PROSPECTIVE SELF-DENIAL:
CAN CONSUMERS CONTRACT TODAY TO ACCEPT
HEALTH CARE RATIONING TOMORROW?

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Rationing is a common buzz word in the American health policy debate, conjuring up visions of officious interference in private choices and arbitrary limitations on the freedom of physicians to prescribe for their patients. The sensitiveness of the “R-word” is significant because it illustrates the extraordinary difficulty of ensuring that the nation’s scarce resources are efficiently allocated between health care and other uses. In our political and legal culture, a powerful taboo inhibits any effort, private as well as public, to economize in the provision of health care by withholding any arguably beneficial service.

Eliminating cultural, practical, and legal obstacles to responsible economizing in the purchasing and provision of personal health care should be a primary objective of national health policy reform. An unrecognized reason why the nation is feeling so impoverished these days despite its immense wealth is that purchasers of health care—individuals, employers, and even government itself—lack proven and acceptable methods for ensuring that marginal dollars spent on health services yield at least as much benefit as could be gotten by equivalent spending on other things.¹ Until the nation

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¹ Many observers prefer to define the economizing task as merely eliminating wasteful, unnecessary care and ensuring that lower-cost methods are used whenever quality would not suffer. See, e.g., Arnold S. Relman, *The Trouble with Rationing*, 323 NEW ENG. J. MED. 911, 913 (1990) (expressing a physician’s view that “we should be able to afford all the services we really need”). It is irresponsible, however, not to recognize that efficiency demands the withholding of some (marginally) beneficial care. See Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 SCIENCE 418 (1990); David M. Eddy, *What Care is “Essential”? What Services are “Basic”?*, 265 JAMA 782 (1991); E. Haavi Morreim, *Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care*, 12 J. LEGAL MED. 275 (1991); William B. Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief*, 257 JAMA 220 (1987); William B. Schwartz & Paul L. Joskow, *Medical Efficacy versus Economic Efficiency: A Conflict in Values*, 299 NEW ENG. J. MED. 1462 (1978).

For examples of this author’s early insistence on the importance of attacking the cost problem in the “no-man’s-land” where the benefits curve still slopes upward but less steeply than the cost curve, see Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6 (1975) (with graphic illustrations); Clark C. Havighurst et al., *Strategies in Underwriting*

finds ways to curb the health care sector's propensity to squander substantial resources—perhaps whole percentage points of GNP—on low-priority services, it will continue to neglect such needs as improved education and job-creating capital investment. At the moment, the nation is finding it nearly impossible to pay for existing public and private health care programs. Without better methods of implementing priorities in health care spending,² it is hard to see how health coverage can be extended to the thirty-six million Americans who currently lack it.³

the Costs of Catastrophic Disease, LAW & CONTEMP. PROBS., Autumn 1976, at 122 (a painstaking attempt to be as explicit as possible, and even a bit hard-boiled, about the need for rationing medical care even when life itself seems to be in the balance).

² The nation's search for allocative efficiency in health care began in the 1970s with efforts to build an infrastructure of government regulation preparatory to enactment of some form of national health insurance. Regulation focused on limiting the availability of health care facilities (through certificate-of-need programs) and the amount of hospital expenses or revenues. The resulting resource constraints placed the ultimate burden of actually rationing care on physicians rather than on public officials. Yet the strategy of making the providers do the rationing assumed that providers would serve primarily public values rather than their own interests in allocating resources. See Jeffrey E. Harris, *Regulation and Internal Control in Hospitals*, 55 BULL. N.Y. ACAD. MED. 88 (1979). For appraisals of the obstacles to effective government regulatory action in pursuit of efficiency, see CLARK C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY 20-38 (1982); Havighurst & Blumstein, *supra* note 1, at 21-45.

In 1979, Congress signified that it had lost interest in trying to solve the cost problem through industry-wide regulation by defeating President Carter's proposal to regulate the revenues of the nation's hospitals. In addition, the election of a conservative administration in 1980 underscored that private health costs would henceforth be treated as a private, not a public, responsibility. Thereafter, government turned its attention to controlling the costs of its own programs by more prudent purchasing, including prospective payment for hospital services and selective contracting. Left to fend for itself, the private sector expanded its search for better cost-containment tools. See Clark C. Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL. POL'Y & L. 697 (1986) [hereinafter Havighurst, *The Changing Locus*]. Later discussion highlights the cost-containment methods currently in use, showing that much progress was made but also how much further the nation has to go in fashioning tools precise enough to do the job properly. See *infra* text accompanying notes 40-69.

³ It would be easier to cover the uninsured under public programs if government could establish and enforce appropriate limits on patient entitlements, thus providing a decent level of basic coverage rather than nearly open-ended access to all state-of-the-art medical care. See *infra* notes 9-11 and accompanying text; see also *infra* text accompanying note 47 (discussing the widely watched, but highly controversial, effort in Oregon's Medicaid program to devise limits on entitlements so that coverage can be extended to a wider population). Similar economizing measures in the private sector might permit many of the uninsured, a majority of whom are not destitute, to obtain private coverage. Significant enrollment of the uninsured in private plans is likely, however, only if (1) the market for individual and small-group insurance is

This Article explores whether “prospective self-denial”—that is, voluntary decisions by consumers to economize by accepting substantial restrictions on their freedom to draw upon a common fund for future medical needs—can be useful in rationalizing societal spending on health services. One question is whether the *rationing* label applies to such voluntary restrictions on the availability of financing. More substantively, the Article will address practical questions having to do with the writing and administration of private contracts, legal questions having to do with the enforceability of such contracts, and policy questions having to do with ethics and equity. An overriding question is whether the legal and political culture can tolerate such private economizing or would interfere with it so much that the only allocational mechanism remaining as a health policy option is implicit or explicit rationing by public authorities. At issue ultimately may be the long-run viability of a market-oriented health policy in the United States—for, if consumers cannot effectively exercise choice concerning the level of their spending on health services, some public decision maker will almost certainly have to step in and set priorities for them.⁴

reformed to make such coverage more accessible, (2) more generous and better-designed public subsidies are provided, and (3) private health plans could effectively and strategically limit their legal obligations to make their coverage both efficient and affordable with the resources that individuals have to spend. Although several current reform proposals seek to satisfy the first two of these conditions, none addresses the third. This Article concerns principally the prospects for giving private health plans the new economizing tools they need to accommodate their offerings to purses of different lengths. It may also shed some light, however, on how public health plans, such as Oregon’s Medicaid program, might go about rationalizing spending.

⁴ Thus, although the private sector has recently had the primary responsibility for controlling health care costs, *see supra* note 2, the practical limitations of private contracts as instruments for performing this difficult task may finally cause the policy pendulum to swing back to government as the rationing agent. But contrary to a common assumption, achieving the goal of universal access to care does not require sacrificing whatever advantages private contracts may have in implementing cost-conscious consumer choices. *See supra* note 3. Although many practical difficulties (adverse selection, consumer ignorance, etc.) would prevent the realization of all the theoretical benefits of a choice- and contract-oriented policy, other reforms would have shortcomings, too—not the least of which are the imposition of involuntary rationing and the elimination of private choice as a method of resolving difficult trade-offs. Consequently, even if the ideal vision of a choice-driven market could not be fully realized, the virtues of such a market in legitimizing and facilitating appropriate economizing might still make it, under the principle of second-best, the superior policy choice.

Whatever the “best” policy choice might be, political inertia may leave the nation no alternative to a strategy of incremental change. For this reason, this Article, rather

I. THE SPECTER OF RATIONING IN THE HEALTH POLICY DEBATE

The health policy debate in the United States frequently goes like this:

First debater: Your plan would lead to the rationing of care!

Second debater: We are rationing care already!

Because such discussions deteriorate so easily into semantic quibbles, they are apt to be unproductive. Obviously, however, both parties to this conversation have something serious to discuss. The first wants to talk about the effects of reform on those who currently benefit from mainstream medical care (either as patients or as providers), while the other is principally concerned about the underserved. Although the concerns of each are legitimate, it would be preferable if they could be considered separately, using terms about which there is more agreement. A good case could be made for banning the emotive term *rationing* from such discussions altogether.⁵

Broadly understood, however, some rationing of health care is inevitable in any responsible kind of financial protection against unpredictable health care costs. Third-party financing is notorious for relieving physicians and patients—the primary makers of

than seeking to persuade everyone of the absolute superiority of the market strategy, seeks only to offer constructive guidance for making the market perform better than it has to date. In the author's view, unless the prospects for aggressive economizing in private health care plans can be significantly improved as suggested herein, the policy case for continued reliance on market forces is unconvincing. See Clark C. Havighurst, *Why Preserve Private Health Care Financing?* [hereinafter Havighurst, *Why Preserve Private Financing?*], in *AMERICAN HEALTH POLICY: CRITICAL ISSUES FOR REFORM* (forthcoming 1992) [hereinafter *AMERICAN HEALTH POLICY*] (arguing at length that "firms engaged in the business of privately financing health care can make a plausible case for their own survival only by challenging—both in the policy debate and in their day-to-day business of writing and administering contracts to finance health services—the practical and legal obstacles that currently impede the use of private contracts to express consumer choices in purchasing health care"). For other representative discussions by the author of the progress that has been made toward decentralizing decision making in the health care sector and of the unfinished market-reform agenda, see Clark C. Havighurst, *Decentralizing Decision Making: Private Contract versus Professional Norms*, in *MARKET REFORMS IN HEALTH CARE* 22 (Jack A. Meyer ed., 1983) [hereinafter Havighurst, *Decentralizing Decision Making*]; Havighurst, *The Changing Locus*, *supra* note 2; Clark C. Havighurst, *The Professional Paradigm of Medical Care: Obstacle to Decentralization*, 30 *JURIMETRICS J.* 415 (1990) [hereinafter Havighurst, *The Professional Paradigm*].

⁵ For varying definitions of the term and discussion of how the term is used by different parties to the policy debate, see David C. Hadorn & Robert H. Brook, *The Health Care Resource Allocation Debate: Defining Our Terms*, 266 *JAMA* 3328, 3328-29 (1991).

consumption decisions—of the need to consider costs in diagnosing and treating disease. The resulting propensity to overspend, which economists label “moral hazard,” makes it imperative that there be some rules to limit the freedom of individuals to draw upon the payer’s resources.⁶ Such rules should not, however, be characterized as rationing in any pejorative sense. Although criticism may fairly be directed at the content of the rules themselves and at the fairness and accuracy with which they are administered, there should be no question about the need for some limits on patient entitlements.

Despite the basic legitimacy of rules restricting the availability of health care financing, their invocation in close cases will inevitably be characterized as rationing. Such rules, however, ration only health care financing, not medical care itself.⁷ Thus, a service that is deemed to fall outside a patient’s coverage is not necessarily denied to the patient. It may still be provided at the patient’s personal expense or at the expense of the provider—as in the case of cross-subsidized or charitable care.⁸ Although a coverage limit

⁶ For an unusually careful elaboration by an economist of the moral hazard problem, see PAUL L. JOSKOW, *CONTROLLING HOSPITAL COSTS: THE ROLE OF GOVERNMENT REGULATION* 20-31 (1981). Unlike many observers, Joskow does not give up on the market upon discovery of moral hazard. Instead, he observes that some distortion in spending is an inevitable and very possibly acceptable cost of financial protection, whether publicly or privately provided. He stresses, however, the importance of giving insurers a free hand in attempting to control moral hazard. Thus, “the efficiency of the insurance policies supplied by the market requires [1] that competition among insurance firms yield a menu of health insurance options that reflects the preferences of consumers and [2] that all economical opportunities to mitigate moral hazard problems are exploited.” *Id.* at 43.

⁷ See Mark A. Hall & Gerald F. Anderson, *Health Insurers’ Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1676-77 & n.151 (1992) (“The denial of coverage . . . merely determines that, in the insurer’s judgment, the subscriber pool has chosen not to pay for the particular treatment.” (citation omitted)). As noted *infra* note 9 and accompanying text, exclusions from coverage are ultimately dictated by insurance considerations, not by purely medical concerns. Thus, exclusion of a particular service does not reflect a judgment that services of that type should never be provided.

⁸ See, e.g., *Varol v. Blue Cross & Blue Shield*, 708 F. Supp. 826, 833 (E.D. Mich. 1989) (“Whether or not the proposed treatment is approved [by the insurer], the physician retains the right, and indeed the ethical and legal obligation, to provide appropriate treatment to the patient.” (emphasis omitted)). Neither patients nor providers are likely to be happy with the view that charity and cross-subsidies can ameliorate restrictions on financing from other sources. And indeed it would be wrong to think that “1000 points of light” can make up for significant shortfalls in public financing. Nevertheless, charity and the redistributive capabilities of nonprofit hospitals could provide a useful cushion against the inevitable arbitrariness of rules governing the coverage of public and private health plans. Although this cushion

may often cause a service not to be provided, the constraint on consumption that ultimately produces this result is not any term of the financing plan but the unwillingness (or inability) of the patient to pay for the service out of pocket. *Rationing* is not a helpful term for capturing the reality of such situations. Payers would seem to have an affirmative obligation to curb the incidence of moral hazard by throwing the choice back on the insured whenever there is serious doubt concerning a service's net benefit.⁹ Although this and other cost-sharing strategies should not be used extensively in health plans covering low-income persons, such plans need not cover every desirable service. To characterize as rationing every exclusion from coverage that makes income a potentially decisive determinant of consumption is to imply the existence of an entitlement to receive

would serve better for relatively affordable items (e.g., the brain scan that the doctor badly wants the patient to have), even big-ticket items are sometimes paid for out of hospital resources or by outright charity (e.g., organ transplants for appealing youngsters).

It is perhaps ironic, but efficiency might be significantly enhanced by preserving some of the system's ability to cross-subsidize care. For if providers were able to soften the adverse consequences of strict rules in some individual cases, then the rules themselves could be somewhat stricter than they would have to be if they were always necessarily determinative of the provision of possibly life-saving care.

⁹ Designing optimal health insurance coverage (including the appropriate level of cost sharing) is a more complex undertaking than is usually appreciated. The factors that must be balanced include the magnitude and predictability of the risk; the insureds' aversion to risk and ability to bear out-of-pocket expenses; the elasticity of demand for the service (a measure of the moral hazard associated with insuring the risk); and the administrative cost incurred by insuring rather than paying directly. See Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251, 252 (1973); Clark C. Havighurst, *The Role of Competition in Cost Containment*, in COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE 285, 287-89 (1978) (including a graphic illustration of the reduction in welfare loss from moral hazard that is achievable by closer specification of the circumstances under which payment will be made for a particular procedure). Ideally, coverage should be designed separately for each discrete service, with thought given to every possible exigency.

Although practical considerations would make such minute specification of coverage difficult in any event, the favorable tax treatment of employer-paid insurance premiums has long distorted the calculus, resulting in underuse of out-of-pocket payments (which must be made out of after-tax rather than pretax income) and overspending on marginally beneficial care. Because coverage has been designed to gain a tax break, not to strike the right balance between financial protection and higher cost resulting from moral hazard, insurers have imposed fewer restrictions than would be socially appropriate. See JOSKOW, *supra* note 6, at 24-25; Martin Feldstein & Bernard Friedman, *Tax Subsidies, the Rational Demand for Insurance and the Health Care Crisis*, 7 J. PUB. ECON. 155 (1977); Mark V. Pauly, *Taxation, Health Insurance, and Market Failure in the Medical Economy*, 24 J. ECON. LITERATURE. 629 (1986).

even marginally beneficial care. Although egalitarians would like to proclaim such a "right to health care,"¹⁰ it remains wholly suppositional in the American context.¹¹

The controls on health care financing that are most threatening to patients are those that threaten to deny payment for specific services on economic rather than purely medical grounds. Although most public and private financing plans currently employ some form of utilization management, these cost-containment programs are tolerable because, ostensibly at least, they seek only to eliminate care that is inappropriate by medical standards or to ensure that lower-cost methods are used when medically equivalent.¹² A charge of rationing begins to sound plausible, however, if the plan goes beyond the enforcement of medically validated criteria and threatens to deny patients increments of medical benefit on the ground that the cost is excessive. Nevertheless, as long as the patient remains free to purchase noncovered care out of pocket, the charge that care itself is being rationed should not finally stick. Moreover, there is increasing appreciation that health care cost containment cannot stop at curbing only nonefficacious, "flat-of-the-curve" spending but must enter the treacherous territory of benefit/cost trade-offs.¹³ Although it is very easy to criticize coverage limits that are designed to wage the battle in the benefit/cost no-man's-land, the sensitiveness of such limits alone does not establish their illegitimacy or arbitrariness.

¹⁰ See Maxwell J. Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 WIS. L. REV. 239, 268-74 (summarizing egalitarian approaches to rationing).

¹¹ Although radical egalitarians decry—as "rationing in the cruelest sense"—any distribution of services that reflects differences in ability to pay, the ethical issue they raise was effectively addressed by a presidential commission in the early 1980s. See 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE 4-6, 18-47 (1983) (stressing society's obligation to care for the poor, rejecting the notion of an abstract "right" to health care, and concluding that government is morally bound to ensure, not equality, but a decent minimum level of care for those who cannot pay). For critiques of this report, including some ethicists' expressions of pragmatic regret at the surrender of the political high ground gained by characterizing the issue in terms of rights, see *Symposium*, 6 CARDOZO L. REV. 223 (1984).

¹² See INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE: THE ROLE OF UTILIZATION MANAGEMENT (1989). For further discussion of managed care, see *infra* text accompanying notes 50-57.

¹³ See *supra* note 1. But see Mehlman, *supra* note 10, at 249-82 (arguing that the costs of rationing expensive lifesaving treatments are prohibitively high); Relman, *supra* note 1, at 913 (expressing a physician's fear of any restrictions that "would cut ever more deeply into the body of accepted medical practice").

As the foregoing discussion shows, the ultimate issue in appraising refusals by payers to pay for physician-prescribed health services is not their similarity to rationing but whether they are consistent with legitimate, pre-established rules. In a public program providing coverage for persons generally unable to finance their own care, the legitimacy of restrictive rules cannot be questioned; the public has a clear right to limit any entitlements it democratically creates.¹⁴ Legitimacy is in doubt, however, in any program that limits the freedom of individuals to spend *their own* resources as they wish, and it is infringements on this freedom that are most plausibly challenged as rationing. Thus, true rationing would be salient in any government program that precluded persons from buying for themselves either fuller coverage or more or better care than the public program undertook to finance or provide directly.¹⁵

In today's health policy debates, the rationing specter is most pertinent to proposals to create either a fixed budget for the health

¹⁴ State Medicaid programs, for example, can justify exclusions from coverage as efforts to live within the state's limited means. Thus, a much-discussed experiment currently under way in the State of Oregon seeks to define with more precision than ever before those services for which Medicaid funding will be available; a prominent objective of that effort is to free funds so that the population covered by the program can be expanded to include all low-income persons. See Daniel M. Fox & Howard M. Leichter, *Rationing Care in Oregon: The New Accountability*, HEALTH AFF., Summer 1991, at 7; Symposium, *The "Oregon Plan"*, 1 HEALTH MATRIX 135 (1991). Although Oregon is frequently attacked for threatening to ration medical care, the issues raised by its experiment are more helpfully discussed in more objective terms. See *infra* text accompanying note 47.

¹⁵ Although the Medicare program, as a government-run "single-payer" program for the elderly, purports to cover all needed care, it has the power to second-guess specific provider prescriptions and significantly limits beneficiary freedom to pay separately for services it disallows or to pay more for what may be higher-quality services. Real rationing occurs, however, only when government decisions to withhold payment reflect economic rather than purely medical considerations, and Medicare has mostly been operated with only minimal direct constraints on the clinical freedom of physicians and on the freedom of consumers to choose their own treatments. Instead, cost controls have taken the form of resource constraints (e.g., the Prospective Payment System for hospital care) that may force providers to ration care *sub rosa*. Some observers apparently prefer such indirect rationing over case-by-case allocational decisions of a bureaucratic kind. See, e.g., Relman, *supra* note 1, at 912 (favoring a fixed national budget for health care that will force all providers to make do with less). This preference for *sub rosa* rationing accounts for the acceptability of HMOs, which rarely offer patients additional services at an additional cost. See *infra* text accompanying notes 63-69. Decisions by providers under resource constraints to omit desirable services involve real rationing of a nonconsensual kind that might be (but is generally not) viewed more critically than adverse coverage decisions by conventional third-party payers.

care system as a whole or a single public payer to serve all citizens under centrally determined rules and resource constraints. Implicit in such proposals is the threat that cost controls will go well beyond anything yet tried in the United States. If an American program were based on the popular Canadian model, for example, one would have to forgo public financing altogether in order to jump any queues created by the public system. Thus, Canadian patients going to the United States for quicker or better treatment usually must pay their own way entirely, not just the added cost of immediate treatment. American consumers of health care might fairly question the legitimacy of similar restrictions on their freedom to provide for themselves and their families.

Such rationing concerns are most likely to be voiced, of course, only by those who are relatively well cared for under the existing system. Although not unworthy of consideration, rationing fears expressed by such privileged persons may not always be sincere or well founded. Instead, they may simply be rationalizations for opposing a fixed-budget or single-payer health care plan on other grounds, such as its cost to taxpayers and its redistributive features. Because it is difficult to distinguish between the invocation of rationing as a legitimate policy objection and its use as a code word for resistance to the claims of the poor, most expressions of rationing fears should probably be discounted in the policy debate.

Critics can reasonably insist, however, that any national health policy reform—such as a fixed-budget or single-payer plan—be designed to minimize true rationing. Thus, it could fairly be asked that government leave room for supplementation and perhaps even permit individuals to opt out of the unified program—joining an HMO, for example—without losing public support, for which they have contributed their tax dollars.¹⁶ In addition, other legal restrictions impinging on consumer choice—such as regulatory

¹⁶ Precedent for such an option appears in the HMO option under Medicare. Under this program, a beneficiary may enroll in an HMO with the government paying his premium up to 95% of the estimated Adjusted Average Per Capita Cost of supporting him in the public program. 42 U.S.C.A. §1395mm (a)(1)(E) (West Supp. 1992). See generally Paul B. Ginsburg & Glenn M. Hackbarth, *Alternative Delivery Systems and Medicare*, HEALTH AFF., Spring 1986, at 6. A defect in this program, however, is the requirement that the HMO provide essentially the same benefits as Medicare. Regulation that prevents HMOs from explicitly limiting benefits in some areas (implicit limitations are apparently less objectionable, see *infra* text accompanying notes 63-69) in order to offer alternative benefits of other kinds denies beneficiaries the opportunity to realize any saving by expressing an economizing preference—say, for minimal life-saving efforts toward the end of life.

limitations on facility growth, on the introduction of new technology, or on hospital revenues—can also be objected to as true rationing if carried too far.¹⁷ If the specter of rationing could be understood only as one of the details to be addressed in any government-controlled program, then use of the term might be helpful in drawing attention to particular fairness issues. Unfortunately, however, the term has lost much of its precision and utility in policy debates.

II. RATIONING IN PRIVATE CONTEXTS

How valid is the rationing charge when it is a private financing intermediary, not the government, that imposes a restriction that interferes with a patient's treatment? Putting aside the point that it may be only financing, not medical care itself, that is denied to the patient, what is the force of the patient's claim to more or better treatment than the payer is willing to finance? The issues are still consistency of the denial of coverage with written rules and the legitimacy of those rules. In this case, however, once legitimacy is established (perhaps by the consensual character of the restrictions imposed), the restrictions themselves, having been privately adopted, would not seem to be open to scrutiny on public policy grounds. Still, it may not be so easy to remove the substantive merits of particular cost controls from the health policy debate to the realm of private contract. There is substantial resistance in the legal and political culture to the idea of letting contracts be contracts whenever they operate to restrict the availability of health care financing.¹⁸

The argument here is that private contracts in which consumers accept well-considered, explicit limitations on their future claims

¹⁷ See *supra* note 2.

¹⁸ See ADVISORY COUNCIL ON SOCIAL SECURITY, *THE INFLUENCE OF CURRENT JUDICIAL DOCTRINES ON THE COST OF PURCHASING HEALTH CARE* 15-26 (1991); Alice G. Gosfield, *Value Purchasing and Effectiveness: Legal Implications*, in 1991 HEALTH LAW HANDBOOK 185-87, 194-211 (Alice G. Gosfield ed.) (despite public policy's increased reliance on payers to control health care costs, "some traditional legal principles have the capacity to undermine these new and apparently well-accepted policy goals" *Id.* at 187); James S. Cline & Keith A. Rosten, *The Effect of Policy Language on the Containment of Health Care Cost*, 21 TORT & INS. L.J. 120 (1985); Hall & Anderson, *supra* note 7, at 1684 & nn.173-75; Paul J. Molino, *Reimbursement Disputes Involving Experimental Medical Treatment*, 24 J. HEALTH & HOSP. L. 329 (1991); Paul E. Kalb, Note, *Controlling Health Care Costs by Controlling Technology: A Private Contractual Approach*, 99 YALE L.J. 1109, 1117-19 (1990).

against a health insurer can and should be employed more actively and aggressively in the cost-containment effort.¹⁹ To be sure, contracts having the requisite degree of specificity and clarity would be extremely difficult to write.²⁰ But insurers and other private financing intermediaries cannot reasonably be expected to develop, market, and implement innovative contractual limitations on patient entitlements unless they have some assurance that the legal system will be receptive to their efforts. A crucial question is whether *ex ante* self-denial by economizing consumers would be accepted at face value by the legal system when issues arise *ex post*.²¹

A. *Alternative Conceptions of the Health Insurance Contract*

The easy equation of private cost containment with government rationing results from the perception that a private payer denying payment for a desired service is not accountable to the individual patient and is similar in this respect to a public financing program. Particularly in the context of litigation challenging a refusal to pay for a particular service, a private payer necessarily appears as a corporate deep pocket with interests fundamentally opposed to those of insured patients.²² The legal resolution of health insurance coverage disputes is greatly influenced by the perception of the insurer as a powerful player in an unequal game. Unless health

¹⁹ The stronger message is that insurers and other payers must address choices at the margin where the health benefits yielded by a service may not be great enough to warrant the expenditure of private funds. See *supra* note 1. For an ethicist's strong claim that the only rationing of medical care that is morally legitimate is that to which the patient has explicitly or implicitly consented *ex ante*, see PAUL T. MENZEL, *STRONG MEDICINE: THE ETHICAL RATIONING OF HEALTH CARE* (1990). For additional, mostly pragmatic arguments for relying on decentralized rather than centralized decision making to address the central dilemmas of health care spending, see sources cited *supra* note 4.

²⁰ See *infra* text accompanying notes 87-89.

²¹ See generally sources cited *supra* note 18. Hall & Anderson observe that the legal system has not yet had to worry about aggressive health care rationing pursuant to contractual undertakings, yet still resists insurer efforts to curb spending. Without endorsing aggressive rationing, they note that "at present, the issue is two steps removed from this more controversial stage since insurers are bogged down in the first level of assessment, namely, basic safety and effectiveness." Hall & Anderson, *supra* note 7, at 1638 n.85. For the view that, if insurers do not begin fairly soon to fight the cost-containment battle where it must be won, a governmental takeover may be inevitable, see Havighurst, *Why Preserve Private Financing?*, *supra* note 4.

²² "Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business." *Brown v. Blue Cross & Blue Shield*, 898 F.2d 1556, 1561 (11th Cir. 1990).

insurance contracts can be viewed in a different light, consumers will be limited in their ability to control, through their choices, the cost of the health care they receive.

1. The View Apparent in Insurance Law

Insurance law generally reflects the perception that consumers are never equal to the task of negotiating fair terms with insurers. Thus, courts customarily view insurance contracts as contracts of adhesion and construe them liberally in favor of the insured.²³ This practice is also justified on the familiar ground that the party drafting an agreement should bear the consequences of any ambiguity.²⁴ Moreover, even in the absence of ambiguity, courts

²³ "[B]ecause insureds almost never have any bargaining power vis-a-vis their insurance carrier, insurance policies are often characterized as 'contracts of adhesion,' meaning courts should give the benefit of the doubt to the insured because the insured had little or no choice about the selection of the policy language." David B. Goodwin, *Disputing Insurance Coverage Disputes*, 43 STAN. L. REV. 779, 787 (1991) (reviewing BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES (3d ed. 1990)).

²⁴ *Contra proferentum* ("against the proffering party") is a principle of contract interpretation generally employed in insurance coverage disputes. "There are literally thousands of judicial opinions resolving insurance coverage disputes in favor of claimants on the basis that a provision of the insurance policy at issue was ambiguous and therefore should be construed against the insurer." ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW § 6.3(a)(2), at 629 (Student ed. 1988).

Although this principle is reasonable in the abstract, the ambiguity triggering pro-plaintiff interpretation lies to a considerable extent in the eye of the beholder—that is, the judge, who may be naturally inclined to exercise interpretive authority to reach pleasing results rather than intended or efficient ones. Some modern students of the problem of interpretation, extending insights of the earlier "legal realists," denigrate the ability of constitutional, statutory, or contractual language to convey any precise meaning, thus leaving much of the power to prescribe rules *de facto* in the hands of interpreters, particularly judges. See, e.g., Stanley Fish, *Fish v. Fiss*, 36 STAN. L. REV. 1325 (1984). Although Fish's view that "language is always apprehended within a set of interpretive assumptions," *id.* at 1331 n.13, is unexceptionable, problems arise when the interpreter decides precisely which assumptions, whose "understanding, largely tacit, of the enterprise's general purpose," *id.* at 1343, should guide interpretation. Thus, even while conceding the skill with which Fish and others have demonstrated the shortcomings of language for expressing useable, objective principles, one can regret the legitimacy that their theories implicitly confer upon the activism of judges, who may already be overly inclined to reform private relationships and to shape substantive law and policy to accord with the predilections of some "interpretive community." In its most dangerous forms, the new denigration of language combines with a dogmatic perception that power and repressive politics govern all drafting efforts, thus strengthening the interpreter's presumed warrant for bringing his own political preferences into play. In insurance law, the legitimacy of judges' policy-writing role depends heavily upon the perception that consumers have no effective say in writing the contract. This is an empirical issue, however, and it

sometimes require insurers to honor the "reasonable expectations" of the insured, with the result that insurers regularly find themselves offering judge-made rather than contractually defined coverage.²⁵ In addition to being held to high standards of clarity in drafting and of disclosure in marketing, insurers are also generally deemed to have a special duty of fair dealing toward their insureds. Consequently, they face punitive damages for acting in bad faith if they deny claims too casually or insist too strongly upon their own construction of their contracts.²⁶

As demonstrated by Hall and Anderson elsewhere in this symposium, courts tend to approach health insurance coverage disputes with many of the same attitudes they bring to the interpretation of other insurance contracts.²⁷ Health insurers thus find themselves in a poor position to engage in aggressive economizing. One problem they face is that ambiguity is especially hard to avoid in drafting rules which attempt to limit health coverage to vital needs. Insurers first tried to define meaningful coverage limits in their contracts by requiring that covered care be "medically necessary." Because this condition was inherently ambiguous,

would be destructive of general consumer interests for the legal system, looking out only for the interests of individual patients, to proceed under general principles premised on an assumption that consumer interests are never well served in insurance contracts.

²⁵ See KEETON & WIDISS, *supra* note 24, § 6.3; see also Kenneth S. Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151, 1154-55 (1981) (noting that the doctrine of "reasonable expectations" has two aspects: an insurer may merely have some duty to dispel incorrect expectations of unsophisticated insureds; alternatively, contracts may be judicially rewritten in light of community standards of fairness and equity).

²⁶ See generally PROPERTY INS. LAW COMM., AM. BAR ASS'N, BAD FAITH AND PUNITIVE DAMAGES: ANNOTATIONS TO FIRST-PARTY INSURANCE CASES, STATUTES, AND REGULATIONS (1986) (incorporating cases from the fifty states and the District of Columbia); WILLIAM M. SHERNOFF ET AL., INSURANCE BAD FAITH LITIGATION ch.8 (1991 & Supp.). Although this legal rule is entirely reasonable (in view of the temptation for insurers to adopt a "So-sue-me!" stance instead of paying valid claims), there is again a risk that it will fall into the wrong hands—in this case, juries unsympathetic to insurers and unappreciative of their efforts to control costs. See also *infra* note 35 and text accompanying note 76.

²⁷ See Hall & Anderson, *supra* note 7, at 1684 nn.173-75; see also sources cited *supra* note 21. Contracts for group health insurance are negotiated with the insurer by relatively sophisticated employers and therefore do not have the take-it-or-leave-it character of contracts of adhesion—unless one believes that employers, instead of being reliable agents of their employees, are themselves inclined to impose unfair terms. See *infra* text accompanying notes 78-81. The nonadhesive character of such contracts has apparently not caused courts to alter their approach in construing them, however.

however, courts were free to adopt expansive readings, requiring coverage whenever the doctor's prescription did not offend the standards of the medical profession.²⁸ Moreover, when insurers tried to be more precise in writing their contracts, they were hardly more successful. Because greater precision required longer words and finer print, courts could take the view that the contract was now beyond subscriber understanding and deny it an objective reading on that account.²⁹ In each case involving retrospective denial of a claim, courts could cite the reasonable expectations of the insured as a basis for requiring payment for any service not irresponsibly prescribed by the physician.³⁰

Many health insurers have tried to solve these problems—ambiguity and patient expectations—by establishing procedures under which coverage is established prospectively, before treatment is actually rendered. Although this “managed-care” approach has allowed some treatments to be tailored to insurers’ economizing requirements,³¹ it has also raised a risk that the insurer or those administering pretreatment review may be liable for adverse consequences arguably resulting from the denial of payment.³² It

²⁸ See, e.g., *Schroeder v. Blue Cross & Blue Shield*, 450 N.W.2d 470, 475-77 (Wis. Ct. App. 1989) (doctor's prescription of home nursing care honored); *Tudor v. Metropolitan Life Ins. Co.*, 539 N.Y.S.2d 690, 691 (Dist. Ct. 1989) (diagnostic testing held covered despite insurer's claim that it was not medically reasonable); *Sarchett v. Blue Shield*, 729 P.2d 267, 270-73, 277 (Cal. 1987) (discussing application of medical necessity test and finding liability for insurer's failure to bring to insured's attention his contractual right to have a medical society committee finally resolve dispute); *Aetna Life Ins. Co. v. Lavoie*, 470 So. 2d 1060, 1074-75 (Ala. 1984) (hospitalization deemed covered despite claim that outpatient care would have sufficed). *But see* *Lockshin v. Blue Cross*, 434 N.E.2d 754, 757 (Ohio Ct. App. 1980) (reversing trial court's requirement of reimbursement for private nursing care following uncomplicated Cesarean delivery). See generally Annotation, *What Services, Equipment, or Supplies Are "Medically Necessary" for Purposes of Coverage under Medical Insurance*, 75 A.L.R.4th 763 (1990).

²⁹ See, e.g., *Ponder v. Blue Cross*, 193 Cal. Rptr. 632, 639-40 (Ct. App. 1983). Hall & Anderson observe that, although courts frequently cite a lack of contractual specificity as a ground for finding a service covered, they are apt to object to the contract's opacity when confronted with a highly technical explicit exclusion. See Hall & Anderson, *supra* note 7, at 1648 n.34 & 1684 nn.173-74.

³⁰ See, e.g., *Hughes v. Blue Cross*, 263 Cal. Rptr. 850, 857 (Ct. App. 1989), *rev. denied*, 1990 Cal. LEXIS 890 (Cal.), *cert. dismissed*, 495 U.S. 944 (1990) (allowing an award of punitive damages on the grounds that an insurer's employment of “a standard of medical necessity significantly at variance with the medical standards of the community . . . frustrat[es] the justified expectations of the insured [and] is inconsistent with the liberal construction of policy language required by the duty of good faith”).

³¹ See *infra* notes 50-57 and accompanying text.

³² It is widely anticipated, and California courts have indicated, that tort-like

has also meant that some major coverage disputes have arisen while the patient was awaiting expensive treatment, often of an arguably life-saving kind. In these cases, the issue is frequently the application of a contractual provision excluding "experimental" therapy from coverage under the policy. Almost by definition, an experimental procedure cannot be precisely identified in advance for the purpose of unambiguously excluding it from the contract. Moreover, in addition to being inherently ambiguous and interpretable only with the help of partisan experts, such exclusions usually come before the court on a motion for preliminary relief. In these circumstances, instead of finally interpreting the contract, the court "balances the equities," which often means weighing the insurer's wealth against the patient's (unproved) claim that his life is in the balance. As demonstrated in a series of cases involving coverage of costly autologous bone-marrow transplants as a cancer treatment, ambiguities are easy to find and to resolve in the patient's favor.³³ It is particularly easy in such cases to forget that more than the cost of a single medical emergency is at stake.

The federal Employee Retirement Income Security Act (ERISA)³⁴ offers some apparent relief from state law to health plans established by employers for their employees. One significant effect of ERISA is to foreclose state common-law remedies for bad-faith breaches of the plan contract.³⁵ In addition, although the

liability may be imposed for injuries deemed to have been caused by a utilization manager's failing to adhere to community medical standards in deciding on the availability of financing. *See Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 882-85 (Ct. App. 1990) (reversing grant of insurer's summary judgment motion and holding contract, which gave plan no discretion to deny payment on medical grounds, determinative); *Wickline v. State*, 239 Cal. Rptr. 810, 819-20 (Ct. App. 1986) (no liability where physician had not sought extension of previously approved hospital stay). *See generally* John D. Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191 (1989); William A. Helvestine, *Legal Implications of Utilization Review*, in INSTITUTE OF MEDICINE, *supra* note 12, at 169; *see also infra* note 77.

³³ *See, e.g., Pirozzi v. Blue Cross-Blue Shield*, 741 F. Supp. 586, 589-94 (E.D. Va. 1990) (coverage found on strength of physicians' testimony that treatment was not experimental); *Cole v. Blue Cross and Blue Shield*, 738 F. Supp. 42, 43 (D. Mass. 1990) (coverage found despite evidence that treatment is successful in only 9% of similar cases); *Bradley v. Empire Blue Cross and Blue Shield*, 562 N.Y.S.2d 908, 908 (Sup. Ct. 1990) ("[B]oth chemotherapy and bone marrow transplants have a sufficient history to support the medical community's conclusion that they are not investigative treatments"). *See generally* ADVISORY COUNCIL ON SOCIAL SECURITY, *supra* note 18, at 19-21; *Hall & Anderson, supra* note 7, at 1684 nn.173-75; Frank P. James, *The Experimental Treatment Exclusion Clause*, 12 J. LEGAL MED. 359, 360-62 (1991).

³⁴ 29 U.S.C. §§ 1001-1461 (1988).

³⁵ *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987) (state tort remedy for

statute preserves state regulation of the business of insurance, employers that opt for self-insurance escape scrutiny under state insurance law. Review of such plans' denials of coverage thus occurs in federal court under ERISA itself. On its face at least, ERISA is more permissive than state law. Thus, if an ERISA plan contract explicitly gives the plan administrator the power to interpret the scope of benefit provisions, the resulting discretionary determinations will be upheld if they are not arbitrary or capricious; *de novo* review occurs only when the contract does not confer such a presumption of legitimacy on the administrator's interpretations.³⁶ Nevertheless, because ERISA incorporates fiduciary principles from trust law, courts reviewing administrators' actions are alert to administrators' apparent conflicts of interest. Thus, judicial review of coverage disputes under ERISA may not be as permissive as the arbitrary-or-capricious standard would suggest.³⁷

bad faith held not so specifically directed at insurers as to be a state law that "regulates insurance"; remedy thus not saved from federal preemption by ERISA's "saving clause" for state insurance regulation); *see also* Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-67 (1987) (holding complaints in state court purporting to plead state common-law causes of action against insurer are removable under ERISA to federal court); *McRae v. Seafarers' Welfare Plan*, 933 F.2d 1021 (11th Cir. 1991) (holding punitive damages unavailable under ERISA).

Partly as a result of activism by trial lawyers, there is significant interest in Congress at the moment in proposals to overturn the *Pilot Life* ruling, making administrators of ERISA plans subject once again to the stringencies of state law. *See* S. 794, H.R. 1602, H.R. 2782, 102d Cong., 1st Sess. (1991); HEARING ON H.R. 1602 AND H.R. 2782: BILLS RELATING TO ERISA'S PREEMPTION OF CERTAIN STATE LAWS BEFORE THE SUBCOMM. ON LABOR-MANAGEMENT RELATIONS, HOUSE COMM. ON EDUCATION AND LABOR, July 18, 1991 (Ser. No. 102-38); *infra* text accompanying notes 76-77. Such legislation would have potentially severe adverse effects on insurers' ability to contest questionable spending decisions by providers. ERISA itself provides for attorney-fee shifting and removal of plan administrators as sanctions against poor management.

³⁶ *See* *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (construing ERISA § 1132(a)(1)(B)).

³⁷ For examples of the ease with which arbitrariness is found, *see* *Egert v. Connecticut Gen. Life Ins. Co.*, 900 F.2d 1032, 1036-38 (7th Cir. 1990) (held arbitrary not to classify *in vitro* fertilization as "treatment" for an "illness"); *Reilly v. Blue Cross and Blue Shield United*, 846 F.2d 416, 420-24 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988) (held arbitrary for Blue plan, acting as administrator of ERISA plan, to find *in vitro* fertilization an uncovered "experimental" procedure on the basis of standards that were developed by association of Blue plans in their capacity as self-interested insurers and that used a 50% success rate as an arbitrary rule of thumb in deciding on the acceptability of costly new procedures). For ERISA cases on coverage for autologous bone marrow transplants, *see* *Adams v. Blue Cross/Blue Shield*, 757 F. Supp. 661 (D. Md. 1991) (coverage found on *de novo* review); *Sweeney v. Gerber Prods. Co. Med. Ben. Plan*, 728 F. Supp. 594 (D. Neb. 1989) (coverage not found). *See also* ADVISORY COUNCIL ON SOCIAL SECURITY, *supra* note 18, at 21-23 ("The result

2. The Insurance Contract As an Instrument of Prospective Self-Denial

Although courts are accustomed to interpreting insurance contracts on the assumption that insurers resist claims solely in their own interest, it is often valid to view a health insurer in a very different light—as the administrator of a contract among all the insureds covered by the policy. Thus, some health insurance policies are appropriately conceptualized as agreements by which members of the covered group mutually elected to be bound in order that the fund created by their contributions would be sufficient to cover their essential needs and would not be squandered on nonessential, inefficacious, or overly costly services demanded by any individual. Under this view, an insurer rationing health care financing by invoking a coverage restriction can be seen as serving consumer interests as well as its own. Moreover, it is of little conceptual relevance that the form of the transaction puts the insurer's interest directly on the line.³⁸ Even if a specific case features a commercial insurer or a self-insured employer seeking to minimize a short-term risk that it assumed, the cost of open-ended contractual entitlements must ultimately be covered by raising insurance premiums or reducing take-home pay. Although insurers do not always act solely as executors of the wishes of their insureds, a conceptualization of the health insurance contract that casts them presumptively in that role would greatly improve the legal climate for private economizing in the purchasing of health care.³⁹

of the *Firestone* case [see *supra* note 36] has been that almost every ERISA welfare benefit case has since been decided in favor of the participant who has been denied coverage.”)

³⁸ Mutual insurers and insurers acting as administrators of health plans of self-insured employers have no direct conflict of interests, and freestanding utilization management firms normally have no financial interest in denying coverage in a given case. In each case, of course, there is a responsibility to control cost, poor performance of which could result in a loss of lucrative business for the firm. Nevertheless, the market makes all parties ultimately accountable in some degree to insureds and their agents, see *infra* notes 78-81 and accompanying text, making it a mistake to be too fastidious about apparent interest conflicts, which are difficult to avoid in this area without incurring high costs. (HMOs, after all, have served consumers well precisely because they have a disincentive to spend.) On conflict of interests in the management of ERISA plans, see Hall & Anderson, *supra* note 7, at 1668 nn.120-23.

³⁹ Hall & Anderson observe that, in ERISA cases, the employer creating the plan and those administering it on the employer's behalf are more apt to be regarded as fiduciaries with a responsibility for protecting the fund for the benefit of the employees as a group. See Hall & Anderson, *supra* note 7, at 1669 n.124; see also

Plaintiffs' lawyers and other bashers of the insurance industry naturally reject so benign a view of the health insurance contract. But rules of policy interpretation premised upon their paradigm of insurer/insured relationships in health care ignore the stake that consumers themselves may have in enforcing contractual limits on entitlements. Precisely because of the unusual degree of moral hazard encountered by consumers in pooling health care risks, a more objective approach to contract interpretation is needed. Health insurance coverage disputes not only determine which party will bear a large incurred loss but also affect future decisions to consume care. Finding coverage in a given case will encourage additional spending of the same kind by other insureds and discourage insurer efforts to control marginal spending by contractual exclusions. Unless the legal system respects and assists responsible, aggressive insurer efforts to control costs and curb the influence of chronic moral hazard on consumption decisions, health care costs will continue to elude effective control through private efforts.

B. *The Need for Better Contractual Authorization for
Health Care Rationing*

To be sure, health insurers have some weapons with which to combat moral hazard. Their armamentarium is generally inadequate, however, for fighting the battle for cost containment where it must ultimately be won—in the no-man's-land where unpropitious benefit/cost ratios mean that some potentially beneficial care should be forgone. Brief examination of the shortcomings of payers' existing weaponry will reveal why health care plans of various kinds need to be able—both practically and legally—to write and enforce contracts by which consumers can commit themselves today to accept some rationing of health care financing tomorrow.

1. Cost Sharing

Patient cost sharing is perhaps the most familiar device by which health insurers attempt to curb moral hazard. Because of its administrative simplicity and its dampening effect on insurance-subsidized demand,⁴⁰ cost sharing should be part of any program

Daniel Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105 (1988).

⁴⁰ But see Albert L. Siu et al., *Inappropriate Use of Hospitals in a Randomized Trial*

of health care financing. Deductibles and coinsurance tend to be underutilized in practice, however, partly because out-of-pocket payments for health care are more costly to the consumer, after taxes, than the same payments made indirectly through an insurance fund (most contributions to which escape both income and payroll taxes).⁴¹ In addition, one sees little effort by payers to fine-tune cost sharing in pursuit of microefficiency in health care spending. Instead, most deductibles are set at low levels signifying a desire only to shift some basic costs to insureds, not to use price to curb moral hazard. Similarly, coinsurance rates are set at levels that underdeter consumption of many marginal services.

In optimal insurance schemes, deductibles would often be such that the plan would pay only for relatively catastrophic care; in addition, coinsurance rates, instead of being generally uniform across all covered services,⁴² would vary from service to service, depending upon the degree of discretion involved and the likelihood of patient benefit.⁴³ Such fine-tuning of cost sharing would obviously challenge the drafters of health plan contracts. But that is precisely the point to be appreciated—the need for better contractual tools with which to attack cost problems at the micro level.⁴⁴

2. Exclusions from Coverage

Another common strategy for reducing health insurance costs is to exclude whole categories of disease or treatment from coverage under the policy. As presently employed, however, this strategy is also not capable of reliably directing money to meeting only the

of *Health Insurance Plans*, 315 NEW ENG. J. MED. 1259, 1259 (1986) (“cost sharing did not selectively reduce inappropriate hospitalization”).

⁴¹ See *supra* note 9.

⁴² This is the normal pattern, although many policies cover a lesser percentage (often 50%) of outpatient mental health care, on the theory that such care is especially discretionary.

⁴³ See *supra* note 9 on the design of optimal health insurance. Many decisions in designing an optimal plan depend upon nonmedical considerations such as income and attitudes toward risk.

⁴⁴ Query whether a court would be any more receptive to an exclusion from coverage if it were partial rather than complete—e.g., if the plan required 50% coinsurance on any “experimental” procedure rather than attempting to exclude such procedures from coverage altogether. Also, would a plan fare any better if it actively assisted subscribers in financing their share of possibly costly noncovered procedures? Such an approach, although it would expose the plan to some credit losses, would betoken a kinder and gentler attitude on the payer’s part.

most essential needs. The most common exclusions—including such things as mental health care, preventive care, home health care, long-term care, dental care, cosmetic surgery, organ transplants, substance abuse, and care provided by nonphysician practitioners—may certainly involve care of somewhat lower priority (either as health needs or as candidates for insurance coverage) than many covered services. But such gross exclusions are clumsy rationing tools in the same way that meat axes are inferior to scalpels in doing surgery.⁴⁵ Some highly beneficial services in the excluded categories are inevitably excised from coverage, while some very questionable services continue to be financed because contract language is not precise enough to exclude them.⁴⁶

The need for more precision in contract drafting is once again apparent. In order for coverage to be withheld or limited only in circumstances where moral hazard looms too large, gross exclusions need to be replaced by more particularized benefit packages. Although the current and much-discussed experiment with benefit redesign in the Oregon Medicaid plan seeks to establish better priorities for public financing, it still depends heavily upon a categorical approach.⁴⁷ Thus, it undertakes to rank 709 medical conditions and procedures in order of medical and social priority, allowing the state legislature to decide how far down the list to go with public funding. (Currently, it is proposed to draw the line just above #588, low-back pain.⁴⁸) Ideally, however, instead of employ-

⁴⁵ A particularly worrisome feature of categorical exclusions is the opportunity they present for consumers to use their superior knowledge of their own circumstances to switch in and out of plans in anticipation of particular needs. See CLARK C. HAVIGHURST, *HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS* 1108, 1108-10 (1988) ("Adverse selection is potentially the Achilles heel of a health policy based on consumer choice It is, however, an intensely practical problem that may be amenable to practical solutions."). For thoughtful discussions of adverse selection under the Federal Employees Health Benefits Program (a possible model for a system based on individual consumer choice), see Alain C. Enthoven, *Effective Management of Competition in the FEHBP*, *HEALTH AFF.*, Fall 1989, at 34; Stanley B. Jones, *Can Multiple Choice Be Managed to Constrain Health Care Costs?*, *HEALTH AFF.*, Fall 1989, at 54. For the view that insurance contracts tailoring coverage across the board to reflect benefit/cost ratios would not encounter adverse selection to nearly the same degree as plans that economize by categorical exclusions, see *infra* note 118. Regulation that may be needed to prevent insurers from themselves playing adverse-selection games—to attract healthy risks and repel or discard bad ones—should not preclude economizing contracts of the kinds proposed later in this Article.

⁴⁶ Ironically, however, this same clumsiness is a virtue when the contract comes to court. Lacking ambiguity, categorical exclusions are more certain to be enforced than exclusions that depend on medical or administrative judgment.

⁴⁷ See *supra* note 14.

⁴⁸ Robert Steinbrook & Bernard Lo, *The Oregon Medicaid Demonstration Project*:

ing this categorical approach, Oregon would prescribe for every medical condition a standard treatment protocol that the state would agree to finance. Allowing for exceptional cases, these protocols would omit—that is, exclude from coverage—any specific service whose expected benefits under particular circumstances did not measure up in a rough comparison with the benefits achievable by putting the same funds to alternative medical uses. Private plans, too, need to get beyond categorical exclusions and to practice a more precise kind of selectivity with respect to covered services, thereby placing more specific and more appropriate limits on the freedom of providers and patients to draw on insurance funds.

Even if contractual exclusions from health insurance coverage cannot be made clinically specific beyond a certain point, it makes sense to take specificity as far as it is practical to go. Later discussion will show that some of the apparent difficulties could in fact be overcome. There is at least a reasonable prospect that courts would respect any responsible public or private effort to fine-tune coverage.⁴⁹

3. Managed Care

In recent years, many cost-containment strategists have begun to shift their attention away from strategic weapons—such as across-the-board cost sharing and gross categorical exclusions from coverage—to measures that can be aimed at more precise targets. The tactical weapons that have been deployed so far all fall under the heading of “managed care.”⁵⁰ In its most overt form, managed care involves sending specially trained strike forces, equipped with computer technology, to make preemptive attacks on questionable uses of resources in conventional medical practice.⁵¹ This tactical

Will It Provide Adequate Medical Care?, 326 NEW ENG. J. MED. 340, 341 (1992).

⁴⁹ See *infra* text accompanying notes 71-82.

⁵⁰ “Managed care” is an umbrella term covering a wide range of cost-containment efforts aimed at influencing clinical decision making with a view to preventing overutilization of services.

⁵¹ Utilization management may occur implicitly, as in a group-practice HMO, or overtly, as in a fee-for-service insurance plan that makes prior authorization by the payer a condition of coverage for nonemergency care. In plans of the latter type, it is common for the payer—either an insurer or a self-insured employer—to employ a freestanding utilization management firm whose personnel use advanced communications and information technology to screen and approve specific physician prescriptions. See INSTITUTE OF MEDICINE, *supra* note 12, at 13-21, 58-90. Such utilization management is controversial because of its interference with physician/patient decision making and the high administrative cost of overseeing individual

approach still has only limited potential, however, for effective action in the heartland of the cost problem. Indeed, it is usually targeted only at limited objectives lying on the problem's fringes. As with other strategies, its limitations lie partly in the shortcomings of private contract. Payers have not yet gotten clear contractual authority from consumers to withhold financing in the most contested territory—where beneficial care must be forgone if consumers' resources are to be saved for other, more beneficial uses.⁵²

It is doubtful that a consumer, in joining a health care plan that practices utilization management, thereby authorizes the plan to deny payment for any beneficial service within the scope of the plan's general coverage. Nor does a consumer joining such a plan authorize any provider of covered care to omit any precaution or to sacrifice any increment of arguable quality in his treatment. Indeed, the legal situation is quite otherwise. The typical health plan generally undertakes to cover all diagnosis and treatment that is "medically necessary,"⁵³ and physicians are generally subject to malpractice liability for any injury deemed to have been caused by a failure to take or prescribe any measure or precaution required under the prevailing legal standard of care.⁵⁴ In this legal environment, there is little room for economizing beyond that which has been generally accepted in medical practice. Without contractual

treatment decisions. Physicians find such oversight burdensome, offensive to their professional pride, and illegitimate insofar as it restrains their efforts to provide professionally (as opposed to economically) optimal care. They also object to the absence of clear standards and to the multiplicity of payers whose differing, sometimes bewildering, expectations they must try to satisfy. See Gerald W. Grumet, *Health Care Rationing Through Inconvenience: The Third Party's Secret Weapon*, 321 NEW ENG. J. MED. 607 (1989).

⁵² If health plans had a clear contractual warrant for withholding coverage of some marginally beneficial care, their managed-care efforts would enjoy more legitimacy than under present arrangements. See *supra* note 51. In theory at least, that legitimacy would be even greater if the plan openly spelled out in advance and in detail, for both subscribers and providers to see, the conditions under which specific services would and would not be paid for. Currently, utilization managers generally refuse to reveal their criteria for screening treatment proposals on the ground that physicians might learn how to evade them.

⁵³ See *supra* note 28 and accompanying text.

⁵⁴ See Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L.J. 1375; Allan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959) (classic article illustrating and approving the legal system's embrace of professional standards, without reference to the role of health insurance in diminishing the accountability of physicians for the cost of care).

authorization, economizing forays by payers or providers into the no-man's-land of benefit/cost trade-offs are likely to be unsuccessful and may be heavily penalized, perhaps with punitive damages.⁵⁵

The legal system's authority, *de facto* or *de jure*, to prescribe the payment obligations of health care plans and the diagnostic and treatment obligations of health care providers is fraught with peril to the efficiency with which society uses its scarce resources. Both the legal test for identifying what care is "medically necessary" under conventional insurance contracts and the legal standard of care employed in identifying medical negligence are drawn by courts in specific cases from customary medical practice, as testified to by partisan medical experts. Because the legal-cum-professional standard applicable to a particular clinical situation is often difficult to discover, both payers and providers, fearful of liability, tend to give the law a wide berth, resolving doubts systematically in favor of overspending. Even when its requirements are clear, the law regularly sends inappropriate signals. What physicians customarily do under the distorted economic incentives and ill-considered legal compulsions they face is a wholly unsatisfactory benchmark for deciding what is appropriate either for society as a whole or for any particular insured group.

Indeed, the legal environment practically guarantees that the nation will spend excessively on useless and marginally useful medical care. Customary medical practice, from which the law borrows its standards, is by definition what consumers and taxpayers

⁵⁵ On the liability risks faced by payers and utilization managers, see *supra* note 32. For scholarly efforts to come to grips with the problem of defining malpractice standards of care that are realistic about economic trade-offs, see Bovbjerg, *supra* note 54, at 1408-14 (addressing the defenses available for economizing efforts by HMOs and their physicians); Mark A. Hall, *The Malpractice Standard of Care Under Health Care Cost Containment*, 17 LAW MED. & HEALTH CARE 347 (arguing that malpractice standards can evolve toward efficiency under the "respectable minority" principle); Edward B. Hirshfeld, *Economic Considerations in Treatment Decisions and the Standard of Care in Medical Malpractice Litigation*, 264 JAMA 2004 (1990) (view from the legal department of the American Medical Association); E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719 (1987) (arguing that third-party judgments on appropriateness should affect standard to which provider is held); E. Haavi Morreim, *Stratified Scarcity: Redefining the Standard of Care*, 17 LAW, MED. & HEALTH CARE 356 (1989) (similar); John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 VA. L. REV. 439 (1991) (arguing that standard should be modified to reflect patient's resources and ability to pay). It is a revealing feature of the legal culture that scholars such as these typically propose their favored reforms for spontaneous implementation by the courts rather than as ideas to be incorporated in private contracts.

are currently finding it so difficult to pay for. And only cognitive dissonance, endemic in our political discussion of these issues, can account for the prevalent confidence that the nation could afford to give millions of uninsured Americans uninhibited access to customary, state-of-the art medical care. For conclusive evidence that the nation will never be able to afford to pay for all the services that would become customary in a heavily insured medical care system, one need look no further than the fact that each year the cost of personal health care increases faster than national wealth, as measured by GNP.⁵⁶ The goal of ensuring universal access to the miracles of modern medicine is, in other words, becoming costlier, not easier, to achieve with each passing year and with nearly every medical advance. By one means or another, the nation will someday have to learn how to economize on medical care even when it hurts. It is hard to overstate the magnitude of this challenge or the desirability of seeing whether private contract can be enlisted in the effort to meet it.

In the current legal environment, managed care is severely limited in the economizing it can accomplish. Without radical contractual redefinition of patient entitlements, care must be managed to meet objectives that are prescribed by the legal system in conjunction with professional interests, not by those who must somehow pay the cost. Although managed care is certainly useful in eliminating some truly unnecessary, inefficacious care and in inducing the use of some (medically acceptable) lower-cost methods, it can be of little help, without better contractual warrants, to consumers seeking to economize in those areas where they might find some actual risk taking worthwhile. Conceivably, the legal limits on economizing are so vague, so elastic, or so rarely invoked that managed-care guerrilla units can effectively fight some battles in the no-man's-land of benefit/cost trade-offs. It should still be asked, however, with what authority they do so.⁵⁷ Without contractual authority to fight the war, managed-care plans will never be able to win it.

⁵⁶ See Sally T. Sonnefeld et al., *Projections of National Health Expenditures Through the Year 2000*, HEALTH CARE FIN. REV., Fall 1991, at 1, 7 (table 4).

⁵⁷ Menzel argues that, in some circumstances, the patient's implied consent ("presumed prior consent to risk") can provide a sufficient moral warrant for rationing. See MENZEL, *supra* note 19, at 22-36. It would seem apparent, however, that explicit authority is always to be preferred. But see *infra* note 80 on the inapplicability of the legal doctrine of informed consent.

4. Selective Contracting

A final cost-containment strategy—one that has worked to an impressive degree in many contexts—is the practice of denying plan subscribers the freedom to choose any provider available in the marketplace. The best known successes with this strategy have occurred in Health Maintenance Organizations (HMOs) that employ closed panels of full-time physicians and undertake contractually to cover only care rendered by those physicians.⁵⁸ Conventional health insurers and self-insured employers have also reduced costs somewhat by giving their insureds financial incentives to patronize so-called “preferred providers”—hospitals and physicians selected by the plan in part because of their willingness to reduce their charges. Such plans can also facilitate managed care, designating as preferred providers only those who agree to cooperate in cost containment. Indeed, it is only by limiting subscribers’ choices and selectively contracting with providers that financing intermediaries can obtain competitive prices from providers and their acceptance of any limitations on their spending freedom.

Although HMOs and other choice-limiting plans can be effective economizers, they share the fundamental handicaps of managed care when it comes to letting cost considerations dictate that some medical risks should be run. Because the law of medical malpractice governs providers in HMOs, they face possible legal liability if they depart from the costly practice standards customary in the insured-fee-for-service sector. Although it can be argued that physicians in HMOs constitute a so-called “respectable minority” of the profession and therefore should be deemed to set their own standard of care,⁵⁹ even this theory exposes innovators who depart from dominant medical practice to serious legal risks until such time as others follow their lead. In any event, courts and juries cannot be counted upon to be forgiving in specific cases. Indeed, HMOs and their physicians may feel themselves especially vulnerable to criticism for even seeming to economize by putting a patient at risk.⁶⁰ In light of this vulnerability, they may hesitate to offer

⁵⁸ On the procompetitive benefits of allowing restrictions on consumers’ freedom to choose a provider, see Charles D. Weller, “Free Choice” as a Restraint of Trade in American Health Care Delivery and Insurance, 69 IOWA L. REV. 1351, 1375-92 (1984).

⁵⁹ See Bovbjerg, *supra* note 54, at 1385.

⁶⁰ There are occasional suits alleging negligent underservice by HMO physicians or challenging HMO inducements to their physicians to economize. See, e.g., Madsen v. Park Nicollet Med. Ctr., 419 N.W.2d 511, 515 (Minn. Ct. App. 1988) (excluding,

efficiency defenses in litigation and may tend toward conservatism rather than aggressiveness in their economizing. Lacking freedom to contract for an alternative legal regime under which to serve their subscribers,⁶¹ so-called "alternative delivery systems" are not offering consumers a full range of economizing options.

Contracts requiring insured consumers to obtain covered care only from plan-designated providers do have some significant legal advantages over contractual restrictions on the specific services that the plan will pay for. They are unambiguous, easily administrable, and comprehensible to patients. On their face, at least, they are noncontroversial, because they do not purport to affect the quality or quantity of care a patient will receive.⁶² In addition, because providers are beholden to the plan for supplying them with patients, there is little likelihood that the plan will end up (as third-party payers regularly do) in an open coverage dispute in which the prescribing doctor actively backs the patient's claim to costly treatment. Although coverage disputes still arise,⁶³ HMOs and

as prejudicial, evidence of incentive arrangement in HMO); *Pulvers v. Kaiser Found. Health Plan*, 160 Cal. Rptr. 392, 393-94 (Cal. Ct. App. 1979) (unsuccessful challenge to plan's incentive arrangements); see also BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS & PROBLEMS* 719-22 (2d ed. 1991) (listing unreported cases). Protection against publicity and jury overreaction to HMO economizing efforts in malpractice suits might be obtained by providing, by contract, for alternative dispute resolution. See, e.g., *Madden v. Kaiser Found. Hosps.*, 552 P.2d 1178 (Cal. 1976) (leading case upholding contractual requirement to arbitrate future malpractice claims). To the extent that the plan relies on its contractual authority to economize in particular respects, alternative dispute resolution offers an opportunity to find arbiters committed to objective reading of the contract.

⁶¹ Private contract has been proposed as a possible vehicle for reforming medical malpractice law both in general and as it impacts on HMOs. See, e.g., Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87; Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, LAW & CONTEMP. PROBS., Spring 1986, at 143; Clark C. Havighurst, *Altering the Applicable Standard of Care*, LAW & CONTEMP. PROBS., Spring 1986, at 1, 143-303 [hereinafter Havighurst, *Altering the Applicable Standard*] (suggesting contractual language by which an HMO might escape being bound by customary practice). See generally Symposium, *Medical Malpractice: Can the Private Sector Find Relief?*, LAW & CONTEMP. PROBS., Spring 1986, at 1, 143-303. See also *infra* text accompanying notes 90-101.

⁶² Compare *Madden*, 552 P.2d 1178, in which the court, in upholding an arbitration clause in an HMO contract, stressed that the clause "does not detract from Kaiser's duty to use reasonable care in treating patients, nor limit its liability for breach of this duty." *Id.* at 1186. As a practical matter, however, changing the forum in which negligence is evaluated could affect the duties to which plan providers are actually held.

⁶³ Like health insurance policies, HMO contracts typically exclude certain procedures, including "experimental" therapies.

other closed-panel plans achieve most of their efficiencies by involving physicians directly in the cost-containment effort, obviating the need for explicit contractual limitations on patient entitlements.⁶⁴

A central feature of closed-panel plans—striking because it is not more controversial outside the medical profession—is that the physicians they select typically provide fewer services than other physicians. Indeed, providers are usually selected or retained partly on the basis of their spending habits, not just their professional skills. In addition, plans often give them special incentives to economize or subject them to internal managed-care procedures or other supervision.⁶⁵ Because such plans work primarily by co-opting or controlling the medical professionals making treatment choices, the economizing they achieve usually reflects the rationing of care itself, not just the availability of financing.⁶⁶ One also looks in vain in the HMO contract for any acknowledgment that plan physicians may actively ration care or depart from conventional modes of practice.⁶⁷ In comparison with the ideal of prospective

⁶⁴ There is evidence that the more tightly-knit group-practice and staff-model HMOs are more successful in controlling utilization than are looser arrangements, such as individual practice associations (IPAs). The difficulty may be that IPAs “must rely more heavily upon formal processes, meetings, and rules.” Thomas Palay, *Organizing an HMO by Contract: Some Transaction Cost Considerations*, 65 NEB. L. REV. 728, 746 (1986). Palay suggests, with some cogency, that administrative or transaction costs may prevent contractual specification from ever working as well as organizational innovations in controlling provider behavior. The question raised in the instant Article, however, is whether the observed inadequacies of private contract in this field are all inherent in the vehicle itself. It is at least possible that innovative contracting has been inhibited by a variety of factors, including the threat of opportunistic intervention by the legal system, activated by plaintiffs’ lawyers, whenever explicit language is relied upon to accomplish economizing objectives.

⁶⁵ For observations on the ethics of some managed-care arrangements in HMOs, see Robert A. Berenson, *Hidden Compromises in Paying Physicians*, BUS. & HEALTH, July 1987, at 18; Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743 (1987) (with accompanying commentary). Congressional concerns about incentives in HMOs were finally resolved in 1989 amendments to the provisions allowing Medicare and Medicaid beneficiaries to enroll in HMOs at public expense. OBRA 1990, Pub. L. 101-508, 104 Stat. 1388–108-09, §4204, amending §1876(i) of the Social Security Act, to be codified in 42 U.S.C. §1395mm(i) (HMO enrolling public beneficiaries required to satisfy the Secretary that its incentive arrangements are reasonable).

⁶⁶ Indeed, it is very rare for a service such as a marginally helpful diagnostic test or an added hospital day to be withheld from an HMO patient as a covered service but made available to him on an optional, fee-for-service basis. This interesting circumstance reflects the HMO’s conception of itself as an integrated system committed to offering an alternative, but still physician-developed, style of care.

⁶⁷ Cf. Havighurst, *Altering the Applicable Standard*, *supra* note 61, at 271-72

self-denial—that is, consensual economizing in accordance with a written insurance contract—the strategy of limiting consumers' free choice of physician should raise some ethical eyebrows.⁶⁸

It is thus anomalous that closed-panel plans encounter fewer legal obstacles than plans that seek to obtain from consumers express contractual authority for their economizing efforts. Indeed, there is a potentially illuminating irony here: Explicit, consensual limitations on the future availability of health care financing may be less viable legally than true rationing of medical care that is undertaken by providers *sub rosa*, under payer-imposed inducements, and without the consumer/patient's consent (except insofar as consent is signified by voluntary enrollment, with limited information, in the plan). It is worth asking rhetorically why, in view of the nonconsensual character of the economizing in which they engage, HMOs and other closed-panel plans are so popular with some policy analysts and why there is not more interest in making private contract an effective vehicle by which consumers, instead of merely entrusting themselves to plan-selected providers, can specify some actual preferences with respect to their future care.⁶⁹

(suggesting contractual language to this effect).

⁶⁸ Lest these observations concerning HMOs seem too critical or negative, see Clark C. Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROBS. 716 (1970) (representative early expression of the author's strong support for HMOs, despite incentive problems, as a competitive alternative to insured fee-for-service medicine). Although the ethical issues are real, they are not decisive, particularly in view of the experience of many HMOs in giving excellent value for the consumer's dollar. See HAROLD S. LUFT, *HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS OF PERFORMANCE* 386-406 (1981); Willard G. Manning et al., *A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services*, 310 NEW ENG. J. MED. 1505 (1984); see also PAUL T. MENZEL, *MEDICAL COSTS, MORAL CHOICES: A PHILOSOPHY OF HEALTH CARE ECONOMICS IN AMERICA* 144-48 (1983) (offering a favorable ethical appraisal, premised on choice and implied consent). But fee-for-service insurance has significant ethical attractions, and it would be a grave oversight not to encourage any innovations in its administration that can keep it competitive (even at a higher price).

⁶⁹ See Havighurst, *Decentralizing Decision Making*, *supra* note 4, at 38-39 ("A truly competitive market that is responsive to consumers' individual concerns and circumstances cannot be said to exist if HMOs represent the only economizing option and if the fee-for-service sector must continue to operate, however clumsily, [under standards prescribed by the courts].").

C. *Improving the Legal Environment for Innovative Contracting for Health Care Financing*

The notable absence of radical redefinitions of patient entitlements in private contracts for health care financing may, of course, be wholly explainable by purely practical, not legal, considerations.⁷⁰ Nevertheless, it is also possible that innovation has been discouraged by a legal regime that is unduly hostile to precisely the kinds of innovation that efficiency requires. Before it can be assumed that financing intermediaries are already doing every feasible and efficient thing to mitigate the moral hazard problem, it must be clear that the legal system would pose no undue obstacles to responsibly developed contracts—however controversial—by which members of insured groups mutually waive future coverage of particular services.

Prescribing an appropriate stance for courts to take in interpreting health care contracts is not difficult. To avoid effectively eliminating them as potential vehicles for addressing the myriad trade-offs in medical care, courts should construe objectively health insurance contracts that can reasonably be viewed as mutual covenants of the insureds.⁷¹ In such cases, instead of seizing upon

⁷⁰ For a full review of factors discouraging insurer cost-containment initiatives, see Clark C. Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers*, in *HEALTH CARE IN AMERICA: THE POLITICAL ECONOMY OF HOSPITALS AND HEALTH INSURANCE* 221 (H.E. Frech ed., 1988); Jon R. Gabel & Alan C. Monheit, *Will Competition Plans Change Insurer-Provider Relationships?*, 61 *MILBANK MEMORIAL FUND Q.* 614, 626-29 (1983). In addition to facing the practical problems of drafting and administering innovative contracts, see *infra* text accompanying notes 90-109, an individual insurer will have no interest in investing in costly initiatives that are especially risky (legally or otherwise) for the first mover or easily imitated by competitors if they succeed. See Havighurst, *supra*, at 239 (noting that "free-rider and public-good problems preclude innovators from recouping the costs of desirable innovations," thus discouraging insurers from undertaking them). Other obstacles to contractual innovation are noted at other points. State insurance regulation, which imposes varying (though not disabling) degrees of supervision on modifications of group insurance policies, has not been specifically investigated.

⁷¹ The specific problem with conventional methods of interpreting health insurance contracts is their effect on innovation and the cost of coverage. For an exhaustive theoretical exposition of the general problem of contract interpretation that is pregnant with significance for the reading of health insurance policies, see David Charny, *Hypothetical Bargains: The Normative Structure of Contract Interpretation*, 89 *MICH. L. REV.* 1815 (1991). For example, Charny has this to say concerning the doctrine of *contra proferentum*:

The *contra proferentum* rule is highly wasteful because it forces parties constantly to revise terms to override judicial rulings that are overly protective of the nonproffering parties. In addition, the rule makes it

ambiguity as an excuse for extending the policy's coverage, courts should make allowances for the difficulties facing policy drafters.⁷² Specifically, they should respect responsible efforts to customize coverage by employing unconventional contract terms in the interest of economizing. In general, they should attempt to give effect to whatever economizing impulse—greater or lesser—they can detect in an overall contract scheme.⁷³ A court should, for example, honor a clause expressly waiving the insured's right to have the policy construed liberally under the principle of *contra proferentum*.

Although health insurers seeking to assist consumers in economizing on medical care should have their contractual

harder for parties to adopt innovative contract terms, for an innovative term will leave the parties uncertain about what "ambiguities" courts will find to resolve against the drafter.

Nor can the *contra proferentum* rule redistribute between the proffering and nonproffering parties [citing Kennedy, *Redistributive and Paternalist Motives in Contract and Tort Law, With Special Reference to Compulsory Terms and Unequal Bargaining Power*, 41 MD. L. REV. 563, 609 (1983) (describing purported redistributive effect of *contra proferentum* rules)]. The proffering party that recognizes that the *contra proferentum* rule will be applied in various contingencies not clearly covered by express contract language will simply "price" the probability of such contingencies

Id. at 1854-55 (footnotes omitted).

Given the need to facilitate innovation in contracting for prepaid medical care, objective interpretation of the contract may be appropriate only where unconventional coverage has been elected and there is some sign that the insureds and their agents were aware of the effort to design less costly (i.e., riskier) coverage. Contrary to their present impulse in such cases, courts should resist the temptation to find an innovative economizing contract ambiguous and should instead strive for an objective interpretation with a view to ascertaining and enforcing the drafters' probable intentions.

⁷² "The interpreter must first determine whether subsequent transactors will be in a position to bargain around the interpretation that it will proffer. This is a crucial yet generally ignored first step to choosing the method of interpretation." Charny, *supra* note 71, at 1877.

⁷³ The conventional, anti-insurer approach to construing insurance contracts seems never to ask whether insurance for the particular risk was intentionally purchased or whether, from objective evidence of their preferences, it would have been a logical insurance buy for the particular insured group. Under the alternative paradigm of the health insurance policy, a court faced with an ambiguity would attempt to ascertain what choice the insured group would probably have made. Clues could be found, for example, in the attitude evinced toward similar risks elsewhere in the contract. As suggested by Charny, because broad coverage terms are easier to write than well-defined narrow coverage, courts should strive to give due, not narrow, effect to any responsible effort to economize by closely specifying limitations. "The court should consider the costs that future parties will incur in bargaining around the rule." *Id.* at 1878.

limitations on coverage objectively construed, the law should continue to require that they be candid concerning the limits of the coverage they are selling, holding them liable when they misrepresent it.⁷⁴ The insured's "reasonable expectations" should have no other bearing on a coverage dispute, however. Indeed, the whole point of having contracts specify coverage is to create opportunities for payers to offer, and for consumers to buy, insurance that stops short of covering everything that doctors order in good faith or everything that patients have become accustomed to having insurers pay for. Patients, unfortunately, have developed a pervasive entitlement mentality about health care. Indeed, it is their "reasonable expectations" that, more than anything else, explain why the nation spends too much on mainstream health care for the majority and too little on other things. For courts either to adopt this mentality themselves⁷⁵ or to derive from it a presumption of coverage that the drafters and marketers of the insurance policy must affirmatively overcome would severely chill much responsible economizing.

Another question concerns the amenability of private payers and health plans to tort actions for bad faith in resisting the payment of claims. Although such actions could serve a useful function in keeping payers honest in their dealings with patients, there is currently a danger that fear of juror and judicial misunderstanding or hostility, premised on the conventional paradigm of the health insurance contract, will deter insurers from performing the dirty work of protecting the insurance fund. Thus, it would be a grave

⁷⁴ See KEETON & WIDISS, *supra* note 24, § 6.5; Abraham, *supra* note 25, at 1152-57. A realistic disclosure requirement would encourage the education of consumers to the existence of trade-offs and would create opportunities for questions concerning the appropriateness of the limits adopted and for refinements taking better account of group preferences.

⁷⁵ In the famous and controversial case of *Helling v. Carey*, 519 P.2d 981 (Wash. 1974), the court held it negligent for ophthalmologists to adhere to their specialty's custom of not testing younger patients for glaucoma. Because the test in question was one that was not normally covered by insurance, its nonuse might have been deemed market evidence that it was not generally worth its cost. Although the case is normally viewed as holding physicians to a judge-made standard of care, it can also be viewed as holding them to the more general, insurance-induced standard that prevails throughout most of medical practice—namely, a requirement that everything beneficial be done without regard to cost considerations. Although aberrant in its main thrust, the *Helling* case is a typical instance of judicial regulation compelling providers to offer, and consumers to buy, whatever cannot be omitted without some arguable risk. In *Helling*, conventional expectations, inspired in the first instance by no-questions-asked insurance coverage, were extended even to self-financed care.

error to enact proposed legislation to reintroduce this remedy against ERISA plans.⁷⁶ There is inadequate evidence at the moment that courts accept the basic legitimacy of insurers' cost-containment measures introduced *ex ante* or are realistic concerning attempts by insurers to enforce them *ex post*. Given the need for insurers to engage the cost problem in territory that is far more treacherous than any they have yet entered, they need to be spared the risk of misdirected juror anger. They should, however, be held to reasonable standards of care in administering their coverage in individual cases.⁷⁷

The willingness of a court to construe an innovative health care financing contract objectively will turn in large measure on the success of advocates in presenting the contract as, in substance, a covenant among the insureds—or at least as an agreement that was negotiated on behalf of the plaintiff patient and benefitted that patient *ex ante*. To overcome the conventional paradigm, it can be argued with some force that payers are ultimately accountable to consumers and their agents in the marketplace.⁷⁸ Some critics

⁷⁶ See *supra* notes 34-37 and accompanying text.

⁷⁷ For a useful discussion of cases involving coverage disputes that takes particular note of whether the defendant insurer conscientiously used fair procedures, see Gosfield, *supra* note 18, at 194-211 (noting that coverage is likely to be found where procedures were inadequate). It is a different (and vexing) question when consequential damages should be available for injuries allegedly incurred by a patient as a result of negligence in refusing to authorize payment for a particular service. Cf. note 32 *supra*. Insurer or reviewer liability in such cases would be more akin to products liability than to liability for medical malpractice. The issue would be care in the administration of the contract, not professional judgment, and the procedural duty owed the patient should be ascertained from the contract, not by letting a fact-finder apply some general reasonableness test. Cases under ERISA suggest that trust-law principles might come into play. See *supra* notes 34-37 and accompanying text. It would appear that there are interesting opportunities here for using contracts to specify patient procedural rights and to introduce alternative dispute-resolution techniques and (one- or two-way) attorney-fee shifting to improve the efficiency and reliability with which inevitable disputes are handled.

⁷⁸ In an antitrust case in which a question of dental insurers' reliability had been raised, the Supreme Court said:

Insurers deciding what level of care to pay for are not themselves the recipients of those services, but it is by no means clear that they lack incentives to consider the welfare of the patient as well as the minimization of costs. They are themselves in competition for the patronage of the patients—or, in most cases, the unions or businesses that contract on their behalf for group insurance coverage—and must satisfy their potential customers not only that they will provide coverage at a reasonable cost, but also that coverage will be adequate to meet their customers' dental needs.

FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 463 (1986).

would object, however, that such accountability as exists does not ensure that the choices made express the preferences of the individual consumer.⁷⁹ Nevertheless, this objection is highly unrealistic, given the need for collective choice in any financing program. It is also disingenuous, since the only alternative consumers have is to accept collective choices made for them at some even more aggregated level—by persons who are even less accountable to them and less attuned to their individual interests. As a general rule, the adverse effects of collective choice on individuals will be less pronounced in a decentralized system in which the groups making cost-conscious choices are relatively homogeneous and in which some individual choice can be preserved—by such means as multiple options in the choice of a plan, well-designed cost sharing, and preferred-provider arrangements. For courts to insist on perfect consumer knowledge, perfect accountability of payers and agents, and fully individualized choice as prerequisites of an enforceable contract for private health coverage⁸⁰ would effectively destroy private contract as a vehicle

⁷⁹ E.g., Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 406-09 (1990).

⁸⁰ A possible obstacle in getting legal and medical observers to accept complex contract terms as binding on individual patients in subsequent medical encounters is the legal and ethical doctrine of informed consent. Under this doctrine, a physician is required to include the patient in the loop in making specific decisions regarding his treatment and to make a real effort to give the patient information relevant to his choice. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972); 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP (1982); F. ROZOVSKY, INFORMED CONSENT: A PRACTICAL GUIDE (2d ed. 1992). Obviously, the standard of informed consent could never be met in any insurance contract—if only because the patient does not yet know what disease he is likely to have in the future and cannot fully inform himself on all the possible exigencies he might encounter. But informed consent principles were developed to protect important dignitary interests of patients and ethical values in doctor/patient relationships, not to accomplish the impossible task of making every patient a truly informed, technically competent decision maker. Such principles should therefore be irrelevant, as such, in assessing insurance contracts. On the other hand, by vindicating the freedom and right of patients to choose for themselves, the law of informed consent empowers patients against a professional elite systematically disposed to view them as too ignorant to be allowed to decline professional ministrations. It would be regrettable if judges—another professional elite—were to seize on consumers' presumed ignorance in purchasing health coverage as a blanket excuse for shutting down contract as a vehicle of change. For an example of how far such consumer-disabling legal thinking can go, see Mehlman, *supra* note 79, which would "require the better informed party to disclose its superior information," *id.* at 416—a requirement under which Mehlman would invalidate even the eminently

for curbing moral hazard in the interest of the very insureds whose interests the legal system purports to protect.

Before viewing a health insurance contract under the alternative paradigm, a court might wish to satisfy itself that the insurer or employer did not act irresponsibly in designing or administering innovative coverage. Thus, it might consider whether the drafters consulted with objective sources and medical experts, expressly considered trade-offs from a consumer perspective, and disclosed the economizing nature of the exercise to the insureds and anyone acting on their behalf. It might also credit an insurer's reliance on objective medical advice in implementing exclusions from coverage, its willingness to consult with the treating doctor in difficult cases, and its use of reasonable procedures for finally resolving close questions.⁸¹ If a court could be satisfied on these scores, there is every likelihood that health care "rationing" that accorded reasonably with contractual language would be permitted to proceed.

Instead of counting on the courts to be reasonable, however, some advocates of innovative contracting might favor seeking legislation to smooth the way for it. But any approach to the legislature would open the door for special interests and adherents of the old paradigm of the health insurance contract to introduce burdensome statutory preconditions to, and limitations on, contractual reforms, inevitably undercutting the effort to make payers primarily accountable to consumers, not to government. The payers themselves, under their lawyers' influence, would seek highly specified "safe harbors" against legal attack—under which they would concentrate on satisfying statutory requirements, not on giving consumers true choices. The alternative of leaving insurers and

reasonable result in the *Madden v. Kaiser Found. Hosps.*, 552 P.2d 1178 (Cal. 1976), see *supra* note 60, because he did not deem the individual interests of the plaintiff to have been adequately represented by her employer in bargaining for the arbitration clause and because the plan did not succeed in independently making the plaintiff aware of what her agent had agreed to on her behalf. See *Mehlman supra* note 79, at 406-09.

In some respects, the emerging law on advance directives concerning patient care when the patient is no longer able to make choices is more relevant to the issues under discussion here. Courts and public policy are increasingly receptive to prospective self-denial in this area. See, e.g., the Patient Self Determination Act, Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388-108.09, §4206 (1990). By extension, consumers should be free to accept some limitations on their claims on insurance funds as a way of economizing in the purchase of health insurance.

⁸¹ See *supra* note 77.

employers with some responsibility for demonstrating to courts the conscientiousness with which they conceived and introduced their innovations would probably give consumers more real protection than they would get under legislative prescriptions of contracting rules and minimum benefit packages.⁸² Only if the courts are finally shown to be truly recalcitrant, frustrating desirable consumer-oriented innovations, should legislative authority for innovative contracting be sought.

III. NONLEGAL OBSTACLES TO ECONOMIZING INNOVATIONS IN HEALTH CARE CONTRACTS

Although aggressive rationing of marginally beneficial health services is essential to reduce a serious misallocation of the nation's resources, it faces major cultural, political, and professional obstacles. Given the difficulty of overcoming deeply entrenched interests and values by political means, it is worth considering very seriously whether private contracts, although underutilized in the past, are not, after all, the most promising and ethically attractive vehicles available in the American context for introducing benefit/cost trade-offs into medical decisions. Despite its special costs⁸³

⁸² See Havighurst, *Decentralizing Decision Making*, *supra* note 4:

To the extent that the law does pose problems for employers, HMOs, and insurers seeking to implement such changes, it promises to move them in directions [e.g., disclosure, consumer education, etc.] that are entirely compatible with the competition strategy, and to be helpful both in clarifying and expanding consumer choices and in protecting consumers against abuse and unwarranted hardship.

Id. at 42. Well advised insurers and employers would adopt their innovations in ways that demonstrate the legitimacy and conscientiousness of their effort. Courts, however, should not go nearly as far in regulating or second-guessing the initiators of reforms as Mehlman, writing about something called "fiduciary contracting," suggests. See Mehlman, *supra* note 79 (discussed *supra* note 80).

⁸³ Complaints have been voiced recently about the allegedly excessive administrative costs of private health care financing. See U.S. GENERAL ACCOUNTING OFFICE, CANADIAN HEALTH INSURANCE: LESSONS FOR THE UNITED STATES (1991); Steffie Woolhandler & David U. Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, 324 NEW ENG. J. MED. 1253 (1991). Because of ubiquitous moral hazard, however, some administrative burden is inevitable in any scheme for protecting individuals against unpredictable or unaffordable health care costs. Whether administrative costs are excessive depends upon whether, at the margin, they exceed controllable waste. See *supra* note 6.

The operation of free markets always entails some special costs and duplication of effort. Marketing, search, and other transaction costs are usually justified, however, by the benefits that flow to consumers from continual innovation, the diversity of products produced, and the desirable incentives that result from making

and the inevitable shakiness of any institution's claim of moral authority to undertake explicit health care rationing,⁸⁴ private contract may be one of those democratic, choice-based institutions that is unsatisfactory only as long as it is not objectively and realistically compared to its freedom-limiting alternatives.

Those who resist allowing private contract to become a potent vehicle of change in the health care sector cannot deny the force of contract's claim to legitimacy.⁸⁵ They seek to deny that claim, however, by asserting, essentially, that freedom of contract is illusory and that honoring it allows the strong systematically to overreach the weak. Yet, ironically, the market and the courts impose upon employers and payers a great deal more accountability to consumers than is imposed upon the academic critics and judges who pronounce so assuredly on what rights consumers should have. Moreover, the political process, on which critics would also rely for difficult choices, is much more adept at conferring power on a political/legal/academic elite than at translating the preferences of individual consumer/voters into responsive action. It is worth remembering that critics who purport to view private contract only as a weapon of the powerful are members of the so-called "new class," whose own power and influence would diminish if rights were specified in private contracts rather than by the legal system.⁸⁶

The facial legitimacy and relative ethical attractiveness of contracts providing for prospective self-denial are sufficient reasons to explore the prospects for developing such contracts and for overcoming the obstacles to their widespread and effective use. There are, to begin with, obvious practical questions concerning the

sellers accountable for the quality and cost of their products in the marketplace. The health policy issue is simply whether consumers get, or might get, sufficient similar benefits in return for whatever additional costs they bear by having private intermediaries rather than a government monopoly pay for their health care. See Havighurst, *Why Preserve Private Financing?*, *supra* note 4 (addressing the importance of having a diversity of products available and noting constraints on the offering of a full range of choice).

⁸⁴ See generally MENZEL, *supra* note 19.

⁸⁵ See, e.g., Mehlman, *supra* note 79, at 365 ("Chicago School theorists wield a formidable weapon in the theory of contract.").

⁸⁶ On the "new class" and its self-serving antimarket ideology, see HANSFRIED KELLNER & FRANK W. HEUBERGER, *HIDDEN TECHNOCRATS: THE NEW CLASS AND NEW CAPITALISM* (1991); IRVING KRISTOL, *TWO CHEERS FOR CAPITALISM* 27-31 (1978), and Paul H. Weaver, *Regulation, Social Policy, and Class Conflict*, PUB. INTEREST, Winter 1978, at 45.

capacity of contract drafters to articulate, *ex ante*, reasonable rationing schemes to which consumers might fairly be said, *ex post*, to have consented. If one finds that significantly better private rationing rules could in fact be written, there is then the question how well a system tolerating their use would perform in practice. This empirical question cannot be answered, however, because serious experiments using private contracts to introduce benefit/cost trade-offs into medical decisions are, for the vast majority of people, simply unthinkable. This intellectual blind spot in the conventional wisdom may be the most severe obstacle to anyone's embarking on the prodigious effort needed to put the idea of aggressive, contract-based rationing to a fair market test. The legal environment for innovative contracting, while not inviting, is not finally prohibitive; a policy-aware insurance lawyer should be able to persuade most courts of the validity of prospective self-denial in a given case—if those who wrote, marketed, and administered the contracts did their jobs with care.

A. *Finding New Ways to Specify Entitlements and Obligations*

The market failure that causes resources to be overinvested in health care has only rarely been attributed specifically to contract failure—that is, to the inability of drafters of insurance contracts to specify with the requisite precision just what services the insured group wishes (and does not wish) to purchase from health care providers on a prepaid basis.⁸⁷ Analysts have instead focused most of the blame for runaway health care costs on third-party payment operating in conjunction with provider ingenuity and consumer ignorance. Only a few have observed that increased costs attributable to insurance-induced moral hazard are an acceptable cost of needed financial protection—as long as payers take all feasible, cost-effective actions to offset that inefficiency.⁸⁸ Unfortunately, however, earlier discussion has shown how insurer cost-containment efforts are themselves severely hampered by the difficulty of articulating clear, enforceable contract rules to govern spending in each doctor/patient encounter. Even HMOs confront such

⁸⁷ Contract failure is characteristic of any profession, such as medicine. Indeed, it has been suggested that a profession can best be distinguished from other service occupations by "reference to the ease or difficulty of precisely specifying a provider's performance obligations in advance of the provision of services." Havighurst, *Altering the Applicable Standard*, *supra* note 61, at 265.

⁸⁸ See *supra* note 6.

specification problems. Although not all HMOs need explicit internal rules to govern the clinical practices of their physicians,⁸⁹ the general inability of HMOs to write contracts closely specifying their physicians' legal obligations to subscribers in specific clinical situations creates malpractice liability risks that preclude much desirable economizing.

Contract drafters initially responded to the difficulty of specifying payer and provider obligations to patients, not by making each contract the equivalent of a customized medical textbook, but by incorporating in the contract, by explicit or implicit reference, the norms and standards of the medical profession. Thus, payers undertook to pay for whatever care was "medically necessary," and physician/patient relationships were established on the assumption that care would not fall below professional standards. Although borrowing standards observable in the marketplace originally made good practical sense,⁹⁰ general use of this expedient in conjunction with third-party payment dramatically weakened the market's usual constraints on spending. With those on the demand side of the market unable to communicate their priorities to the supply side, the medical profession became virtually the sole arbiter of what consumers would pay for through cost-spreading insurance mechanisms. The legal system, by unquestioningly accepting professional norms and standards as its touchstones in defining payer and provider obligations, added its own compulsions to the other cost-escalating incentives bearing on providers. With private contract unable to play its usual central role in specifying buyer/seller obligations, the legal system moved into the vacuum, assuming its now dominant role in specifying relationships.

Although physicians and payers should be bound by reasonable professional standards in the absence of any clearly articulated alternative standard, private health plans should not be denied opportunities to redefine provider and payer obligations contractu-

⁸⁹ See *supra* note 64.

⁹⁰ On the efficiency of having reference to professional standards in private contracts, see Richard A. Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, LAW & CONTEMP. PROBS., Spring 1986, at 201; Havighurst, *Altering the Applicable Standard*, *supra* note 61, at 266-72. Note that the efficiency explanation for why professional standards were adopted in the first place undercuts any claim that such standards are superior, for any specific purpose, to any other standards that may subsequently appear. Precisely because such standards were adopted by default and not by choice, courts should be open-minded, not suspicious, if consumers and their agents attempt to implement a different standard.

ally. Thus, the question arises whether there is any reason to think, at the present juncture, that private health care contracts could, as a purely practical matter, perform a substantially expanded function in specifying and limiting patient entitlements and payer and provider obligations. Is there any practical yet still untried way in which consumers and their agents might effectively authorize providers to economize by omitting services of doubtful value if those services seem mandated by professional norms? Obviously, it is premature to worry about the receptiveness of the legal system to innovative contracts responding sensitively to consumers' economizing needs if there is in fact no realistic basis for believing that such contracts are feasible.

One untried set of feasible contractual innovations are voluntary agreements limiting the tort-law rights of plan subscribers.⁹¹ Many malpractice reforms that might be adopted privately—for example, limits on the kinds and amounts of recoverable damages—have precedents in reforms that have been widely adopted by state legislatures.⁹² Although one would expect voluntary reforms to fare better in the courts than government-imposed alterations in patient rights, lawyers tend to be doubtful about letting people redesign their own rights by any means—especially where they sense an effort to economize on legal services.⁹³ Nevertheless, even

⁹¹ See *supra* note 61. Although lawyers are skeptical about the enforceability of such contracts, the cases that arouse their skepticism have uniformly involved pure exculpatory clauses and the like—not well crafted modifications of legal rights of the kind contemplated here. See *Emory Univ. v. Porubiansky*, 282 S.E.2d 903 (Ga. 1981); *Tunkl v. Regents of the Univ. of Cal.*, 383 P.2d 441 (Cal. 1963). For an anticontractarian effort to extrapolate from these and other narrow holdings principles that would bar virtually any private reform of malpractice rights, see Mehlman, *supra* note 79.

⁹² See, e.g., PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL 19-69* (1991); Glen O. Robinson, *The Malpractice Crisis of the 1970's: A Retrospective*, LAW & CONTEMP. PROBS., Spring 1986, at 5. The constitutionality of such statutory reforms has been widely litigated because of their mandatory character and the concern that they were enacted only to serve provider interests. See HAVIGHURST, *supra* note 45, at 704-47; David R. Smith, *Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws*, 38 OKLA. L. REV. 195 (1985).

⁹³ For academic objections to private reform of malpractice law, exaggerating the risks and barely acknowledging any cost-saving benefits from diminishing the role of courts and lawyers, see Sylvia A. Law, *A Consumer Perspective on Medical Malpractice*, LAW & CONTEMP. PROBS., Spring 1986, at 305, 316-18 ("Patients have little capacity to make informed judgments about cost and quality trade-offs"); Mehlman, *supra* note 79 (discussed *supra* note 80); see also P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, LAW & CONTEMP. PROBS., Spring 1986, at 287, 302 (accepting contractual reform of malpractice rights only after concluding "at the end of the day" that legislative reform strategies are likely to fail in the U.S. political system) and

given an overweening legal culture distrustful of private choices, enforcement of innovative contracts should be obtainable by skillful advocacy, preceded by care in drafting and by consumer education in marketing. Private health plans should therefore be alert for opportunities to assist consumers in economizing by surrendering legal rights that systematically induce or excuse excessive spending by physicians.⁹⁴ Although contracts limiting recoverable damages could lower malpractice insurance premiums and might somewhat lessen the pressure on physicians to practice defensive medicine, the net saving to consumers might be too small either to justify the effort or to offset the dilution of incentives deterring real negligence.⁹⁵ Creative lawyering should therefore be directed instead to developing and introducing alternative standards for determining liability.⁹⁶ Contractual language could, for example, seek to eliminate the requirement of compliance with professional norms and standards by generally authorizing departures from custom which are not unreasonable in benefit/cost terms or which are warranted by the findings of medical or health services research.⁹⁷

Peter A. Bell, *Analyzing Tort Law: The Flawed Promise of Neocontract*, 74 MINN. L. REV. 1177 (1990) (having little specific reference to malpractice). A major point of the instant article is that the medical profession alone should not be the final arbiter of the standards of medical care. Similarly, the legal system's prescriptions of costly tort rights for patients should yield to consumer choice, reasonably exercised. *See generally* sources cited *supra* note 61.

⁹⁴ Collective-action and free-rider problems, rather than consumer preferences, go a long way—together with overcautious lawyering—toward explaining why existing opportunities of this kind have not been seized. *See* Havighurst, *Altering the Applicable Standard*, *supra* note 61, at 171 n.91. Solutions to these problems are not immediately in sight, but legislative encouragement or a few well-publicized, easily imitated successes could induce a flurry of innovation.

⁹⁵ Real negligence is already underpoliced. *See* HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK, at executive summary 6 (1990) (finding that "[a]bout 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system"). Different conclusions might be drawn from this fact, however. For example, one might conclude either that it would be risky to dilute incentives further or that existing rights provide so little protection (and cost so much to administer) that they can be curtailed. Or one might choose a totally different approach. *See infra* text accompanying notes 100-01.

⁹⁶ For a legislative proposal expressly inviting contractual innovations of this kind, see S. 1232, 102d Cong., 1st Sess. (1991) (introduced by Senator Domenici). *See also* Clark C. Havighurst & Thomas B. Metzloff, S. 1232—A Late Entry in the Race for Malpractice Reform, LAW & CONTEMP. PROBS., Spring 1991, at 179. Although the contemplated contracts would directly affect doctor/patient relationships, it would be preferable for them to be negotiated by payers, who could capture the cost savings for consumers.

⁹⁷ For proposed contractual language by which an HMO might protect its freedom

Or a contract drafter, observing that general practitioners use significantly fewer resources than medical specialists in treating comparable patients, might provide that only the standard of care prevailing among family physicians in the area would be used in evaluating the spending choices of all participating physicians, whatever their specialty, and would be used as well in determining the plan's payment obligations.⁹⁸ Another possible contractual approach would be to limit patients' right to sue for anything but gross negligence, suitably defined.⁹⁹ Or compensation for injuries might be based on something other than provider fault.¹⁰⁰

Other promising opportunities for redesigning the contractual basis of patient/provider/payer relationships may exist in the near future. Major efforts are currently being made to supply clinicians and other decision makers, including contract drafters, with better

to depart from customary practice, see Havighurst, *Altering the Applicable Standard*, *supra* note 61, at 271-72.

⁹⁸ In a recent study, certain subspecialists were found to use more resources in treating comparable patients than general internists, who in turn used somewhat more resources than family physicians. See Sheldon Greenfield et al., *Variations in Resource Utilization Among Medical Specialties and Systems of Care*, 267 JAMA 1624 (1992). Legally, medical specialists are generally held to the standard of their specialty, which is viewed on a national basis. See, e.g., *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 349 A.2d 245, 250-51 (Md. Ct. App. 1975) (reviewing doctrine). General practitioners, on the other hand, are often evaluated on the basis of practice in a narrower geographic area. See Annotation, *Modern Status of "Locality Rule" in Malpractice Action Against Physician Who Is Not a Specialist*, 99 A.L.R.3d 1133 (1980). It would seem relatively easy for a contract drafter to specify that the latter standard should govern the obligations of physicians to prescribe extra tests and more costly treatments and the payment responsibilities of the plan itself. (Physicians would still be bound to demonstrate the care and skill characteristic of their respective specialties in carrying out indicated procedures or treatments.) Just as consumers are free to receive their care from family physicians, they should be free to choose a health plan that undertakes to economize as they do. It is difficult to see any basis for a judicial refusal to give effect to a contract specifying, with adequate disclosure, such a standard. By such contracts, fee-for-service insurers might be able to reduce resource use to levels comparable to HMOs, which the Greenfield study, *supra*, shows to be independently lower.

⁹⁹ See Havighurst, *Altering the Applicable Standard*, *supra* note 61, at 273-75 for a surprisingly persuasive rationale for adopting such a clause.

¹⁰⁰ See, e.g., Clark C. Havighurst, "Medical Adversity Insurance"—*Has Its Time Come?*, 1975 DUKE L.J. 1233; Clark C. Havighurst & Lawrence R. Tancredi, "Medical Adversity Insurance"—*A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 MILBANK MEMORIAL FUND Q. 125 (1973); Laurence R. Tancredi & Randall R. Bovbjerg, *Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, A Malpractice and Quality Reform Ripe for a Test*, LAW & CONTEMP. PROBS., Spring 1991, at 147. See *supra* note 95 for a reason for shifting to a limited strict-liability system as a way of lowering claims-resolution costs and getting quality-assurance incentives right—as these proposals seek to do.

scientific information on the effectiveness and outcomes of various courses of diagnosis and treatment. In what could become the most important health policy development of the 1990s, professional and other groups are actively developing "practice guidelines," which define in substantial detail, based on the best scientific learning, recommended clinical methods to be employed in commonly encountered situations.¹⁰¹ Although guideline development has a long way to go, the efforts under way should eventually yield sets of scientifically grounded, highly specific recommendations for clinicians to follow.

Practice guidelines have been heralded mostly as a new generation of professional standards that will improve the regulation of medical practice, including the administration of malpractice law.¹⁰² It is also possible, however, to view them as a new technology that could enable consumers, for the first time, to choose the exact style of medical care they wish to purchase on a prepaid basis.¹⁰³ For guidelines to serve consumers in this way, there would have to be more than a single set of professionally promulgated guidelines expressing a medical consensus or equally approving a range of acceptable practices. Fortunately, although the guidelines movement has some monolithic features,¹⁰⁴ it seems likely in time to yield a variety of guidelines, including alternatives prepared by experts not accountable to organized medicine. Even

¹⁰¹ See generally AMERICAN MED. ASS'N, LEGAL IMPLICATIONS OF PRACTICE PARAMETERS (1990); INSTITUTE OF MEDICINE, CLINICAL PRACTICE GUIDELINES: DIRECTIONS FOR A NEW PROGRAM (Marilyn J. Field & Kathleen N. Lohr eds., 1990) (providing guidelines and examples of good practice guidelines); PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT TO CONGRESS 1989, at 219-36 (recommending federal support for effectiveness research and development of practice guidelines); Clark C. Havighurst, *Practice Guidelines for Medical Care: The Policy Rationale*, 34 ST. LOUIS U. L.J. 777 (1990) (describing guidelines movement and important federal legislation supporting guideline development); Symposium, *Getting It Right: The Making of Practice Guidelines*, 16 QUALITY REV. BULL. 38 (1990); William L. Roper et al., *Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice*, 319 NEW ENG. J. MED. 1197 (1988) (proposal by officials of the Health Care Financing Administration).

¹⁰² See Troyen A. Brennan, *Practice Guidelines and Malpractice Litigation: Collision or Cohesion?*, 16 J. HEALTH POL. POL'Y & L. 67 (1991); Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, LAW & CONTEMP. PROBS., Spring 1991, at 119.

¹⁰³ See Havighurst, *supra* note 101, at 792-804; Clark C. Havighurst, *Practice Guidelines as Legal Standards Governing Physician Liability*, LAW & CONTEMP. PROBS., Spring 1991, at 87.

¹⁰⁴ See Havighurst, *supra* note 101, at 783-92 (discussing the "traditional professional" and "political" models of practice guidelines).

if the initial guidelines were produced by professional authorities, there would be little—at least as a practical matter—to stop other experts from marking them up, modifying them at crucial points to reflect cost concerns or different views of the evidence on efficacy and cost-effectiveness.¹⁰⁵ Once they could choose from a variety of practice guidelines, health insurers and other health plans would finally possess some tools with which to specify the style of medical care they wish to underwrite. Consumer protection against ill-conceived guidelines could be provided by public or private certification programs verifying, not their ultimate merit, but the objectivity and scientific rigor with which they were prepared.¹⁰⁶

Practice guidelines produced by reputable sources taking different views of the scientific evidence and the benefits and costs of treatment could easily be incorporated by reference into private contracts. In contrast to the protocols and screening criteria currently employed in utilization management, contractual guidelines would be disclosed both to consumer representatives and providers at the outset, would be open to discussion and modification as their shortcomings became apparent, and would be readily accessible through computer technology to guide practice and resolve issues. Although guidelines could never address all clinical exigencies or immediately reflect new scientific findings and technological developments, they would nevertheless greatly facilitate communication and cooperation between payers and providers.¹⁰⁷ Even where they failed to provide for a particular case, they would serve as helpful reference points for interpolating coverage and for resolving malpractice claims.¹⁰⁸

¹⁰⁵ Some copyright problems might be encountered but should not be insurmountable.

¹⁰⁶ The federal guidelines program is already charged by Congress in such a way that it could assume this certification function. See Havighurst, *supra* note 101, at 804-16.

¹⁰⁷ Important insights into how guidelines might work in practice might be gained by considering them in light of the law and economics literature on transaction costs and relational contracts. See generally Palay, *supra* note 64, at 738-46; Oliver E. Williamson, *Transaction-Cost Economics: The Governance of Contractual Relations*, 22 J.L. & ECON. 233 (1979); I. R. MacNeil, *The Many Futures of Contract*, 47 S. CAL. L. REV. 691 (1974). These references adopt a more dynamic and contextual view of private contracts than the simplistic conception of each contract as the embodiment of a discrete, fully bargained transaction. Progress in making contracts work in medical care must recognize, as modern scholars are beginning to do, that relationships cannot be governed by contract language alone and that ambiguity is a common and inevitable, not an exceptional, circumstance.

¹⁰⁸ The Domenici malpractice reform bill expressly invites private and public

If practice guidelines are developed specifically for, and put to, such voluntary contractual uses, they will greatly expand the ability of private financing intermediaries to be selective in the many grey areas of medical practice and to implement a consistent plan policy toward risk and cost across the entire range of patients' medical needs.¹⁰⁹ Specifically, they could be used to fine-tune patient cost sharing, to make exclusions from coverage less categorical and more sensitive to medical circumstances, to give providers and utilization managers objective points of reference in their interactions, and to insulate participating providers from liability for authorized economizing. Of course, practice guidelines will never truly solve all the problems of introducing cost considerations appropriately into medical decision making. But, with proper encouragement by government and acceptance by the courts, they could represent a great leap forward for consumers, empowering them to make choices they have heretofore been unable to make. In giving private health plans the means to offer their customers sensitive economizing with their most essential health needs in view, practice guidelines could finally bring cost-conscious consumers and their agents to the table where crucial, costly medical decisions are made.

B. *Needed: A New Paradigm of Medical Care*

Unfortunately, the idea that consumers might participate effectively in decisions to reduce the cost—and perhaps even the content and quality—of their own health care flies directly in the face of most thinking about medical care and the directions health policy should take. The pervasive assumption in public and private conceptions of medical care is that it could never be a consumer good, to be purchased in greater or lesser quantities depending upon its price and made available in the marketplace in a variety of forms designed to appeal to different preferences and pocketbooks. Instead, health care is generally thought of as a “merit good”—that is, as something that should be distributed equitably, not simply according to ability to pay. To the extent that it has been necessary

health plans to incorporate practice guidelines as standards for determining provider liability. See Havighurst & Metzloff, *supra* note 96, at 189-91.

¹⁰⁹ Public programs, such as the Medicaid program in Oregon, would likewise benefit from the enhanced ability of plan designers to reduce the scope of coverage at points where outcomes are least likely to suffer, avoiding the necessity for lopping off whole categories of sometimes highly beneficial care. See *supra* text accompanying notes 45-47.

under this paradigm of medical care to specify the precise content of patients' entitlements—as in medical malpractice cases and insurance coverage disputes—, society has been generally content to rely in the first instance on the judgment of treating physicians and ultimately on the collective norms and standards of the medical profession. Despite their universal use as reference points for evaluating clinical practices, however, professional norms and standards have rarely been scrutinized for consistency with the public interest.¹¹⁰ In a striking reversal of the pattern in normal demand-driven markets, the health care industry is in the enviable position of prescribing without appreciable accountability the quantity and characteristics of the services it renders—and for which the consuming public must pay.¹¹¹

Contrary to conventional wisdom, the conceptions of medical care as a consumer good and as a merit good are not mutually exclusive. Redistributive goals could easily be achieved without depriving medical care of its character as a consumer good at the margin. For example, a government voucher program could give everyone the means to purchase adequate health care coverage while leaving them free, within limits, to decide for themselves among the styles and standards of service available and whether to purchase additional services or financial protection at their own expense. Just as Oregon's Medicaid program is attempting to find better ways to allocate and supplement the subsidy it gets from the federal government and to specify new rights for Medicaid beneficiaries, private middlemen might assist both publicly subsidized and self-supporting groups in defining their future entitlements. As discussed earlier, changes in the way contract drafters specify

¹¹⁰ Tort-law standards present analogous problems in other contexts. Thus, products liability for jury-determined design defects may be imposed without regard to whether all efficient safety measures were taken, and contractual disclaimers of liability are unlikely to be respected. As a result, some socially desirable products are kept off the market. See W. Kip Viscusi & Michael J. Moore, *Rationalizing the Relationship between Product Liability and Innovation*, in *TORT LAW AND THE PUBLIC INTEREST* 105 (Peter H. Schuck ed., 1991). In the medical area, the risk is not that some desirable services will be omitted but that services will be regularly supplied in quantities and versions that are more costly than is socially appropriate. This results from the externalization of the costs of treatment through payment systems and the legal system's borrowing of standards from professional sources.

¹¹¹ Standard setting occurs in other fields as well, and producers run liability risks in offering lower-cost, substandard alternatives. Nevertheless, medicine is probably the only standard-setting industry that does not face a downward-sloping demand curve that significantly limits what it can force the public to accept.

provider and payer obligations could give consumers a much greater say over what they are obligating themselves to pay for. If contractual innovations are developed and implemented with appropriate care, it should be possible to convince courts that economizing in the purchase of health care financing is no different than economizing in any other consumer purchase.

Although contract drafting problems and legal uncertainties still remain, the chief obstacle to contractual innovations in purchasing health care is probably the unthinkability under the conventional wisdom of the entire idea of expanding the role of consumers and their agents in making trade-offs with respect to medical care. The main source of the paradigm of medical care portraying it as something other than an ordinary article of commerce is the medical profession itself. Physicians strongly believe that the content of medical care is primarily a technical matter and that its determination is ultimately a professional responsibility.¹¹² These beliefs add up to a powerful ideology that leaves little room for cost considerations either in individual physicians' clinical decisions or in collective judgments by professional bodies concerning the appropriateness of various measures.¹¹³

The medical profession's paradigm of medical decision making stifles the transmission of cost concerns from the demand side of the market to the supply side by denying the legitimacy of both the message and the messengers. Physicians keep cost considerations subsidiary to questions of safety and efficacy by stressing patient welfare and the ethical duty of physicians to consider only that in clinical decisions. Physicians also find it easy to characterize cost-control efforts by both private and public payers as interference by uncaring interests in sacred professional relationships. To the extent that prospective financing of medical care necessitates bifurcation of the consumer's stake—with health concerns entrusted

¹¹² For a fuller exposition of the professional paradigm of medical care and the obstacles it poses to a variety of badly needed reforms, see Havighurst, *The Professional Paradigm*, *supra* note 4.

¹¹³ For revealing insights into evolving medical thinking, see David M. Eddy, *Cost-effectiveness Analysis: A Conversation with My Father*, 267 JAMA 1669 (1992). The younger Dr. Eddy is an effective leader in the effort to get physicians to accept the appropriateness of cost considerations in the formulation of clinical policies. One reason is that he remains true to the professional paradigm. Thus, he frames the issues as technical ones (with costs to be explicitly factored into calculations) and emphasizes the need for the profession to reform itself. Although he would tolerate changes originating on the demand side of the market, he neither welcomes such diversity nor invites consumers' purchasing agents to force changes on practitioners.

to physicians and cost concerns entrusted to financing intermediaries—, physicians have the advantage of being on the side of the angels in most disputes over spending on a particular patient.¹¹⁴ Their paradigm of medical decision making thus carries great weight in the popular mind. There is little room in the dominant paradigm of medical care for acknowledging a role for payers as consumer agents in defining the standard and intensity of the care they underwrite.

The professional paradigm of medical care also has many points in common with the egalitarian ideal that underlies much political thinking about health care. Although the medical profession and liberal reformers differ on many issues, they are united on the premise that decision making about medical care should be centralized, not left in the hands of consumers and their agents. To be sure, these interests struggle incessantly over who—government or the profession—should have the ultimate authority to define the content of medical care and over the propriety of regulatory or fiscal constraints on clinical practice. Nevertheless, the assumption that hard economizing choices must be made, if at all, at the level of the entire society, is very firmly entrenched in the thinking of both the medical care industry and its most vigorous critics. By thus denying consumers or government programs any discretion openly to forgo any beneficial care in the interest of economizing, the professional/egalitarian conception of medical care contributes to the current political stalemate in health policy. Because the nation can neither afford to guarantee state-of-the-art medical care for all nor bring itself to do any less, it does nothing at all for the mass of uninsured Americans—a particularly tragic example of how the best can be the enemy of the good.¹¹⁵

¹¹⁴ See *supra* notes 27-37 and accompanying text.

¹¹⁵ There is no sign at the moment that voters will not continue, as they have in the past, to reject the egalitarians' program, whether pursued by a levelling-up strategy or by levelling down. As long as voters refuse both to pay taxes to finance state-of-the-art care for all and to accept rationing of their own care in order to make care available to others, the needs of the underserved will continue to be neglected. Because the egalitarians' best hope for achieving their preferred solution lies in letting the system as a whole deteriorate to a point where radical reform will finally be possible, many of them tend to oppose incremental reforms that would improve the existing marketplace by getting incentives right through tax reform, decentralizing decision making, and making low-cost private insurance options available. Under the resulting political stalemate, the gap between the haves and the have-nots is much wider than it would be under a regime that conceived of medical care as a consumer good at the margin while offering subsidies to assist everyone in getting at least basic care as a merit good. The irony in the political standoff is that those who hold out

Employers concerned about rising fringe benefit costs would seem to be the parties most likely to initiate contractual innovations in the purchasing of health care. Employers are severely limited, however, in their ability to assist their employees in economizing by the dominant paradigm of medical care as it persists among the employees themselves. Health benefits have long symbolized employers' concern for their workers' welfare, and economizing moves might easily be misinterpreted as something other than an effort to make sure that compensation takes the most efficient forms. Indeed, cutbacks of health benefits have been a common cause of worker discontent. The dominant paradigm portraying health care as an entitlement rather than as an object of consumer choice thus looms large as an obstacle to employers' efforts to carry the fight against rising costs into the no-man's-land of benefit/cost trade-offs.¹¹⁶ The burden of reeducating consumers about the nature of health care, together with the other costs of innovation,¹¹⁷ make it highly unlikely that administrators of existing employee benefits will be in the forefront in brokering insurance agreements incorporating the concept of prospective self-denial.

for making health care a uniform entitlement bear much of the blame for the burdens borne by the uninsured—as their visions of the best frustrate realization of attainable improvements. See, e.g., *Waxman: Reject Oregon Waiver*, HEALTH LEGIS. & REG., Apr. 22, 1992, at 1.

¹¹⁶ An issue for the future is whether health insurance should continue to be procured as a fringe benefit of employment. This way of providing coverage is largely an artifact of the tax treatment of insurance premiums and creates significant problems, particularly with respect to continuity and portability of coverage. An interesting proposal originating at The Heritage Foundation would break the employment link and require all individuals, with appropriate public assistance, to maintain adequate, portable coverage (to offset the temptation for individuals to free-ride on the health care system's charitable impulses as protection against becoming sick). See STUART M. BUTLER & EDWARD F. HAISLMAIER, *A NATIONAL HEALTH SYSTEM FOR AMERICA* (1989); Stuart M. Butler, *A Tax Reform Strategy to Deal with the Uninsured*, 265 JAMA 2591 (1991). Even without tax incentives to purchase insurance through the workplace, however, employers would continue to play a large role in making coverage available, helping employees obtain it at favorable group rates, searching the market for desirable options, and educating workers to make wise choices. With employers no longer directly concerned about the cost of coverage and with health coverage no longer a central symbolic feature of the employer/employee relationship, insurers would be the main source of innovation in coverage design and would be more easily perceived as offering contracts designed to serve consumer interests. In this context, the paradigm of medical care as a consumer good—and as an object of prospective self-denial—rather than as a centrally determined entitlement would stand an excellent chance of taking hold.

¹¹⁷ See *supra* note 94.

Innovative contracts providing for aggressive rationing of health care financing might catch on, however, among employers who now offer no health coverage at all. These employers and their employees are acutely conscious of the staggering cost of the only health care options currently available to them—namely, coverage entitling covered individuals to standard, high-cost, state-of-the-art medical care. It would seem that the millions of employed persons who are currently priced out of the market for health insurance should be positively grateful for new lower-cost options, even if they carry some risks that other insured persons do not bear. Likewise, the fiscal problem of caring for the uninsured would seem less overwhelming to the federal and state governments if health care were viewed not as an all-or-nothing proposition but as a consumer good which can be purchased in affordable increments. The economizing effort under way in Oregon illustrates how, by facing marginal trade-offs and accepting some rationing of beneficial care, government might provide essential health care to all low-income persons. Nothing would do so much to enable the nation to close the gap between private coverage and public financing as a reconceptualization of medical care as a consumer good rather than as an entitlement to a set of services fixed by central authority. The current political stalemate reflects, above all, the difficulty under the dominant paradigm of proceeding incrementally to close the gap in either direction.

If new, low-cost packages of prepaid health care were to become available and achieve some acceptance, employers offering health benefits might then feel comfortable offering such packages to their employees as options, along with more traditional coverage. Workers would then have an opportunity to increase their individual welfare by accepting some risk—just as they do, for example, by purchasing smaller, less safe cars.¹¹⁸ More than anything else, eye-catching price tags could induce consumers to scrap the

¹¹⁸ Unfortunately, offering choices opens up possibilities for adverse selection. See *supra* note 45. Nevertheless, if the low cost of the alternative plan reflects careful cuts made all along the margin of health care rather than gross categorical exclusions, the employer should experience less shifting between plans by employees trying to game the system (or be able counter it by simply excluding treatment of pre-existing conditions from coverage under a newly selected policy). Although some promoters of competition in health care markets believe that adverse selection can best be avoided by establishing a standard benefit package, see, e.g., Enthoven, *supra* note 45, at 42 (“I believe there is a strong presumption in favor of standardization.”), this Article suggests that creativity in designing options might achieve even lower costs without encountering severe adverse selection.

entitlement paradigm and consider their options.¹¹⁹ As consumers wake up to trade-offs and economizing opportunities, courts and the larger culture might finally accept that in purchasing health care, as in purchasing other things, choices must be made. Although individual physicians would remain free to choose the health plans in which they would participate, the medical profession as a whole would have no choice but to go along with a new paradigm of medical care in which consumers ultimately call the shots.

CONCLUSION

At a recent conference, economist Henry J. Aaron advanced the hypothesis that consumer choice serves no very useful purpose when it comes to private health care financing.¹²⁰ Although not finally asserting the truth of this proposition, Aaron challenged others to refute it, and many of the assembled economists, like true believers defending a central tenet of their faith, undertook to do so. Certainly, they could argue, the nation benefitted significantly from consumer choice in the 1980s, when a real choice-driven revolution occurred in the private purchasing of medical care.¹²¹ Indeed, in that decade, HMOs finally began to grow dramatically; the emergence of selective contracting and preferred-provider arrangements gave consumers for the first time the benefit of real price competition among providers; and managed-care mechanisms were developed to challenge some uneconomic utilization practices in the fee-for-service sector. Consumer choice, unleashed by antitrust enforcement and the withdrawal of government as a dominating regulatory presence, triggered these developments. In response to Aaron's suggestion that choice and competition are of little use in

¹¹⁹ A major uncertainty is how, given the symbolic significance of health care, occasional apparent hardships would affect demand for low-cost options. Many of these hardships would be more apparent than real, of course, because of the patient's poor prognosis or quality of life even with a costlier form of treatment. (Indeed, one of the costliest incidents of moral hazard against which the insurance fund must be protected is the powerful impulse to "do everything possible" whenever near-certain tragedy impends.) Other potential hardships might be rectified to some extent by charity. *See supra* note 8. The unanswered question is the extent to which occasional hardships would be accepted as a fact of life in a world of limited resources.

¹²⁰ Conference on American Health Policy: Critical Issues for Reform, sponsored by the American Enterprise Institute for Public Policy Research, Washington, D.C., Oct. 3-4, 1991; *see also* HENRY J. AARON, *SERIOUS AND UNSTABLE CONDITION: FINANCING AMERICA'S HEALTH CARE* 27-37 (1991).

¹²¹ *See supra* note 2.

the market for private health coverage, it could be observed, optimistically, that the glass is far from empty—indeed it is probably half full.

On the other hand, to any true-believing economist categorically denying Aaron's hypothesis, it must be pointed out, pessimistically, that the choice glass is half empty. The ultimate issue is not the present state of affairs, however, but whether the choice glass is *inevitably* no more than half full—because, if the market cannot give consumers a rather full measure of meaningful choice, the nation might as well opt for a single government payer and be done with it.¹²² At the moment, it is quite likely that, as Aaron implies, purchasers of health care could make more effective and satisfying economizing choices through the political process than they can make on their own in the market they face. Specifically, they are denied *de facto*—and to a lesser extent *de jure*—the chance to make many economizing choices that would, for many, be highly rational in light of the very high cost and often limited benefit of much state-of-the-art medical care.

This Article has identified a largely unrecognized but crucial reason why consumer choice has not been a helpful force for rationalizing private spending on health care in the United States. Although analysts frequently blame the market's dysfunction on tax subsidies that encourage overinsurance¹²³ and on cost-escalating regulatory requirements imposed on financing plans,¹²⁴ the inutility of private contracts in specifying health care bargains is a far more fundamental and less obviously correctable cause of the market's inability to solve cost problems. The thesis advanced here is that, before giving up on the market and turning crucial decisions over to government, a concerted effort should be made to see

¹²² This thesis was advanced rather aggressively in Havighurst, *Why Preserve Private Financing?*, *supra* note 4, but only as a tour de force to inspire firms engaged in private health care financing to challenge the dominant paradigms of medical care and the practical and legal barriers to innovative contracts in order that they could finally offer consumers a full range of economizing choices.

¹²³ See *supra* note 9.

¹²⁴ On forms of insurance regulation raising the cost of traditional coverage, see Gail A. Jensen, *Regulating the Content of Health Plans: A Review of the Evidence*, in AMERICAN HEALTH POLICY, *supra* note 4, and Robert S. McDonough, Note, *ERISA Preemption of State Mandated-Provider Laws*, 1985 DUKE L.J. 1194. There is currently great interest in creating limited legislative exemptions from such regulatory requirements as a way of making low-cost health insurance packages available to small businesses. This Article proposes using private contract to open up further avenues of escape from legal impediments to intelligent economizing.

whether private contracts can become effective vehicles for implementing private choices. Certain legislative reforms prerequisite to such an effort are currently under serious consideration. Such reforms include changes in the way government subsidizes private purchases of health coverage, federal preemption of certain forms of state insurance regulation, and new regulation designed to increase the security that health insurance provides (by drastically limiting the conditions under which coverage may be terminated). Malpractice reform is also being viewed as a possible target of the reform effort. The usual proposals, however, do not come close to addressing tort law's cost-escalating regulatory features. The most practical way to change malpractice law's costly standard of care is to facilitate its modification in private contracts specifying consumer choices.¹²⁵

Although a wave of contractual reform could conceivably begin in the private sector as a spontaneous response to the increasing need to make trade-offs with respect to health care, a high-level public effort to encourage choice-driven reforms might be necessary to get the first olives out of the bottle. Ideally, this effort would take the form of a presidential commission charged with educating the public to the existence of promising economizing opportunities in purchasing health care, the methods by which these opportunities might be seized, and the legal and other barriers that currently block promising initiatives. Although legislative reform would be one object, the primary goal of this commission should be to legitimize economizing innovations in the private sector and to break down the interconnected practical, legal, and cultural obstacles to private choice that have been identified in this Article. This initiative to focus more attention on how to get value for money in health care might be modeled on an earlier such commission that addressed ethical issues in medicine.¹²⁶ It might appropriately be called the President's Commission on Effectiveness and Efficiency in Health Care.¹²⁷

¹²⁵ The only federal malpractice reform bill expressly adopting this strategy is the Domenici bill, *supra* note 96.

¹²⁶ The earlier presidential commission is cited *supra* notes 11 & 80.

¹²⁷ In a classic book, *EFFECTIVENESS AND EFFICIENCY: RANDOM REFLECTIONS ON HEALTH SERVICES* (1971), A. L. Cochrane eloquently proposed that the British National Health Service employ outcomes and effectiveness research to establish spending priorities. It would be fitting if the effort to bring similar insights to bear on the private and public purchasing of health care in the United States bore a similar title.

Many challenges would face any educational effort to encourage the use of private contracts to memorialize the preferences of consumers for the purpose of forcibly communicating them to health care providers through the medium of health care financing plans. The seeming impracticality of specifying the obligations of providers and payers in writing is what originally occasioned widespread reliance on professional standards to define patient entitlements and resolve disputes. Even though professional standards were originally turned to only out of practical necessity, the convention of relying on them is now reflected, if not securely fixed, in law. Moreover, the policy of letting the medical profession set standards for society is generally accepted; not only is the profession itself generally trusted, but because of the large components of science and professional judgment in clinical decisions, there is little awareness that standards could be set in any other way. Finally, the professional paradigm has become so deeply entrenched that consumers now perceive health care as an entitlement rather than as a consumer good to be purchased only to the extent affordable.

Despite the substantial obstacles to making medical care an object of cost-conscious consumer choice, the nation sorely needs alternative sources of standards to govern care in various circumstances. Indeed, the full economic cost of deferring to nonaccountable physicians has now finally appeared. Indeed, the current, nearly unbearable cost of health care is the inevitable result of giving physicians, hospitals, and technology suppliers nearly a generation (since the enactment of Medicare and Medicaid) in which to invent and sell ever more costly goods and services in a market lacking significant price sensitivity. Precisely because the cost of looking solely to professional sources for standards is now so high, even daunting practical, legal, and cultural obstacles to the discovery and implementation of alternative standards ought not to deter the needed effort. What is needed most is a major intellectual effort to put aside conventional ways of thinking about medical care so that it can be approached, at the margin, as a consumer good as to which economizing is not only desirable but inevitable.

It would be extremely helpful in advancing the needed rethinking of medical care if private agreements for health care financing could be conceptualized and implemented as contracts of prospective self-denial—that is, as instruments by which persons pooling resources to meet future health care needs agree mutually to limit their future claims against the common fund. Because radical

public health reform is likely to be stymied for the foreseeable future by severe gridlock in the political process, there is an immediate need to improve the market's ability to control cost and to offer affordable options to those currently without any coverage at all. This can only be done by letting consumers (and public health care programs as well) exercise more control over what they spend. Health care contracts should be viewed as promising tools for achieving this goal. If society can find the will and the skills needed to use these tools well, it should be possible by private action to end the medical profession's dominance and to restore to consumers their customary sovereignty—their right to write their own tickets in buying health care services.