible to come to an agreement when fifty parties try to divide multiple pies.¹¹⁸ Furthermore, the states would have incentives to misrepresent their interests, and there would be problems of unequal bargaining power.¹¹⁹

Of course, the Framers were aware of these problems with interstate bargaining, and they designed Congress to correct them as effectively as possible. The Senate, for example, is specifically designed to correct unequal bargaining power; electoral politics are meant to force revelation of preferences; and established voting rules fix the difficulties in dividing the pie. The cheapest mechanism for interstate agreements, thus, is federalized voting in Congress.

3. *Block Grants*. — The second least intrusive option for fixing the snowball problem without dismantling federal programs would be for the federal government to provide the states with block grants;¹²⁰ we could simply pay the states to enact malpractice reforms. This option, if it could be implemented correctly, would solve the snowball problem by ensuring that each state gained a monetary benefit—in the form of a federal grant—to compensate for the externalized savings of malpractice reforms. In the current system, each state expects to recover only sixty cents of every dollar saved through medical malpractice reform, while expecting the federal government to recover the remaining forty cents.¹²¹ If the federal government offered those forty cents back to the state in the form of a block grant, then the state would once again have a full incentive to invest in medical malpractice reforms.

117. See Shapiro, *supra* note 107, at 41 (pointing to lack of sufficient resources as deterrent to agreement in complex governmental bargaining processes); Inman & Rubinfeld, *Making Sense*, *supra* note 83, at 1224–25 (noting political motivations of different jurisdictions likely to interfere with fair or efficient bargaining process).

118. See, e.g., Inman & Rubinfeld, *Making Sense*, *supra* note 83, at 1224 (elaborating on increased likelihood bargaining process will break down as more actors are involved and have competing interests).

119. See *id.* at 1222–24 (discussing five potential problems facing bargaining efforts between governments).

120. See generally Wallace E. Oates, *Fiscal Federalism* 65–105 (1972) (discussing economic theory and empirical use of intergovernmental grants); Jerry L. Mashaw & Dylan S. Calsyn, *Block Grants, Entitlements, and Federalism: A Conceptual Map of Contested Terrain*, 14 *Yale L. & Pol’y Rev.* 297, 14 *Yale J. on Reg.* 297, 300–06 (1996) (Joint Symposium Issue) (defining block grants and discussing their operation).

121. For the derivation of this ratio, see *supra* notes 58–61 and accompanying text.

Because it would allow each state to choose its own approach to reform, this option would preserve the competition and experimentation benefits of decentralized decisionmaking; it would preserve the states' sovereign authority over the substance of medical malpractice policy; it would fix the snowball problem without requiring a costly bargaining process among the states; and it would keep decisionmaking power at a lower level of government so as to allow greater political participation by all interested parties. The only previously identified federalism value that would not be served by a functioning block grants regime would be the uniformity interest, and as noted, that interest is not a strong one in medical malpractice policy.¹²² In theory, therefore, block grants are an extremely appealing option.

But there is a prohibitive practical problem with block grants: The real dollar level of the grant would be nearly impossible to determine. In order to fix the externality, the federal government would need to figure out how much money the state was likely to save through malpractice reform and would need to offer a grant amounting to forty percent of that total. Given the difficulties in fashioning and evaluating cost-saving malpractice reforms, that project would be nearly impossible as a predictive matter and might, in fact, be quite difficult even as an evaluative matter after the state policy had been implemented. The federal government would not, therefore, be able to offer an effective block grant before the state implemented its policy and probably would have a hard time offering an effective grant even *after* the state implemented its policy.

The only way for the federal government to set a reasonable grant level would be for it to conduct an independent substantive evaluation of particular malpractice reforms and the savings one could expect from those reforms. States that accepted grants would then be required to enact those particular reforms. That system, however, would be a categorical grants system rather than a block grants system, which I will discuss in the next section.

4. *Categorical Grants.* — The third most intrusive option would be for the federal government to provide grants that are conditional on substantive requirements for their use. The federal government could agree to finance malpractice reforms contingent on the states' compliance with federal statutory criteria. This option would correct the snowball problem in the same way that the block grants would, by providing a monetary benefit to compensate for externalized savings, but unlike block grants, a categorical grants regime would give the federal government substantive regulatory authority to guide the states' malpractice policy choices. This substantive authority might help the federal government to calibrate grant levels because it would give the government authority to condition grants on the states' enactment of those policy designs that are most

122. See *supra* Part I.B.2.b.

likely to create savings. The federal government could examine a variety of reform options, estimate future savings or measure captured savings, and then offer grants to states that are willing to enact those reform options. This possibility still would be difficult in practice since savings would remain difficult to calculate, but the substantive authority would allow the federal government to tangle with a much smaller set of reform options.

Even if it worked as theorized, a categorical grants regime would, of course, represent a degree of incursion on state sovereignty, but the incursion would not be as great as a fully preemptive federal statute. Substantive requirements attached to categorical grants would bind only those states that voluntarily accept grant money, so the states could ignore federal standards—and thereby retain full sovereignty over malpractice policy—simply by turning down the federal money. Of course, allowing the federal government to take even partial substantive control over malpractice policy could weaken the competition and experimentation virtues of decentralization. Interstate competition will be weaker if federal legislation mandates interjurisdictional uniformity of certain policy issues that matter to taxpayers, and experimentation might be weaker if federal legislation prevents the states from enacting a policy option that they would otherwise want to try. Partial federalization of malpractice policy substance would also weaken the political participation and tradition advantages of decentralization; certain substantive issues would become the province of a larger, harder-to-contact government, and that government would lack institutional experience with substantive tort issues.

Some of these basic problems with substantive intrusion could be minimized by designing federal policy to avoid them. For example, the federal government could allow waivers for states that want to experiment, and it could leave most quotidian administration to preexisting state institutions in order to preserve the advantages of institutional experience and to allow accessible state officials to have some power to respond to constituent suggestions and complaints.

As with block grants, however, there are practical reasons to be wary of categorical grants (even if they are more likely than block grants to work as theorized), which we have learned from our experience with the Medicaid program. Even carefully designed categorical grants tend to allow so much agency slack between state and federal governments that their intended operation regularly fails.¹²³ Federal administrators prove to be poor watchdogs of state agencies, and state agencies prove to be poor agents of federal policy. This kind of cooperative federalism has not

123. Cf. Matthew C. Stephenson, *Public Regulation of Private Enforcement: The Case for Expanding the Role of Administrative Agencies*, 91 Va. L. Rev. 93, 110 (2005) (defining agency slack as “tendency of government regulators to underenforce certain statutory requirements because of political pressure, lobbying by regulated entities, or the laziness or self-interest of the regulators themselves”).

been a successful model for federalization. I therefore hesitate to endorse such a plan.

5. *Full Federalization*. — The final option—and the most intrusive on state sovereignty—would be for the federal government to pass preemptive medical malpractice reforms, as Congress nearly did with the HEALTH Act of 2003.¹²⁴ Preemptive federal legislation would solve the snowball problem by requiring the states to provide an adequate level of patient safety regulation. Regardless of whether federal legislation simply created a floor for state standards—as the HEALTH Act would have done¹²⁵—or instead replaced all state standards with federal standards, preemptive legislation would correct the externalization problem by requiring at least a minimum level of patient protection. Both floor-setting federal legislation and fully preemptive federal legislation would prevent the states from undersupplying patient safety standards.

Preemptive federal legislation, of course, might threaten several federalism values. First, it obviously poses a greater threat to state sovereignty than grants since it fully strips the states of authority over their malpractice policy choices. Second, even a floor-setting statute significantly weakens interjurisdictional competition by limiting the states' options. A floor-setting statute might also serve as a cognitive anchor for the states' policy choices, limiting their creativity in the competition.¹²⁶ Third, any federal legislation that did not include a robust waiver provision would prevent the states from experimenting with alternative reforms. Fourth, preemptive legislation would weaken the states' political accountability for malpractice choices and would take control out of the hands of the more accessible state legislature. And, finally, federal tort reform would depart from the tradition of the common law of torts and would place authority in the hands of federal institutions that lack experience with the regime.

As with categorical grants, it might be possible to avoid some of these pitfalls by designing the federal legislation with federalism values in mind. For example, federal legislation could preserve the value of experimentation either by providing waivers to the states so that they can deviate from federal substantive regulations to experiment with alternatives or by funding federal demonstration projects so that the federal govern-

124. Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003). The HEALTH Act would have federalized all of the first-generation reforms that the states have tried thus far. It would not, therefore, have done much by way of bolstering patient safety standards in the states. Nevertheless, it provides a model of preemptive legislation and demonstrates that Congress has actively considered such legislation in recent years.

125. Cohen, *Medical Malpractice Liability Reform*, *supra* note 36, at 2–3 (summarizing provisions of HEALTH Act).

126. See Gretchen B. Chapman & Eric J. Johnson, *Incorporating the Irrelevant: Anchors in Judgments of Belief and Value*, in *Heuristics and Biases: The Psychology of Intuitive Judgment* 120, 120–21 (Thomas Gilovich, Dale Griffin & Daniel Kahneman eds., 2002) (defining cognitive anchors and surveying empirical evidence of their effect).

ment can run its own controlled experiments with alternative regulatory approaches.¹²⁷ Indeed, federally funded and federally controlled demonstration projects might provide better, clearer information than state controlled experimentation since sample groups could be based on relevant characteristics rather than state boundaries, which are entirely arbitrary from the perspective of malpractice policy.

In short, a preemptive federal law seems necessary since a grants-based approach would be difficult to administer. But such a law should be designed to preserve as many benefits of decentralization as possible, allowing waivers to preserve interstate competition and funding demonstration projects to promote experimentation. Although this approach represents the greatest threat to state sovereignty, it seems to be the only approach (other than the costly and politically impossible option of dismantling existing programs) that could actually melt the medical malpractice snowball.

This proposal does not include any recommendations for the substance of federally implemented reforms. There is already an extensive literature that develops options for second-generation reforms, including proposals for alternative dispute resolution, enterprise liability, no-fault insurance, administrative adjudication (or “health courts”), and uniform practice standards.¹²⁸ Through either legislative or executive implementation, the federal government could try a variety of these reforms in demonstration projects or through state experimentation under federal waivers, allowing decisionmakers to determine which reforms accomplish the best results in terms of decreased defensive medicine and decreased patient injury. If the government then discovers that one such system of patient protection accomplishes the best results, the federal government could unify the nation under that system. Alternatively, given regional differences in patient populations and hospital structures, the federal government could continue to enforce different patient protection systems in different regions, much as the Medicare and Medicaid programs enforce different quality controls and reimbursement systems for different kinds of hospitals, acknowledging that rural hospitals have different needs than urban ones.¹²⁹

I thus envision a process of experimentation and information aggregation, developed and implemented at the federal level, that would lead over time to a stable system of medical malpractice and patient protection policy. Although created at the federal level, that stable system need not be uniform across different patient or hospital groups. Federal decisionmaking and implementation is necessary only to ensure alignment of incentives, not to ensure uniformity of substantive policy.

127. For explanation of waivers and demonstration projects, see *supra* notes 102–103.

128. See *supra* Part I.B.1.

129. For example, Medicare and Medicaid contain special treatment for Disproportionate Share Hospitals (DSH). 42 U.S.C. § 1396r-4 (2000 & Supp. 2005); 42 C.F.R. § 412.106 (2007).

V. OTHER SNOWBALLS

So far, I have limited myself to medical malpractice policy, which is my primary focus here. I have shown that prior federalization decisions in healthcare policy have created an incentive problem for the states in governing medical malpractice policy, and I have shown that at least some federalization of medical malpractice reform is necessary to correct that incentive problem. More generally, though, I have also shown that any decision to federalize part (but not all) of a regulatory regime will allow the states to externalize costs in a way that will alter their regulatory incentives. It would be surprising—even incredible—if medical malpractice were the only regime in which we found this kind of snowball effect. After all, Medicare and Medicaid are not the only federal programs that regulate only a portion of a policy field, and there must be others that affect related regulatory decisions in the states. There might even be others that cause sufficiently significant externalization problems to justify jurisdictional integration under Tiebout's model. Although a full consideration of other such snowball scenarios is beyond the scope of this Essay, it is worth highlighting two historical federalization decisions that could be justified by reference to snowball problems, to demonstrate that the snowball story is not limited to healthcare.

First, the Americans with Disabilities Act of 1990 (ADA)¹³⁰ could be theoretically justified by reference to a federalization snowball. The ADA set a federal floor for antidiscrimination protections for persons with disabilities. There might be some economic justification, independent of a snowball story, for federal antidiscrimination standards because there could be a race to the bottom scenario; each state might worry that protective regulations would attract disabled people to its economy. On the other hand, the presence of disabled people need not create a significant strain on the economy if those people are employed—if they are not discriminated against in the labor market. And, of course, the strain of already-present disabled people would be lessened if the states prohibited disability-based employment discrimination. Before the ADA, thus, the states would have had some race to the bottom incentive to underprovide antidiscrimination regulations, but the incentive might not have been as strong as the race to the bottom incentive in, for example, environmental law. That incentive alone, thus, might not justify federalization of antidiscrimination standards.

But that story ignores the impact of Supplemental Security Income (SSI).¹³¹ Under the Social Security program, the federal government foots the bill for disabled citizens' unemployment. The states, thus, externalize onto the federal government a significant portion of the costs associated with unemployment among disabled citizens, including those asso-

130. Americans with Disabilities Act, Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified at 42 U.S.C. §§ 12101–12213 (2000)).

131. 42 U.S.C. §§ 1381–1383.

ciated with discrimination against those citizens. If the employers in a state choose not to hire disabled citizens for discriminatory reasons, the federal government will step in to support the consequently unemployed citizens, relieving the state of a significant portion of the unemployment costs associated with underprovision of antidiscrimination laws. The effect here is thus the same as the effect in medical malpractice; the federal SSI program skews the states' cost-benefit calculation in a way that causes systematic underprovision of antidiscrimination regulation. In the end, then, federalization of antidiscrimination standards may have been necessary (in part) to correct the externalization problem caused by federal Social Security benefits—to correct for the states' skewed cost-benefit calculations. The ADA was a theoretically justified and appropriate response.

A similar story may justify the Employee Retirement Income Security Act of 1974 (ERISA).¹³² Like the ADA, ERISA may have served in part as a solution to the states' externalization of costs associated with their pension policies. Of course, there was a uniformity justification for ERISA—for federalized pension regulations—since more and more employers were operating across state lines, but there might also have been a significant externalization problem arising from the federal Social Security program. By providing Social Security benefits to the over-sixty-five population, the federal government foots part of the bill when employers abuse or raid their employees' pensions, harming those employees during retirement. The states are not forced to support impoverished retirees; instead, they externalize those costs onto the federal government and, by extension, onto the other forty-nine states. ERISA (whether intended to or not) provided a solution to that problem by fully federalizing and codifying a trust model for employers' pension management, taking pension regulation out of the hands of the states.

As noted above, there are undoubtedly other examples of regimes in which snowball problems exist and other examples of regimes in which partial federal programs have already snowballed into full federalization of related regulatory regimes. Although comprehensive consideration of those other examples could potentially fill another whole article, it is worth emphasizing here that the federalization snowball story is important not just for health policy but for a wide range of regulatory regimes.

CONCLUSION

The legal literature has long held that any federal incursion into medical malpractice policy would be functionally unjustified. But that position ignores the externality—the distortion of the states' incentives to regulate—that arises from the federal government's large and growing role in financing American healthcare utilization. The federal government's significant role in healthcare financing justifies a federal takeover

132. 29 U.S.C. §§ 1001–1461 (2000).

of medical malpractice reform in order to ensure that the decisionmaker holds the right balance of regulatory incentives.

This necessary growth of the federal government is not mere centralization creep or empire building. It is a necessary expansion of federal power that follows inevitably from the prior creation of partial federal programs. It is a federalization snowball.