

PAYING FOR WHAT YOU GET AND GETTING WHAT YOU PAY FOR: LEGAL RESPONSES TO CONSUMER-DRIVEN HEALTH CARE

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I

INTRODUCTION

In a *tour de force*, Clark Havighurst and Barak Richman advance the bold and sweeping thesis that health care law and policy systematically favor those who are relatively well-off to the detriment of the less fortunate, especially lower-income payers of health insurance premiums.¹ Surprisingly, this regressivity can be seen both in market-oriented features of public policy as well as in many policies that seem on first appearance to be more progressive in spirit. Most disturbing is the realization that the current system is not only regressive in many ways, but it is *perversely* or *doubly* so in the sense that lower-income working people with more or less standard health coverage are (1) contributing disproportionate shares of their incomes to pay for more and better-quality health care than most of them would reasonably choose to buy if given a choice with costs in view, and (2) getting less benefit from their insurance coverage than are their more fortunate coworkers, despite paying the same premiums. Thus, social inequity exists both in what people pay and in what they receive.

Recognition of these inequities should galvanize policy analysts from all parts of the socio-political spectrum to re-examine both the current situation and their favored reforms, with an eye toward determining which features exacerbate or ameliorate these distributive injustices. Some objectionable features may be unavoidable, others may be regressive only from a perspective that presupposes ideal alternatives that are unrealistic, whereas others may be rectifiable in some fashion. In short, observing the distributive features of health care delivery and finance is a critical starting point for deeper

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1. Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) In American Health Care*, 69 LAW & CONTEMP. PROBS. 7, 8 (Autumn 2006).

understanding, but this does little to determine what can and should be changed and how.

Nevertheless, change is inevitable. It is seemingly the only constant in health care financing over the past fifty years. During that time, health insurance surfaced and spread. It became more and more generous and unaffordable, and was eventually followed by managed-care restrictions on patients' choice of physicians and their choice of treatments, which produced widespread backlash and so was neutered. As inflation in health care spending continues apace, the current trend is "consumer-driven health care" (CDHC). In various forms, it requires insured patients to pay a major—or the entire—portion of their own medical costs out-of-pocket or from a designated savings account.² The most visible signs of this intensifying consumerism are the generously tax-sheltered "health savings accounts" (HSAs) authorized by recent federal legislation.³ HSAs can be used to pay for medical costs not covered by insurance if they are linked with "catastrophic" insurance policies that have annual deductibles in the range of \$1000 to \$10,000.⁴

HSAs and other forms of patient cost-sharing embrace a much more explicitly tiered approach to health care finance and delivery. These innovations therefore represent at least one version of the more differentiated coverage that Havighurst and Richman would apparently like to see. Under the deeply tiered approach they favor, rather than requiring everyone to contribute roughly equal amounts for essentially identical coverage—which in fact is less valuable to some than to others—people would purchase and pay for the level of care they actually receive, at widely varying levels of value and cost.⁵ To invoke an oft-used metaphor, instead of requiring everyone to pay for a Cadillac while some drive only a Corolla, each would more or less pay for what he or she drives. Ideally, public or employer subsidies would enable everyone

2. See generally CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS AND POLICY MAKERS (Regina E. Herzlinger ed., 2004) (providing extensive overview of consumer-driven health care policies); James C. Robinson, *Reinvention of Health Insurance in the Consumer Era*, 291 JAMA 1880 (2004) (same); Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777 (2006) (analyzing the claims made by proponents of consumer-driven health care).

3. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 1201, 26 U.S.C.A. § 223 (2003).

4. Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 536, 551–52 (2005); Edward J. Larson & Marc Dettmann, *The Impact of HSAs on Health Care Reform: Preliminary Results After One Year*, 40 WAKE FOREST L. REV. 1087, 1097 (2006). These numbers are not precise because they are adjusted each year for inflation.

5. See Havighurst & Richman, *supra* note 1, at 79 (supporting "proposals to let consumers . . . choose more or less freely the style of health care they want to purchase for their families"). To the surprise of many, they are also amenable to a single-payer government insurance system. See *id.* ("Indeed, we would not object if our [arguments] . . . were cited as a reason to adopt a monolithic national health program."). Still, they insist that those who are well-off remain free to purchase supplemental coverage that provides a higher tier of service. See *id.* (expressing openness to "scrapping private health insurance altogether (except insofar as it might supplement the national system's coverage)").

to afford some form of safe and decent transportation, but some people may ride the bus or choose mini-scooters while others are willing to pay more to enjoy luxury vehicles.

This article surveys a partial range of legal and regulatory issues that might arise if this scenario were realized. The focus here is on the private-law issues of contract and tort and on the regulation of private insurance.⁶ Part II considers whether cross-subsidies in providers' prices and insurance premiums are properly viewed as regressive or progressive and surveys possible legal barriers to either reducing or increasing these cross-subsidies. Part III considers whether either contract or tort law requires providers to deliver more health care than people are actually willing to pay for. In the end, this brief survey concludes that neither existing insurance regulatory policy nor common-law precedents pose major obstacles to consumer-driven health care.

II

LESS REGRESSIVE HEALTH CARE FINANCING

Private-sector payment for medical services might be made more progressive in two broad ways. Either providers could adjust their prices to reflect patients' ability to pay or health insurance premiums could reflect patients' income in some fashion. This section explores various versions of each possibility.

A. Providers' Prices

Havighurst and Richman focus principally on perceived injustices to premium payers, failing to discuss what many people otherwise regard as the primary redistributive mechanism in payment for health care—discriminatory pricing by hospitals. Instead of accepting the conventional view that hospitals engage in Robin Hood-style redistribution from those with greater ability to pay to those with less, they argue that the system is essentially regressive because “ability to pay” is most often a function of having private health insurance—a variable not closely correlated with individual income or wealth.⁷ Thus, they contend that most of the cost of hospitals' good works, however worthy they may be—something they are unwilling to concede—are ultimately borne more or less equally by premium payers, like a regressive “head tax” that is imposed without regard to relative ability to pay.⁸ Many readers, accustomed to viewing hospital cross-subsidies as distributionally progressive, will find this argument hard to swallow. However, despite its unconventionality—and

6. Others in this symposium consider public insurance and government regulation of providers. See, e.g., Christopher J. Conover, *Distributional Considerations in the Overregulation of Health Professionals, Health Facilities, and Health Plans*, 69 LAW & CONTEMP. PROBS. 181 (Autumn 2006); Jonathan Oberlander, *The Political Economy of Unfairness in U.S. Health Policy*, 69 LAW & CONTEMP. PROBS. 245 (Autumn 2006).

7. Havighurst & Richman, *supra* note 1, at 28.

8. *Id.*

indeed because of this quality—the Havighurst–Richman hypothesis deserves to be taken seriously.

Nevertheless, in concentrating on what they see as hospitals' ability to overcharge insured patients, Havighurst and Richman give very little attention to another regressive feature of modern health care finance—namely, that hospitals routinely charge uninsured patients considerably more than insured patients for exactly the same services. Rather than inflate prices by roughly the same amount for all paying patients, hospitals instead charge their well-insured patients prices that are closer to their actual costs and load a great deal more of the burden of cross-subsidies on the smaller portion of patients who are without insurance or who are seeking care outside their health plan's network.⁹ The magnitude of price discrimination against these disadvantaged patients can be staggering, with their bills amounting to several times what insurers pay on behalf of their subscribers for identical care.¹⁰

These bizarre pricing practices result from a combination of market and regulatory factors.¹¹ Although a full analysis is too complex to undertake here, the net result appears to be a perversely regressive pricing system that charges much *more*, not the same or less, to those who, because they lack insurance, are far *less* able to pay for hospital services. This unfairness receives only passing notice by Havighurst and Richman, yet it would seem to be one they should decry as much as they decry the unfairness of the public-good burden imposed on insured patients.¹² Instead, Havighurst and Richman, contending that many uninsured are “uninsured by choice” and have “more money in their pockets” by virtue of not paying insurance premiums,¹³ seem bent on focusing attention away from the uninsured and on emphasizing the share of the public-good burden that falls on the working middle and lower-middle classes. This focus leaves the particular plight of unavoidably uninsured patients as a matter needing further discussion in this symposium.

The legal legitimacy of price discrimination against the uninsured is being attacked in class action lawsuits across the country that accuse tax-exempt hospitals of failing to live up to their charitable missions. So far, most of these

9. Christopher P. Tompkins, Stuart H. Altman & Efrat Eilat, *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45, 52 (2006).

10. Kenneth T. Bowden, *Determining a Reasonable Price for Health Care in the United States: Is This Possible?*, 34 BRIEF 26, 28 (2005); Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 62 (2006); Julie Appleby, *Hospitals Sock Uninsured with Much Bigger Bills*, USA TODAY, Feb. 25, 2004, at B1; Lucette Lagnado, *Anatomy of a Hospital Bill*, WALL ST. J., Sept. 21, 2004, at B1.

11. Havighurst & Richman, *supra* note 1, at 13–82. These factors include the following: (1) the charitable mission of most nonprofit hospitals, which encourages them to support various collective goods, (2) the ability of public and private insurers to insist on deep discounts that eliminate pricing support for collective goods, and (3) hospitals' market power over the uninsured. Also relevant are regulatory barriers to hospitals regularly offering non-negotiated price discounts.

12. *See id.* at 71–72.

13. *Id.* at 72.

suits have been dismissed on procedural or technical grounds,¹⁴ but some early rulings have recognized a valid claim in allegations that hospitals charge uninsured patients a lot more than insured patients.¹⁵ Additional support for attacking hospital price discrimination comes from litigation between insurers and hospitals under managed care plans. When a hospital treats patients covered by insurers with whom it does not have a contract, courts have ruled that the hospital cannot charge its full list prices but instead must give a discount that reflects what that hospital usually is paid.¹⁶ Under the pressure of this litigation, public scrutiny, and congressional hearings, hospitals are rapidly changing their billing practices and adopting sliding-scale charge systems that give lower-income, uninsured patients roughly the same level of discounts as insured patients.¹⁷

Charging each patient roughly equal amounts for equal care would solve the perverse regressivity of current hospital pricing, but it would not restore the progressivity that once prevailed. Starting as far back as the Code of Hammurabi¹⁸ and until about fifty years ago, health care providers were required to explicitly subsidize services for poor patients. Under ancient Roman law and in Renaissance England, physicians,¹⁹ like barristers,²⁰ were

14. For instance, federal courts have refused to certify a class, have found an absence of any federal cause of action, or have declined supplemental jurisdiction over state-law breach-of-contract claims. Moreover, courts have dismissed some contract claims on *res judicata* grounds when the claim was previously settled through normal collection processes. Richard G. Stuhan, *Decisions to Date on Dispositive Motions in the Charity Care Litigation*, HEALTH LAWYER NEWS, Sept. 2005, at 18.

15. *Id.*

16. Temple Univ. Hosp. v. Healthcare Management Alternatives, 832 A.2d 501, 508 (Pa. Super. Ct. 2003); River Park Hosp. v. Bluecross Blueshield of Tenn., 173 S.W.3d 43, 58 (Tenn. 2003).

17. Bowden, *supra* note 10, at 29; Reinhardt, *supra* note 10, at 62; Tomkins, Altman & Eilat, *supra* note 9, at 53.

18. Enacted about 2030 B. C., the Code of Hammurabi declared, for instance:

If a doctor has cured the shattered limb of a gentleman or has cured the diseased bowel, the patient shall give five shekels of silver to the doctor. If it is the son of a poor man he shall give three shekels of silver. If a gentleman's servant, the master of the slave shall give two shekels of silver to the doctor.

Hubert W. Smith, *Legal Responsibility for Medical Malpractice*, 116 JAMA 942, 943 (1941). It is not entirely clear, though, whether these rules were based on ability to pay rather than on the social value of the service to different classes of patients.

19. The historical and legal bases for barring physicians from suing for fees has not been studied as thoroughly as it has been for lawyers. For physicians, the best scholarly discussion is well over a century old. JOHN ORDRONAU, *THE JURISPRUDENCE OF MEDICINE IN ITS RELATIONS TO THE LAW OF CONTRACTS, TORTS, AND EVIDENCE* 10–14, 34–41 (Arno Press 1973) (1869). It appears that medieval Roman law codified the ancient practice based in part on concerns that physicians were overcharging their patients. THOMAS PERCIVAL, *MEDICAL ETHICS: OR A CODE OF INSTITUTES AND PRECEPTS ADAPTED TO THE PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS* 175–76 (Birmingham: Classics of Medicine 1985) (1803). In Renaissance England, the rule appears to be based more on the notion of legal recognition of professional norms, that is, refusing to find an implied promise to pay when the common practice at the time was to receive honoraria. However, it seems there was no rule barring physicians from making and enforcing an express contract. *Id.* at 177–78; *Rondel v. Worsley*, [1969] 1 A.C. 191, 237 (Lord Morris), 280 (Lord Upjohn) (H.L. 1967) (appeal taken from Eng.), *overruled by Arthur J.S. Hall & Co. v. Simons*, (2000) 3 Eng. Rep. 673 (H.L.) (appeal taken from Scot.).

20. In ancient Rome, lawyers and other “liberal arts” practitioners from the nobility undertook service pursuant to a “mandate,” meaning that their services were required without compensation.

legally precluded from enforcing ordinary contracts for their fees because this was seen as inconsistent with their status as noble, learned professionals. Instead, physicians and barristers received voluntary honoraria²¹ and were expected to serve patients regardless of their ability to pay.²²

This honorarium or non-contractual doctrine was never adopted in the United States, where medical and legal services have always had a contractual legal status.²³ However, an explicitly progressive pricing practice was required by U.S. law through the middle of the twentieth century.²⁴ Because physicians typically do not negotiate fees in advance with patients, when, prior to widespread insurance, physicians sued for fees, courts determined the implied payment terms according to what the suing physician and others in the community normally charged. Part of that calculation was the accepted practice, prior to widespread insurance, of charging sliding-scale fees based on ability to pay.²⁵ Almost all of this litigation focused on whether physicians could charge more to wealthier patients,²⁶ but implicitly courts also required physicians to charge poor patients less.

This legal regime, which has gone virtually unnoticed for over half a century, is truly extraordinary. Nowhere else has the common law enforced a highly

This understanding arose from the social order among the Roman nobility that regarded public service as one of the duties of citizenship and that assumed that other nobles would reciprocate in kind with their services, as the need arose. See BARRY NICHOLAS, AN INTRODUCTION TO ROMAN LAW 187–89 (1962); ROSCOE POUND, THE LAWYER FROM ANTIQUITY TO MODERN TIMES 51–55 (1953); REINHARD ZIMMERMANN, THE LAW OF OBLIGATIONS: ROMAN FOUNDATIONS OF THE CIVILIAN TRADITION 413–20 (1996). British barristers adopted the convention of voluntary honoraria rather than contractual fees, in part in order to elevate their social and professional standing over solicitors and attorneys. J.H. BAKER, THE LEGAL PROFESSION AND THE COMMON LAW: HISTORICAL ESSAYS 119 (1986). These legal characterizations were largely just formalities, however, in that both in England and in ancient Rome, lawyers usually expected to receive their standard payment before they took a case. Also, they sometimes could sue for payment on legal grounds other than ordinary contract, such as quantum meruit (equity) or to enforce a sealed bond given in exchange for service. *Id.*

21. Thomas Percival, for instance, in his seminal *Medical Ethics*, carefully refers to physicians' payments as "pecuniary acknowledgements" rather than as fees, charges, or the like. PERCIVAL, *supra* note 19, at 39–40, 174–79.

22. Lawyers never fully adopted this part of the creed. Instead, the practice among barristers was to insist on payment of their usual fee in advance, before taking on a case. Only in criminal cases were barristers required to work without pay. This prepayment practice obviated the need to sue for fees, which legal historians speculate made it convenient for barristers to adopt the non-enforceability doctrine as a means of elevating their professional standing. Later, barristers used the noncontractual basis of legal services to argue for immunity from tort liability. See *Rondel v. Worsley*, [1969] 1 A.C. 191 (H.L. 1967) (appeal taken from Eng.), *overruled by* *Arthur J.S. Hall & Co. v. Simons*, (2000) 3 Eng. Rep. 673 (H.L.) (appeal taken from Scot.).

23. KENNETH ALLEN DEVILLE, *MEDICAL MALPRACTICE IN NINETEENTH-CENTURY AMERICA* 184 (1990); ORDRONAUX, *supra* note 19.

24. D.E. Evins, Annotation, *Ability to Pay as Factor in Determining Reasonableness of Charge of Physician or Surgeon*, 97 A.L.R.2d 1232 (1964).

25. See, e.g., *Zumwalt v. Schwarz*, 297 P. 608, 610 (Cal. Ct. App. 1931) (“[T]here is evidence of a recognized usage, which has grown into a custom, to graduate professional charges with reference to the financial condition of the patient . . .”). One widespread practice was to charge the patient one month of his or her salary for a major operation. *Houda v. McDonald*, 294 P. 249, 251 (Wash. 1930).

26. For instance, *Citron v. Fields*, 85 P.2d 534 (Cal. Ct. App. 1938), was a suit against the famous actor W.C. Fields for \$12,000 in medical fees.

progressive pricing structure that requires service providers to cross-subsidize people who cannot pay as much. From another vantage, however, this was not extraordinary at all. Courts simply used prevailing professional practices and ethical norms to fill in the unstated price terms of implicit service contracts. Once written insurance policies usurped these implicit agreements, the legal framework as well as professional practices quickly changed.²⁷ Professional ethics and public policy remain essentially the same, however. Physicians are still encouraged to reduce or waive fees for patients who cannot pay,²⁸ and hospitals are expected to do the same in order to justify charitable tax exemption. To make up the difference, they must charge somewhat more to patients of means. Building these subsidies into provider pricing may be economically inefficient, but, still, it is the progressive pricing system that is encouraged by many health policy proponents.

B. Insurance Premiums

Regarding health insurance pricing, Havighurst and Richman emphasize the regressive practice of charging lower-income subscribers the same as those with higher incomes, even though the latter tend to use more health services in similar circumstances, thereby taking disproportionate advantage of the collectively purchased coverage.²⁹ They suggest that if employers would subdivide their insurance pools more or less by income class, individuals with different needs and preferences could then purchase appropriate coverage and pay more nearly for only what they get.³⁰ Havighurst and Richman perceive such regressivity even when employers offer their workers a variety of health care options, because few employers require employees wanting higher-cost coverage to pay its full incremental cost.³¹ The issue they identify has not been much recognized, yet it is a potentially important one.

What Havighurst and Richman leave largely unexplored, however, is the fundamental question of what constitutes regressivity in the pricing of *private* health insurance. Lower-income workers tend to have poorer health and greater health needs, necessitating consumption that offsets, at least in part, the

27. Although courts have not specifically repudiated the rule that considers patients' ability to pay, the last reported case following this principle is *Spencer v. West*, 126 So. 2d 423, 426–27 (La. Ct. App. 1960). The principle was briefly mentioned in one unreported case since then. *Anticaglia v. Lynch*, No. 90C-11-175, 1992 WL 138983, at *19 (Del. Super. Ct. Mar. 16, 1992). Most modern cases simply state that patients owe reasonable rates based on prevailing charges. *E.g.*, *Rush Presbyterian-St. Luke's Med. Ctr. v. Hellenic Republic*, 980 F.2d 449, 453–54 (7th Cir. 1992).

28. *See, e.g.*, AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS Op. 8.055 (2005) (“Physicians have a professional obligation to provide care to those in need, regardless of ability to pay, particularly to those in need of urgent care.”); *id.* Op. 9.065 (“Each physician has an obligation to share in providing care to the indigent Caring for the poor should be a regular part of the physician’s practice schedule.”).

29. Havighurst & Richman, *supra* note 1, at 42.

30. *Id.* at 45–46.

31. *Id.* at 46–47.

tendency that concerns Havighurst and Richman. In light of this difference in health status, many believe that employers' large, community-rated insurance pools are more progressive than not. Havighurst and Richman, however, rely mostly on evidence from Medicare and foreign health systems to suggest that the net effect in most employment settings is still likely to be regressive.³² In either event, the distributional effects of private health insurance merit further discussion in this symposium.

In general, community rating is viewed as the most progressive way to price private insurance because it charges healthier people more in order to subsidize the costs of the sick.³³ In contrast, under a *social* or governmental insurance scheme, community rating would amount to a regressive "head tax" that charged everyone the same regardless of their ability to pay. This difference in perspective arises from the different assumptions that attach to private versus public insurance. Even though a flat amount for each person is a highly regressive form of taxation, this is the greatest extent of cross-subsidy that one can reasonably hope for in private insurance pools that are formed voluntarily through policies sold in a competitive marketplace.³⁴ Still, such pooling inevitably combines lower users with higher users, charging each the same premium regardless of health. To the extent lower users also have lower incomes, a form of regressivity exists that Havighurst and Richman hope to avoid.

How this might happen depends on one's source of insurance. The private insurance market is divided between products that are and are not "medically underwritten."³⁵ Insurers medically underwrite insurance that is purchased individually or as part of a small employer group but not insurance purchased through large employer groups. These two market divisions are governed by entirely different economic principles and legal regimes.³⁶ Large group insurance is "experience-rated," meaning that insurers—or employers in the case of self-insured plans—estimate medical expenses for the group as a whole based on historical trends and demographics rather than focus on the health status of each member of the group. Because the extent of regressivity depends on the context and the range of realistic options, these two market segments will be considered separately.

1. Medically Underwritten Insurance

If lower-income people used fewer medical resources, insurers might be expected to include income as a rating factor in their underwriting formulae.

32. *Id.* at 47–49.

33. See Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (1993) (stressing the social value of community rating).

34. See MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE 62–76 (1994).

35. "Medical underwriting" means that insurers in some fashion assess and price the health risk of each subscriber. *Id.* at 16–17.

36. Mark A. Hall, *The Geography of Health Insurance Regulation: A Guide to Identifying, Exploiting, and Policing Market Boundaries*, HEALTH AFF., Mar.–Apr. 2000, at 173, 173.

However, lower-income subscribers also tend to be less healthy on average and therefore have more need to seek medical care.³⁷ On balance, then, income alone is not as strong a predictor of expected health care expenses as are other available rating factors, such as age and prior use of health care services. Therefore, the failure of insurers to adjust premiums for income is not due primarily to regulatory barriers.³⁸ In most states, there are no legal obstacles preventing insurers from adjusting insurance premiums for individual (“non-group”) insurance according to subscribers’ income.³⁹ More restrictions exist in the small-group market, where states typically do not allow rating by income. States tend, however, to exclude rating practices engaged in by only a minority of firms and to allow those factors that most established insurers would prefer to use.⁴⁰ Therefore, it is unlikely that these regulations are blocking insurers from using important rating factors other than individual health status.

This regulatory issue is largely beside the point, however, because Havighurst and Richman do not actually advocate charging lower-income users less for equivalent coverage.⁴¹ Instead, they would like to allow those who use less health care, or who can only afford less, to purchase less coverage at a lower price.⁴² In other words, they call for the separation of broad community-rated pools of comprehensive coverage into smaller pools consisting of more widely differentiated coverage, allowing each pool to set its premiums according to what is actuarially fair for that pool.⁴³ This is in fact happening in the form of high-deductible health plans that meet the federal requirements for tax-protected health savings accounts (HSAs). If insurance policies have deductibles that range from approximately \$1000 to \$5000 for single coverage or \$2000 to \$10,000 for family coverage, then expenditures subject to the deductible can be paid through a tax-sheltered savings account that excludes contributions and earnings thereon from taxable income.⁴⁴

These high-deductible plans are often priced as Havighurst and Richman would want, at a level that reflects actual utilization of health care services by their particular pool of subscribers.⁴⁵ A purer, community-rated approach

37. John D. Graham et al., *Poorer is Riskier*, 12 RISK ANALYSIS 333, 334 (1992); Paula M. Lantz et al., *Socioeconomic Factors, Health Behaviors, and Mortality: Results from a Nationally Representative Prospective Study of U.S. Adults*, 279 JAMA 1703–08 (1998).

38. Another possible explanation is that lower-income people are less likely to purchase insurance, so insurers may consider that it is not worthwhile to add that factor into an already-complex rating formula.

39. Insurance pricing is regulated by state, not federal, law. State law regulates small-group insurance rating in much greater detail than the rating of individual (“non-group”) insurance. See Mark A. Hall, *The Structure and Enforcement of Health Insurance Rating Reforms*, 37 INQUIRY 376, 376–77 (2001) (describing rating rules and practices for the small-group and individual markets).

40. See Mark A. Hall, *The Political Economics of Health Insurance Market Reform*, HEALTH AFF., Summer 1992, at 108, 119 (discussing the insurance industry’s influence over market reforms).

41. See Havighurst & Richman, *supra* note 1, at 49.

42. See *id.*

43. *Id.* at 45.

44. *Id.* at 38 n.94.

45. Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health*

would distinguish the utilization-restraining effects of higher cost-sharing from the “selection effect” resulting from healthier patients tending to choose leaner and less-expensive coverage. In other words, according to the spirit of community rating, lower costs due to cost-constrained use of services would translate into lower premiums, but lower costs due to subscribers’ better health would not. Seldom do regulators actually require insurers to make this distinction, however. Instead, they allow insurers to price policies according to the net utilization under each benefit structure, regardless of what drives the utilization differences.⁴⁶ As a result, if lower-income people were to select these high-deductible policies disproportionately, they would not receive as deep a discount as they might deserve. In effect, their poorer health status would offset, at least to some extent, their cost-constrained demand for services. It would be more progressive to give lower-income subscribers the benefit of their lower demand for services without penalizing them for suffering poorer health. However, it may not be feasible for insurers to make, or regulators to enforce, this difficult actuarial distinction.

2. Employer Pools

So far, this overview has considered only insurance plans that are sold to individuals or small employers, for it is only in these market segments that insurers assess the likely costs of each potential subscriber. Within larger employer pools, however, insurers calculate only the total costs for the entire group based on recent utilization and leave to employers the decision of how to allocate these costs across the workforce.⁴⁷ Legally, employers are largely free to do what they want.⁴⁸ Their decisions are influenced mainly by labor-market economics, workplace equities, and practical administrative considerations. The most visible way in which workers bear the cost of health benefits is through the portion of the premium they are required to pay themselves if they elect to receive health benefits.⁴⁹ That portion is typically calculated as a simple

Care, 31 AM. J.L. & MED. 395, 413–14 (2005).

46. *Id.*

47. See MARK V. PAULY, HEALTH BENEFITS AT WORK: AN ECONOMIC AND POLITICAL ANALYSIS OF EMPLOYMENT-BASED HEALTH INSURANCE 86–91 (1997) (detailing the use of community rating in allocating health insurance costs); W.E. Encinosa & T.M. Selden, *Designing Employer Health Benefits for a Heterogeneous Workforce: Risk Adjustment and Its Alternatives*, 38 INQUIRY 270 (2001) (describing various options for employers to allocate health care costs among employees).

48. As surveyed in Henry Greely, *The Regulation of Private Health Insurance*, in HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION 8-1 (Mark Hall ed., 1993), federal law preempts much of this arena from state regulatory oversight and asserts little direct substantive regulation of its own. Employers’ decisions to offer fringe benefits are affected indirectly by federal tax law, but tax law does not require employers to provide equal benefits to all workers. Instead, unless they self-insure, employers may favor some employees over others. RICHARD SCHMALBECK & LAWRENCE ZELENAK, FEDERAL INCOME TAXATION 125–29 (2004).

49. As Havighurst and Richman discuss, economists argue that workers effectively pay for all premium costs through reduced wages, because total payroll costs are constrained by market forces, and employers are economically agnostic as to whether payroll expenses are paid in the form of wages or benefits. Havighurst & Richman, *supra* note 1, at 44–45. Therefore, it largely does not matter how

average cost per person in the workforce, without adjusting for health risk or demographic factors—a method equivalent to pure community rating. Employers could, but generally do not, charge lower-wage employees less for equivalent coverage.⁵⁰ Some employers do, however, charge workers at least somewhat less when they opt for lower-cost coverage, such as a Health Maintenance Organization (HMO) policy rather than a traditional policy. Thus, as employers begin to offer HSA-qualifying high-deductible plans, they are free to, and usually do, charge less to employees who opt for this cheaper coverage.⁵¹ Providing this lower-cost option moderates the regressive features that Havighurst and Richman identify. Still, this is not as progressive as employers conceivably could become.

One way employers might be even more progressive is to contribute more to the HSAs of workers who would be more disadvantaged by high-deductible insurance, such as those with chronic illness or those with lower wages. Federal law prohibits this, however, by requiring that employers make equal contributions to the HSA of each worker if they contribute anything at all.⁵² Insisting on strict uniformity most likely reflects a desire to avoid favoring more highly compensated employees. Obviously, such a policy does not result from, but rather is at odds with, a desire to be more generous to disadvantaged employees. Therefore, it would make sense from a progressivity standpoint to amend this uniformity requirement accordingly.⁵³

A similar strategy employers could use to make consumer-driven health insurance less regressive is to lessen the cost-sharing elements for lower-income workers. Instead of either providing low-wage workers less generous insurance that is less expensive or charging these workers less for equivalent coverage,

much of compensation goes toward health insurance. This argument is most convincing, however, only for aggregate payroll costs. The economic effects of allocating these costs among classes of employees remain more speculative. As Havighurst and Richman argue, it remains unproven whether having lower costs for the health benefits of one subset of workers would result in higher wages for those workers or whether the opposite would be true. *Id.* at 46. For instance, employers generally do not pay some equally qualified workers more simply because they elect not to receive health benefits. Therefore, it is relevant to focus on the portion of premiums charged explicitly to workers.

50. See Thomas Rice & Kenneth E. Thorpe, *Income-Related Cost Sharing in Health Insurance*, HEALTH AFF., Spring 1993, at 21, 21 (recommending that employers tie cost-sharing to employees' income level); see also Veronica Goff, *Consumer Cost Sharing in Private Health Insurance: On the Threshold of Change*, NAT'L HEALTH POL'Y FORUM ISSUE BRIEF, May 2004, at 8, available at http://www.nhpf.org/pdfs_ib/IB798_CostSharing.pdf; Sally Trude & Joy M. Grossman, *Patient Cost-Sharing Innovations: Promises and Pitfalls*, CTR. FOR STUDYING HEALTH SYS. CHANGE ISSUE BRIEF, Jan. 2004, at 3, available at <http://www.hschange.org/CONTENT/643/>.

51. Gary Claxton et al., *What High-Deductible Plans Look Like: Findings from a National Survey of Employers*, 2005 HEALTH AFF. (WEB EXCLUSIVES) W5-434, W-439.

52. 26 U.S.C.A. § 4980G (2003); U.S. Dep't of the Treasury, HSA Frequently Asked Questions, http://www.ustreas.gov/offices/public-affairs/hsa/faq_basics.shtml (last visited Mar. 6, 2006).

53. Recently, President Bush proposed allowing employers to make higher contributions to the HSAs of chronically ill employees. Press Release, White House Office of the Press Sec'y, State of the Union: Affordable and Accessible Health Care (Jan. 31, 2006), available at <http://www.whitehouse.gov/news/releases/2006/01/20060131-7.html>. This proposal does not include different contributions based on income, however. Currently, this can be done only through a "section 125 cafeteria plan," also known as a flexible spending account. See U.S. Dep't of the Treasury, *supra* note 52.

employers could charge lower-income workers the same as others but provide them *more generous* coverage that reduces their net out-of-pocket expenses. This could be done in the form of equivalent insurance that has lower, although still high, deductibles. One reason lower-income people use health benefits less is that any given deductible or copayment is a greater deterrent to their seeking care than it is for those with more money to spare—a phenomenon that economists refer to as a “wealth effect.” The wealth effect is a major reason lower-income people use health insurance less and is therefore a major contributor to the regressive effect that Havighurst and Richman critique. Adjusting deductibles or copayments to compensate for the wealth effect is conceptually a relatively simple fix for the problem and one that appears to be legally permissible.⁵⁴

In sum, in the complex world of health insurance regulation and employer-sponsored health insurance, few laws actually restrain insurers and employers from adopting more progressive insurance-pricing practices.⁵⁵ Instead, as Havighurst and Richman thoroughly document, plenty of legal and regulatory features artificially and inefficiently increase the overall costs of health care, thereby exacerbating the extent of regressivity that tends to exist naturally.⁵⁶ If those larger problems were solved, however, there would be few legal barriers to making the financing of private insurance more progressive. Indeed, high-deductible health insurance holds some prospect for both reducing overall medical costs and offering more affordable coverage for lower cost.

III

LESS EXPENSIVE HEALTH CARE DELIVERY

Havighurst and Richman’s primary concern is the employer-based tax subsidy, which induces overly generous health insurance and thus excessive health care consumption. Accordingly, their main remedies are aimed at allowing patients, if they choose, to receive a substantially less expensive—and presumably lower overall—standard of medical care than is currently required by contract or tort law.⁵⁷ This same legal dilemma was posed previously by managed-care insurance, but for reasons thoroughly explained elsewhere, the managed-care movement never substantially changed medical standards of

54. See U.S. Dep’t of the Treasury, *supra* note 52. This would comply with requirements for HSAs so long as the lowest deductible meets the HSA floor. For example, employers could give low-wage workers coverage with a \$1000 deductible while giving high-wage workers coverage with a \$5000 deductible—each group being charged the same amount for their coverage. The only constraint set by HSA law is that if the employer contributes to the HSA, it must contribute equal amounts for each employee and no more than the deductible amount. See *supra* text accompanying note 52. Therefore, under this example, employers could fund only one-fifth of the deductible for higher-wage workers.

55. The most notable example is the nondiscrimination requirement for employer contributions to HSAs, which poses a regulatory barrier to implementing these new benefit structures in a way that does not overburden lower-income workers.

56. Havighurst & Richman, *supra* note 1, at 58–71.

57. *Id.* at 66.

care.⁵⁸ Therefore, the academic debates over whether law could and should allow these changes proved to be largely moot.⁵⁹ Health policy is now looking to consumer-driven ideas to force more of the kind of health care resource allocation that has been minimized for the past half-century.⁶⁰ If these new forms of insurance take hold, they will squarely raise whether providers legally may, on account of the cost, render medical services that are “substandard” in some sense or that sacrifice some substantial measure of medical benefit.

As Havighurst and Richman demonstrate, many aspects of law require similar—or even uniform—standards of medical care.⁶¹ These laws developed over the past few decades when uniform comprehensive insurance prevailed and lack of insurance was an exception that law could accommodate without needing to vary basic legal standards.⁶² In the consumer-driven era of high-deductible health insurance, however, limitations in insurance will become much more widespread. Most patients with high-deductible policies will pay for most of their treatment costs out of pocket because most people’s annual medical expenses will not exceed the high-deductible threshold.⁶³ When entirely out-of-pocket payment becomes commonplace, will the law continue to insist on similar medical care for everyone? Thoroughly exploring this broad question would require delving into many areas of legal doctrine. Here, space permits a brief survey of only two of the most prominent issues: first, the contractual standard of medical necessity and, second, the tort liability standard of care.

A. Contractual Medical Necessity

There is no strong reason to expect that consumer-driven health care (CDHC) will produce substantial changes in the contractual definition of medical necessity. The thrust of CDHC is to retain standard insurance for “catastrophic” expenses that exceed amounts for which most people are able to

58. See generally Clark C. Havighurst, *Is the Health Care Revolution Finished?—A Foreword*, 65 LAW & CONTEMP. PROBS. 1 (Autumn 2002) (introducing this symposium discussing the failed potential of managed care).

59. Naturally, it is possible that managed care failed to drive substantial change because law was not more conducive to change, but most observers believe that managed care’s failures were market-driven or were related to federal tax policy. See Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POL. POL’Y & L. 427 (2005) (detailing the reasons for the downfall of managed care). Therefore, the extent of legal resistance was never seriously tested in many arenas. See generally PETER D. JACOBSON, *STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA* (2002) (analyzing legal responses to various aspects of managed care).

60. See text accompanying *supra* notes 2–4.

61. Havighurst & Richman, *supra* note 1, at 63.

62. See generally Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J.L., MED., & ETHICS 141 (1993).

63. See Mark A. Hall & Clark C. Havighurst, *Reviving Managed Care with Health Savings Accounts*, 24 HEALTH AFF. 1490, 1491 (2005) (documenting the highly skewed distribution of health care spending that produces this phenomenon). It is also the case, however, that most medical expenditures will still be insured. This apparent paradox is explained by the fact that the minority of people who exceed their deductible will have medical costs far above average, due to the highly-skewed distribution of medical problems across the population. *Id.* at 1494.

budget on an annual basis.⁶⁴ Below that threshold, people are expected to make their own decisions about what is medically necessary. Above the threshold, insurers' coverage decisions will be subject to essentially the same legal oversight and market forces that currently prevail. Under managed care, there were forceful arguments that insurers should and would enforce more stringent cost-effectiveness standards,⁶⁵ but this did not come to pass. If the basic contractual standards of medical necessity did not materially change under managed-care insurance, this change is certainly not likely to happen under consumer-driven health insurance, particularly as managed-care restrictions are loosened. The basic philosophy of CDHC is to reduce insurer oversight of medical-care delivery and place most decisions in the hands of patients and their physicians. This goal is not advanced by greatly tightening the conventional definition of medical necessity. Moreover, insurers are generally averse to reformulating their contracts and actuarial calculations to incorporate new legal concepts that have not yet been tested in court. Innovating insurers bear the risk of any legal setbacks or financial miscalculations, but any successes in establishing favorable law or addressing market problems can easily be replicated by their competitors. This is not a recipe for fundamental or radical change.

Nevertheless, it is likely that the meaning of "medical necessity" in particular cases will evolve incrementally under high-deductible insurance toward substantially more cost-conservative standards of care. This is true for the following reasons. First, for treatment subject to the deductible, medical necessity will be decided primarily by cost-sensitized patients in consultation with their physicians. Accordingly, prevailing professional practices, to which the contractual standard of medical necessity refers, will likely incorporate much more cost-sensitized norms than is currently the case. When insurance applies, these will become the same norms that insurers enforce, thus giving insurers a broader base of support in actual clinical practice to apply cost-effective standards of medical necessity.

64. See sources cited *supra* notes 2–4.

65. E.g., CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 89–110 (1995); Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992). Although this failure to innovate may be due in significant part to regulatory barriers, it may also be due in large part to the important jurisprudential, relational, and expressive functions served by the standard medical-necessity concept. See Kathy Cerminara, *Dealing with Dying: How Insurers Can Help Patients Seeking Last-Chance Therapies (Even when the Answer Is "No")*, 15 HEALTH MATRIX 285 (2005); William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 600–45 (2003). Health insurance contracts cover complex professional judgments made in an almost infinite array of uncertain circumstances. Therefore, they partake heavily of "relational contracting" features that are difficult or impossible to specify in advance. In general legal theory, one solution is to contract for a broad existing professional norm and to leave specification and application to largely noncontractual processes. See Symposium, *Relational Contract Theory: Unanswered Questions*, 94 NW. U. L. REV. 737 (2000) (detailing various applications of relational contract theory). This solution has prevailed under many types of health insurance for half a century, and it is highly doubtful that consumer-driven insurance will suddenly cause a radical change.

Second, when disputes over insurance coverage are litigated, courts should be less likely under consumer-driven plans to take such a harsh view of insurers' or self-funded employers'⁶⁶ motives for denying coverage. This point can be appreciated by exploring the two different circumstances in which coverage disputes likely will arise under high-deductible plans: when treatment is covered by the deductible, and when it is not. Insurers will sometimes deny medical necessity for expenditures that are entirely subject to the deductible even though the insurer is not obligated in any event.⁶⁷ This is because medical necessity still determines whether these initial expenditures count toward the deductible each year, and the deductible determines insurers' responsibility for costs above the deductible; therefore, insurers retain some stake in reviewing medical necessity below the deductible.⁶⁸ It is likely, however, that such reviews will be done retrospectively, after treatment, rather than requiring patients to obtain permission first.⁶⁹ In addition, patients will be paying for these services regardless of the outcome of the dispute, so the dispute affects only the insurer's future contingent financial liability. Courts therefore should view these coverage denials as mere determinations of financial responsibility rather than as denials of actual treatment, in contrast to the view that prevailed under managed-care insurance.⁷⁰ This will lessen the pressure on courts to award coverage as a means of giving patients every possible chance to receive treatment that might work or that their doctors recommend.

Even when framed simply as financial disputes, older cases have tended to strictly construe coverage language against insurers because of insurers' self-interest in avoiding financial liability.⁷¹ This strict scrutiny may abate somewhat if courts moderate their view of insurers' stakes under high-deductible plans. When insurers deny medical necessity for treatment subject to a deductible, it is

66. Most of the points in this section regarding insurers apply as well to self-insured employers, to the extent they make their own coverage determinations or review those made for them by contracted insurance administrators.

67. These coverage denials will be less frequently appealed, however, because they will be for lower-cost treatments and because many patients will be able to pay for them in any event from their health savings accounts. Underscoring the latter point, the tax qualification of HSAs extends to a broad list of health-related expenditures, regardless of whether they meet the stricter definition of "medical necessity" in the accompanying insurance policy. See sources cited *supra* note 4.

68. Hall & Havighurst, *supra* note 63, at 1495.

69. *Id.*

70. For example, in *Wickline v. State*, the court reasoned:

The stakes, the risks at issue, are much higher when a prospective cost containment review process is utilized than when a retrospective review process is used.

A mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. An erroneous decision in a prospective review process, on the other hand, in practical consequences, results in the withholding of necessary care, potentially leading to a patient's permanent disability or death.

192 Cal. App. 3d 1630, 1634 (1986).

71. See Mark A. Hall, Teresa R. Smith, Michelle Naughton & Andrea Ebbers, *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055, 1063 (1996) (documenting legal factors in coverage disputes prior to widespread managed care).

primarily the patient's money, not the insurer's, that the insurer is attempting to save. Such denials have only a possible impact on the insurer's future liability if the deductible is met later in the year. These factors are similar to ones that previously have convinced courts to find no or a lessened conflict of interest.⁷² Under case law involving the Employee Retirement Income Security Act (ERISA)—which applies to employer-sponsored health insurance—the insurer's conflict of interest heightens the court's scrutiny of the insurer's judgmental coverage decisions.⁷³ When a conflict of interest is absent or lower, courts defer more readily to insurers' medical necessity decisions.⁷⁴ The same is true, at least to some extent, when state courts apply insurance contract law.⁷⁵ Under high-deductible health insurance, when treatment costs are below the deductible, the insurer's role is more akin to that of a "third-party administrator" for an employer plan that is self-funded—that is, the insurer is determining medical necessity as a contracted administrator rather than determining its own immediate financial liability. When these same situations arise under ERISA, courts consistently find no substantial conflict of interest in the insurer.⁷⁶

More often, however, insurers with high-deductible plans will continue to bear part or all of the immediate financial stakes when medical-necessity denials are challenged. This is because appeals are more likely for denials with larger financial stakes that exceed the deductible threshold, such as denials for hospitalization costs. In such cases it is difficult to predict whether the judicial view of insurers will moderate. It is possible, however, that courts will see these situations as a hybrid between the situation just described (involving coverage denials below the deductible) and the overt conflict of interest under comprehensive, no-deductible insurance. For instance, a \$10,000 claim under a policy with a \$5000 deductible would expose the insurer to only \$5000 of potential liability. If decided prior to treatment, a coverage denial might save the patient and the insurer \$5000 each.⁷⁷ In analogous circumstances under

72. See, e.g., *Crossman v. Media Gen. Inc.*, 9 Fed. App'x 147, 151 (4th Cir. 2001) (finding no conflict of interest when the employer paid benefits from a dedicated trust fund); *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998) (finding no conflict when the amount at stake is small compared to total assets available); *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 437 n.4 (3d Cir. 1997) (finding no conflict of interest when the employer paid benefits from a dedicated trust fund); *Kotrosits v. GATX Corp. Non-Contributory Pension Plan for Salaried Employees*, 970 F.2d 1165, 1173 (3d Cir. 1992) (ruling that a potential future benefit to the decisionmaker is not sufficient to create a conflict).

73. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 112 (1989).

74. See generally Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083 (2001); Peter A. Meyers, *Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans*, 28 SEATTLE U. L. REV. 925 (2005).

75. See Hall & Anderson, *supra* note 65.

76. See cases cited *supra* note 72. Leading cases also include *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 383–84 (3d Cir. 2000) and *Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1561–62 (11th Cir. 1990).

77. Alternatively, an insurer might deny coverage because a different type of effective treatment is available that is substantially less costly yet still expensive. If the alternative treatment still costs as much as the deductible, however, then the insurer would enjoy all the benefits of the denial, increasing

ERISA, the court's level of scrutiny moderates following an explicitly sliding-scale level of review that varies according to the extent of conflicted interest.⁷⁸ Viewing medical necessity determinations as entailing overlapping sets of interests, it is conceivable that courts might regard coverage denials as mutually beneficial attempts by insurers to make the best use of both the patient's and their own funds.

B. Liability Standard of Care

As consumers buy more-limited insurance and insurers enforce those limits more aggressively, physicians will more frequently face the dilemma of treating patients whose insurance does not fully cover what physicians believe is medically optimal. The above section explains that deficits in coverage can arise from two directions: If insurance has high deductibles, most subscribers will pay for all of their treatment costs either out of pocket or from their designated savings accounts.⁷⁹ Even when insurance applies, insurers might agree to cover fully only a less expensive version of treatment than the one the physician believes is best, such as a generic rather than a newly patented drug or an ultrasound rather than a magnetic resonance imaging (MRI) scan. These scenarios raise the question whether a physician is potentially liable if he delivers treatment that is less than optimal, assuming the patient can later show that the better treatment would have produced a better health outcome.

Medical law does not provide a clear answer to this question. In considering whether liability law should accommodate cost burdens, previous discussions have focused primarily on more extreme cases in which non-covered treatment is extraordinarily expensive or patients have few or no financial resources.⁸⁰ These are critical situations, but these extremes will not occur as often as the more routine, but still challenging, situations presenting a range of treatment options—all of which are at least somewhat affordable—the best of which cost substantially more than the others.

Full analysis of this situation is complex, so in the space available here it helps to make these simplifying assumptions: (1) the patient could pay for the medically-optimal treatment if he or she felt the benefits were worth the extra costs, (2) the patient was aware of the more expensive option and its advantages but agreed to the less expensive course,⁸¹ and (3) most other physicians would

its financial conflict of interest. It is for this reason that Clark Havighurst and I propose that insurers share some portion of the savings with the patient in such circumstances—for instance, by agreeing to pay for the more expensive option if the patient will pay half the difference in cost. See Hall & Havighurst, *supra* note 63, at 1498.

78. See cases cited *supra* note 72.

79. As explained earlier, this is true even though most treatment costs will still be covered by insurance because insurance will primarily cover the relatively fewer situations of “catastrophic” costs that exceed the high deductible, such as hospitalizations of more than just a few days. See *supra* note 4 and accompanying text.

80. E.g., Hall & Anderson, *supra* note 65.

81. In other words, this analysis purposefully avoids the informed consent aspects of the issue, such as who should raise the question of cost in considering treatment options and how cost issues should be

likely use the more expensive treatment with a fully insured patient under similar medical circumstances. Given these assumptions, the less expensive treatment is not clearly within the existing “standard of care,” so there is a colorable claim that it is substandard.

Framed just this way,⁸² it is open to debate whether physicians would be legally safe in delivering the less expensive treatment. In general, the medical malpractice standard of care does not vary according to a patient’s insurance or financial situation.⁸³ Moreover, if care is substandard, a waiver of medical liability is generally not enforceable due to the fiduciary nature of treatment relationships.⁸⁴ These legal positions have been developed, however, under a highly polarized framing of the issues, such as fully insured versus indigent patients or full liability versus complete waiver of liability.⁸⁵ Limited-coverage insurance does not typically pose these extremes. Instead, the legal issues can be framed in more qualified terms such as the following:

- (1) Are there any resource-sensitive components of the legal standard of care, and if so, how well do they take account of patients’ willingness to pay?
- (2) If patients knowingly accept substandard treatment on account of costs, do physicians have any defenses to liability, or do they have to offer minimally acceptable treatment regardless of patients’ willingness to pay?

These are complex questions that can be viewed from a variety of doctrinal perspectives, only some of which are briefly considered here. On the first question, malpractice law takes financial resources into account in only limited ways that do not directly recognize the financial circumstances of individual patients or their willingness to pay.⁸⁶ Legal scholars have advanced strong

discussed between patient and physician. For analysis of this issue, see E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 VAND. L. REV. 1207 (2006).

82. This precise combination of legal and medical attributes may not be the most common scenario in which liability issues will arise under consumer-driven insurance, but this particular framing helps to focus squarely on the legal issues that are uniquely raised by this form of insurance. See also *id.* (framing and analyzing the issues similarly).

83. For older authorities, see *Becker v. Janiski*, 15 N.Y.S. 675, 677 (N.Y. Civ. Ct. 1891), and *Medical Malpractice in Nineteenth-Century America*, DEVILLE, *supra* note 23, at 183. For a modern analysis, see E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1724–25 (1987), and John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 VA. L. REV. 439, 441 (1991).

84. *Tunkl v. Regents of University of California*, 383 P.2d 441, 448 (Cal. 1963); Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 401–14 (1990); A.M. Swarthout, Annotation, *Validity and Construction of Contract Exempting Hospital or Doctor from Liability for Negligence to Patient*, 6 A.L.R.3d 704 (1966).

85. See, e.g., *President and Dirs. of Georgetown Coll. v. Hughes*, 130 F.2d 810, 827 (D.C. Cir. 1942) (rejecting complete immunity for charitable hospitals).

86. James H. Henderson & John A. Siliciano, *Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice*, 79 CORNELL L. REV. 1382, 1403 (1994) (noting that courts “covertly” adjust the standard of care to resource-dependent professional customs); see also *Hall v. Hilbun*, 466 So. 2d 856, 872–73 (Miss. Ct. App. 1985) (considering resources in determining which

arguments for and against varying the standard of care based on type of insurance,⁸⁷ but few courts have ever ruled on these arguments.⁸⁸ They therefore remain almost entirely a matter of academic debate.⁸⁹ Most convincing is the argument, made independently in various forms by several different scholars, that malpractice law should distinguish between two components of the malpractice standard of care: (1) deliberate decisions about how much treatment to give a patient (the resource component) and (2) the skill with which diagnoses are made and treatment is rendered (the skill component).⁹⁰ Currently, the standard of care lumps together these two different components of resources and skill and asks only whether the treatment received was up to par. Legal scholars reason, consistent with general principles from case law, that although the skill component should not vary by patients' financial circumstances, the resource component should. Otherwise, law would demand more of physicians than is reasonable in the circumstances.⁹¹ Whether courts will accept this reasoning remains to be seen.⁹²

localities are similar).

87. See generally MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS* 324–25 (2005) (surveying various authorities).

88. Courts have not faced this issue for several reasons. One is that defense lawyers are reluctant to raise resource constraints as a defense because financial motivation for substandard care would likely be used by plaintiffs as a sword, even to the extent of justifying punitive damages. *Id.* at 325–26. Another is that medical practices in HMOs or other resource-constrained settings do not in fact vary much from full-payment settings. See MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *THE LAW OF HEALTH CARE FINANCE AND ORGANIZATION* 220–21 (2005) (reviewing empirical studies of HMO impacts).

89. Research has turned up only two cases broadly on point. One suggests financial resources should matter and the second holds they should not. Compare *Moss v. Miller*, 625 N.E.2d 1044, 1051 (Ill. App. Ct. 1993) with *Rogers v. Okin*, 478 F. Supp. 1342, 1384 (D. Mass. 1979), *rev'd on other grounds*, *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980). Neither addresses patient cost-sharing. Instead, they both consider care provided for free by institutions with limited budgets. The first case reversed a defense verdict against a prisoner who alleged negligent failure to refer him to a specialist, reasoning that the jury instructions improperly suggested that “those practicing the medical arts in the penitentiary are held to [a different] standard of care.” *Moss*, 625 N.E.2d at 1051. The second case, however, ruled in a challenge to conditions at a state mental hospital that it was “relevant . . . to consider the medical resources and support facilities available” to the psychiatrists at the hospital in determining whether they used psychotropic medication reasonably. *Rogers*, 478 F. Supp. at 1384.

90. E. HAAVI MORREIM, *HOLDING HEALTH CARE ACCOUNTABLE* 80–82 (2001); Randall R. Bovbjerg & William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 916 (1986); Mark A. Hall, *Health Care Cost Containment and the Stratification of Malpractice Law*, 30 JURIMETRICS J. 501–08 (1990); Siliciano, *supra* note 83, at 482; Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment*, 103 YALE L.J. 1297, 1325–26 (1994).

91. See sources cited *supra* note 90.

92. Some support can be found in *Hall v. Hilbun*, which held that the skill component is uniform but that the resource component varies by similar locality. 466 So. 2d 856, 872 (Miss. Ct. App. 1985); see also *Primus v. Galgano*, 329 F.3d 236, 241 (1st Cir. 2003) (stating that it is permissible to consider local resources as a relevant circumstance in determining the standard of care under a uniform national standard); *Brune v. Belinkoff*, 235 N.E.2d 793, 798 (Mass. 1968) (same). Support is also found in a federal statute that adjusts the standard of care according to whether treatment is consistent with Medicare payment guidelines while still requiring physicians to “exercise[] due care.” 42 U.S.C. § 1320c-6(c) (2000); see Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 LAW & CONTEMP. PROBS. 119, 136–40 (Spring 1991) (discussing the statute); Leah S. Crothers, Note, *Professional Standards Review and the Limitation of Services*, 54 B.U. L. REV. 931

There is more legal authority addressing the second question—whether patients’ informed acceptance of substandard care is a liability defense. Several scholars argue that courts should enforce agreements by patients or their representatives to lower the ordinary standard of care.⁹³ They observe that altering the standard of care differs from waiving liability entirely, which is primarily all that courts have refused to do.⁹⁴ The general tenor of this scholarship, however, is that there is still little or no judicial support for this more moderate position.⁹⁵ This is too narrow a view of the case law. Again, the distinction between deliberate resource decisions and general skill level is critical. Courts are in fact hostile toward using contractual arguments to lower the general skill standard below negligence to, say, gross negligence.⁹⁶ However, several lines of doctrine recognize patients’ ability to agree to lower the resource standard of care. If patients refuse treatment entirely, withholding care is not only legally permissible,⁹⁷ it could constitute battery or false imprisonment to insist otherwise. This accounts for the practice of honoring patients’ demands to be discharged early from the hospital, even when it is against medical advice (AMA). Frequently, these “discharges AMA” are motivated by patients’ concerns about financial responsibility.⁹⁸

Another way of stating this principle is that malpractice law recognizes assumption of risk as an affirmative defense, and informed refusal of recommended treatment is one form of express assumption of risk.⁹⁹ The same principle applies when a patient, rather than refusing treatment, opts for an alternative form of treatment that is less expensive. When there is disagreement over whether the course of treatment is consistent with a

(1974) (same).

93. *E.g.*, Clark C. Havighurst, *Private Reform of Tort Law Dogma: Market Opportunities and Legal Obstacles*, 49 *LAW & CONTEMP. PROBS.* 143 (Spring 1986).

94. Some courts have also refused to enforce agreements to arbitrate malpractice disputes, but most courts have approved these. HALL, BOBINSKI & ORENTLICHER, *supra* note 87, at 427.

95. *See* William H. Ginsburg, Steven J. Kahn, Michael C. Thornhill & Steven C. Gambardella, *Contractual Revisions to Medical Malpractice Liability*, 49 *LAW & CONTEMP. PROBS.* 253 (Spring 1986) (reviewing relevant cases).

96. *Id.*

97. Note, though, that some courts require treatment refusals to meet legal standards of informed consent. *E.g.*, *Truman v. Thomas*, 611 P.2d 902, 906–07 (Cal. 1980) (requiring a physician to better inform a patient of why she needed a cancer screening test that she refused on multiple occasions).

98. Z.Y. Aliyu, *Discharge Against Medical Advice: Sociodemographic, Clinical and Financial Perspectives*, 56 *INT’L J. CLINICAL PRACTICE* 325 (2002); Patricia Green, Diane Watts, Sabrina Poole & Vasant Dhopes, *Why Patients Sign out Against Medical Advice (AMA): Factors Motivating Patients to Sign out AMA*, 30 *AM. J. DRUG & ALCOHOL ABUSE* 489 (2004); David B. Smith & Joel L. Telles, *Discharges Against Medical Advice at Regional Acute Care Hospitals*, 81 *AM. J. PUBLIC HEALTH* 212 (1991); Saul N. Weingart, Roger B. Davis & Russell S. Phillips, *Patients Discharged Against Medical Advice from a General Medicine Service*, 13 *J. GEN. INTERNAL MED.* 568 (1998).

99. *E.g.*, *Baxley v. Rosenblum*, 400 S.E.2d 502, 508 (S.C. Ct. App. 1991) (upholding assumption-of-risk instruction when a patient, who also was a physician, refused a treatment option recommended by his doctor). Other examples arise in cases of Jehovah’s Witnesses who refuse blood transfusions. *See generally* Kurtis A. Kemper, Annotation, *Contributory Negligence, Comparative Negligence, or Assumption of Risk, Other than Failing to Reveal Medical History or Follow Instructions, as Defense in Action Against Physician or Surgeon for Medical Malpractice*, 108 *A.L.R.5TH* 385 (2005).

reasonable standard of care, it is often the case that multiple standards of care exist, some of which only a minority of physicians adhere to. Under the “two schools of thought” or “respectable minority” doctrine, physicians are protected if their practice is consistent with any acceptable standard of care, even if it is not the preferred, best, or most widespread.¹⁰⁰ However, these issues of reasonableness and professional acceptance usually are given to the jury to resolve, leaving physicians in jeopardy of unsympathetic or uninformed juries.¹⁰¹ One way to remove this uncertainty over the reasonableness of an alternative school of thought is to show that the patient knew about the alternatives and requested the course that was taken.¹⁰² Based on a patient’s informed choice, courts have allowed alternatives that objectively are not at all accepted or reasonable.¹⁰³

One final possibility is that instead of declining more expensive treatment, patients might insist on the best treatment but refuse to pay. When this happens, the law is complex and sometimes unclear. The relevant legal principles depend on whether the provider is a physician or hospital, on whether treatment has not yet been initiated or is being ended, and on the extent of medical urgency in a particular case.¹⁰⁴ For some combinations of these factors, there are few or no decided cases, so the legal framework is uncertain. Still, several aspects of this complex doctrine allow physicians in particular to refuse to treat patients who refuse to pay.¹⁰⁵

IV

CONCLUSION

Havighurst and Richman catalogue many of the ways in which distributional inequities in American health law and policy force people to pay too much for health care and insurance. Their basic insight—that social injustice results from requiring everyone to purchase the same level of care preferred by the wealthy—is similar to the following point made by health economist Uwe Reinhardt twenty years ago:

100. See James F. Blumsein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping with an Evolving Reality in the Health Care Marketplace?*, 11 ANNALS HEALTH L. 125, 133–34 (2002) (discussing various ways in which the law accommodates “medical pluralism”).

101. See, for example, the following account by a physician who was sued for following a conservative approach to screening for prostate cancer, as recommended by national guidelines. Daniel Merenstein, *Winners and Losers*, 291 JAMA 15, 16 (2004) (“The jury sent a message . . . that they didn’t believe in the national guidelines.”).

102. Cf., e.g., *Schneider v. Revici*, 817 F.2d 987, 996 (2d Cir. 1987) (signing an informed consent form for unorthodox cancer treatment created a jury question regarding patient’s assumption of risk).

103. See, e.g., *id.* at 993 (permitting jury to find that unorthodox treatment was acceptable despite testimony that the practitioner was a “quack” and “one of the cruelest killers in the United States”).

104. See MARK A. HALL, IRA MARK ELLMAN & DANIEL S. STROUSE, *HEALTH CARE LAW AND ETHICS IN A NUTSHELL* 82–115 (2d ed. 1999) (summarizing the governing law).

105. Mathew Gregory, *Hard Choices: Patient Autonomy in an Era of Health Care Cost Containment*, 30 JURIMETRICS J. 483, 499 (1990); Mark A. Hall, *A Theory of Economic Informed Consent*, 31 U. GA. L. REV. 511, 528–33 (1997).

A remarkable and unique feature of American health policy has been its attempt to accommodate simultaneously both the egalitarian and the libertarian theories of justice in their extreme purity. No other nation in the industrialized West has been quite so bold, or quite so naive, as to attempt that feat There appears to be a casual link between schizoid thinking on the ethical plane and impotence at the level of policy.¹⁰⁶

Unlike Reinhardt, however, Havighurst and Richman are less interested in making health care truly progressive than in making it more efficient. Correcting regressivity is more than just a pretext, however; it is a genuine motivator for reform. Although they refrain from definitive policy prescriptions, they at least raise the possibility that both equity and efficiency will be enhanced by moving toward consumer-driven health care, embodied most straightforwardly in HSAs and high-deductible health insurance.

This survey reveals that although some legal risks would certainly be encountered, there is enough room in regulatory policy and common-law precedents to allow this to happen. Not all aspects of legal doctrine fully embrace the principles of consumer-driven health care, but neither are there obvious major obstacles. It has been half a century since the era when most people paid for most of their medical costs out of pocket. Naturally, the law that developed over these generations tended to take for granted the widespread existence of third-party reimbursement and thus often avoided confronting the economic tradeoffs that health care inevitably entails. Still, the common law has not discarded its historical roots.¹⁰⁷ It embodies in many ways the basic principles that patients should not have to pay for more than they receive and that patients of adequate means cannot expect to receive more care than they are willing to pay for. This legal regime may or may not enforce society's concept of a fair system of health care finance and delivery, but it goes a long way toward allowing the more limited forms of insurance and the less costly standard of medical care that Havighurst and Richman believe many consumers would prefer.

106. Uwe Reinhardt, *Chapter 1, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES* 1, 8 (Frank A. Sloan, James Blumstein & James Perrin eds., 1986).

107. For instance, the leading case on a physician's freedom to refuse patients is a century old. *Hurley v. Eddingfield*, 59 N.E. 1058 (Ind. 1901) (holding that a physician need not give any justification for refusing to treat a patient who subsequently died). The core of medical malpractice doctrine remains largely unchanged from the nineteenth century, other than the locality component of the standard of care. See DEVILLE, *supra* note 23, at 206–14.