CONTRACT FAILURE IN THE MARKET FOR HEALTH SERVICES

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Professor Havighurst examines the claim that the United States is overspending on health care. Finding much of the evidence inconclusive, he nevertheless finds one clear cause of allocative inefficiency to be unwise tax subsidies for the purchase of private health insurance. He avers, however, that a more serious problem is the market's failure to offer consumers a full range of health care choices, specifically low-cost options. Here, he makes the novel claim that overspending on health care is attributable to the failure of private contracts to specify the precise character and scope of the health services to be provided and the particular rights and obligations of the various parties to the transaction. This contract failure, he forcefully contends, is in large part the fault of a legal system that has effectively displaced private contract as the ultimate source of entitlements and rights. He argues for making an expanded role for contracts a cornerstone of health care reform.

INTRODUCTION

Each year Americans spend a larger share of the nation's Gross Domestic Product (GDP) on cellular telephones, yet no one seems concerned. On the contrary, Americans generally applaud such “growth industries” for creating new jobs and giving consumers access to new technologies. The cellular telephone industry is a traditional American success story.

The health care industry, however, is not similarly applauded. Even though it too is a growth industry making new employment opportunities and technological miracles available to the American people, its increasing claims on GDP are regarded only as evidence of a crisis requiring a national solution. Why is it that the increasing consumption of high-tech health care is not viewed in the same way as the increasing expenditures on cellular technology? Is it only because annual health costs are approaching a trillion dollars while spending on cellular technology, although growing at an even faster rate, still constitutes only an

* William Neal Reynolds Professor of Law, Duke University. This article is adapted, with permission, from a study supported by the American Enterprise Institute for Public Policy Research under a grant from The John A. Hartford Foundation, Inc., of New York City. The author expresses gratitude for this support. It is anticipated that the completed study will be published soon under the title HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM.
infinitesimal share of GDP? Do complaints about rising health care costs betoken only growing pains, or is there a fundamental problem? Without precise and satisfying answers to these questions—a diagnosis, as it were—it is impossible to prescribe an appropriate treatment for the health care crisis so widely decried.

This article examines, with more rigor than one sometimes finds, the question whether the United States is indeed overallocating societal resources to certain health care uses—and, if so, why. Rejecting much of the evidence usually cited to prove that resources are being wasted on health care, this article eventually finds persuasive evidence of waste in the systematic failure of the marketplace to offer consumers a full range of economizing options. It then traces this problem to a source never before adequately identified—the contracts under which individuals procure health services. In health care, private contracts systematically fail to perform their usual function of defining the rights and obligations of the parties, especially with respect to the content, quality, and quantity of the goods and services being purchased. To be sure, most commercial contracts are inevitably incomplete in significant respects. But the drafters of health care contracts have virtually abdicated the task of specifying crucial features of the transaction. The extent to which this contract failure may be remedied should be treated as a critical issue in the current debate over health reform.

I. THE DEBATABLE SIGNIFICANCE OF HIGH AND RISING COSTS

Neither the absolute level of spending on health care nor the percentage of GDP that it represents is conclusive proof that the United States is spending too much on mainstream health services. Nor, as the cellular telephone example demonstrates, is a trend toward even higher spending necessarily evidence of the inappropriateness of that spending. On the contrary, there are many reasons why consumers and the nation as a whole might put large and increasing amounts of scarce resources into health services. It is not easy to refute conclusively the hypothesis that health care is simply a growth industry—like cellular telephones. Also, its increasing claims on GDP over time may reflect only the fact that productivity gains are achieved less easily in providing labor-intensive, one-on-one services such as health care than in manufacturing and distribution. A point less often observed is that, in an increasingly international economy, many manufacturing functions are shifted overseas, leaving fewer goods (and relatively more services) to be produced domestically. In any event, even though it seems probable that the United States is indeed wasting substantial sums on unproductive medical care, the nature of the problem needs to be understood on a deeper level if purchasers and policymakers are to address it intelligently.

Although Americans tend to think of personal health care as a basic

necessity, spending on it appropriately depends on many variables, especially the availability of resources and people's preferences about how those resources should be used. In the Third World acute medical care is a luxury, and basic public health measures and nutrition have a much higher priority. As nations (and individuals) become wealthier, they naturally tend to spend greater percentages of their income on personal health services. Thus, one should not be surprised or alarmed when, as GDP grows, proportionately more of it is allocated to health care. Moreover, because the United States is still richer than other nations, international comparisons, while suggestive, do not confirm conclusively that the United States spends too much on health care. Not only can the United States be expected to spend more, but other nations have government-controlled systems which may be systematically denying their citizens some benefits that Americans desire for themselves.

Other explanations for increasing spending on health services demonstrate, even more convincingly, that the upward trend alone does not signify a fundamental problem. The overall population of the United States is aging, partly as a consequence of past medical successes. In addition to the increasing medical needs of older citizens, the demand for health care has increased in recent years due to three severe epidemics—AIDS, drug abuse, and violence. Also, environmental hazards may be taking an increasing toll. Such changes in market demand for medical care explain much of the increased spending on health services witnessed year after year and should temper condemnation of the upward trend.

Perhaps the most important factor contributing to continual increases in health care spending is the proliferation of new medical technologies. Just as modern technology is yielding dramatic breakthroughs in other areas, biomedical research makes each year's health care significantly different from that offered the previous year. Thus, price and cost comparisons quickly become meaningless. Indeed, the nation is buying, not an unchanging product called 'health care,' but really a rapidly changing mix of discrete services. Although it is possible to question the desirability of some new technologies, many of these technologies enormously benefit patients. Without further detailed research, one cannot conclude that spending on new technologies is out of control or that cost increases attributable to them represent poor societal or personal investments.

Because health care costs may naturally rise faster than other components of the cost of living, one cannot readily dismiss the argument that growth in the health care sector reflects simply consumer needs and preferences for greater, improved medical care. It is possible of course—indeed, it is probably the case, for reasons that will eventually appear—that there is a great deal of inefficiency and inappropriate spending embedded in the base from which the health care industry grows each year. Yet it is cost increases, not the attained level or the character of spending, that occasion most of the complaints and most of the political pressure for government intervention to control costs. Indeed, even if all spending were undeniably appropriate, the complaints
about rising costs might still be as vociferous. Conversely, if costs were stabilized, there might be no overt complaints even if the industry wasted a significant portion of its GDP share on activities which yielded too few benefits to justify the costs incurred.

What political figures identify as a severe national problem may therefore not be a significant problem at all from the standpoint of aggregate social welfare. It is quite possible, for example, that those who complain the loudest about rising health care costs—government officials and employers—are special pleaders whose complaints, reflecting mostly their own difficulty in paying the increasing costs of established programs, misrepresent the situation of society as a whole. Health care entitlement programs, for example, offer politicians highly stressful options—either increase taxes without anything new to show the voters or reduce the entitlement in some way. It is no wonder that politicians think that health care cost increases should be controlled or rolled back, especially if the politicians hope to introduce, and take political credit for, new programs to ensure universal access. But cost-control measures designed merely to satisfy such concerns could easily be inappropriate or unfair. Therefore, an independent view of the nature and source of whatever malfunctions occur in the market for health care should be developed.

II. Too Much of a Good Thing?

It is not as easy as one might think to confirm with direct evidence the conventional belief that the nation is spending too much on mainstream medical care. There is a great deal of essentially anecdotal evidence of large amounts of inappropriate spending. For example, researchers at The RAND Corporation examined the use of certain surgical procedures and, using very liberal criteria of appropriateness,

concluded that 17 percent of coronary angiographies, 17 percent of endoscopies, and 32 percent of endarterectomies represented inappropriate overuse. In addition, we considered that the use of the procedure was equivocal (i.e., the health benefit and risk were approximately equal) in 9, 11, and 32 percent of the procedures, respectively.²

There are similar findings by other researchers concerning other procedures. Extensive evidence of wide variations in the use of particular procedures and in hospitalization rates and lengths of stay for particular conditions are also suggestive that the great majority of people could get by quite satisfactorily with a lot less medical care. However, suggestive evidence is, by definition, not conclusive. In addition, many Americans probably prefer that their doctors err, even at some cost, on the side of doing more rather than less. That preference makes it hard to prove that anything is fundamentally wrong when some questionable services are

provided.

The explanation most often given for wasteful health care spending is the externalization of costs that results from financing care through private health insurance and public programs. Relatively little health care in America is paid for directly and in full by the patient who decides (with a doctor’s advice) to purchase the particular service. Whether the entity actually incurring the cost is a private health insurer, an HMO, or a public financing program, the patient and, in many cases, the treating physician have no appreciable reason to consider whether the benefit of some expenditure, large or small, is likely to be worth its cost. Whenever a person is in a position to spend or risk funds belonging to someone else, he will calculate differently than if the money were his own. Although all forms of insurance create distortions of this variety—the result of what economists call “moral hazard”—health care coverage presents the problem with special force because so much health care spending is essentially discretionary.

The insurance-induced divorce of consumption decisions from the obligation to pay undoubtedly justifies concern that increased spending on health care does not truly reflect the preferences of consumers as to how their money should be spent. Indeed, we have now discovered a possible reason for distinguishing spending on health care from spending on cellular telephones. Consumer decisions to purchase cellular telephones constitute judgments that the purchaser is better off with the telephone than with the money exchanged for it. In contrast, decisions to consume health care rarely signify that the benefit derived from the services purchased exceeds the cost of those services. Here is a possible reason to think that the current market for health care systematically diverts resources from higher-value uses, as judged by consumers in individual transactions. Unfortunately, the issue is not nearly that simple.

A. The Benefit/Cost No Man’s Land

The nature of the challenge posed by health care costs can be appreciated best by seeing the graphic representation in Figure 1. By illustrating the potential targets for attack in the war against excessive spending, Figure 1 is helpful in discovering whether that war is being won or lost on the graphical “battlefield” discussed below.
Figure 1. Targets in the War on Health Care Costs

The "benefits" curve in Figure 1 shows heuristically the probable relationship between the benefits of health care (measured in dollars on the vertical axis) and the inputs needed to obtain them. It is assumed that "inputs" are uniform and that they would be added in a sequence dictated by their ability to yield benefits. Thus, at low input levels the benefits curve rises steeply, reflecting the true miracles of modern medical science. The curve rises more and more gradually, however, as the inputs being added yield either cures at increasingly higher costs or benefits of increasingly equivocal kinds. The curve is flat after point x, as added inputs yield no additional benefit, illustrating the notion of "unnecessary care." (The curve actually falls after point y, showing that some medical care is positively harmful.)

The benefits curve alone cannot reveal where society or any given purchaser should stop adding inputs. Although it is obvious that no care should be purchased beyond point x, efforts directed solely at eliminating purchases past point x would not ensure an efficient level of consumption. For efficiency reasons, costs must be considered. The diagram, therefore, introduces a cost curve, a straight line illustrating the cumulative dollar cost of adding uniform inputs. The critical feature of this line for present purposes is its slope (rate of increase), which is reflected in the dotted parallel line having a point of tangency with the benefits curve at point o. At that point the benefits curve is rising at exactly the same rate as the
cost line. Up to that point the inputs added yield benefits that exceed the costs incurred. Beyond point $o$, however, the benefits obtainable from additional inputs are no longer as great as the cost of those inputs. In other words, marginal costs exceed marginal benefits. $I_o$ then represents—only provisionally, however (for reasons that will shortly appear)—the optimal (efficient) level of inputs, and $C_o$ represents the (provisionally) optimal level of spending.

The first crucial point in this demonstration is that, even though adding inputs and expenditures beyond point $o$ would improve aggregate health, that fact does not justify such additional spending; employing the same resources in other ways, dedicating them to nonhealth purposes, would increase aggregate welfare even more. This conclusion, while theoretically correct, may be hard to accept because of doubts about assigning a dollar value to the health benefits of individuals and trading the health benefits for other things beneficial to other individuals. It is not proposed, however, to utilize this calculus in making social decisions or in rationing care. Instead, the analysis here is offered simply to make the point that it is almost certainly socially wrong—in the sense that it reduces aggregate welfare—to pay for every health service that yields some benefit. This point, however, is the beginning, not the end, of the discussion.

An equally important implication of the foregoing demonstration is the obvious practical difficulty of deciding what specific services to omit and of preventing them from being rendered in particular cases. These difficulties will be encountered by whatever entities attempt the cost containment efforts, whether it be society as a whole acting through government, financing intermediaries, providers of care, or individual patients. To highlight these aspects of the problem we are setting for ourselves, the diagram labels the portion of the benefits curve between point $o$ and point $x$ as the “benefit/cost no man’s land.” In this area health care, being beneficial, will seem desirable as long as the decision maker—public or private, as the case may be—does not consider the true cost of providing it. The potential for conflict is clear. The “no-man’s-land” metaphor seems apt; anyone venturing to fight the battle for cost containment in this range is likely to draw criticism of the most intense kind, including lawsuits. Often in the discussion ahead, there will be occasions to ask whether the cost-containment weapons being used are capable of fighting the battle in the benefit/cost no man’s land. We will discover that virtually all of the cost-containment measures in use today seek to eliminate only “flat-of-the-curve” care and do not take on the more dangerous challenge.

Figure 1 does not prove that an excessive amount of care beyond point $o$ on the benefits curve is actually being rendered or that society is wasting resources on medical care. In fact, it is not possible to know where current spending falls on the benefits curve.\(^3\) Indeed, there is no

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3. For a further elaboration of Figure 1, demonstrating the potential for distortion of consumption patterns introduced by payment systems that cause social and private costs to diverge, see Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-
reason to assume inputs are actually added in the orderly fashion assumed in the diagram. A great deal of highly cost-effective care (to the left of point o) may not be currently provided. One challenge in making provision for the uninsured is to find methods that, while ensuring the provision of all care to the left of point o, protect the public in some measure against paying for care to the right of that point. Thus, the nation's ability to wage war in the no man's land directly affects its ability to guarantee all Americans affordable access to basic care.

With respect to the larger, insured portion of the population, the main challenges lie to the right of point o. It will appear, however, that the battle has been waged primarily to the right of point x. Indeed, it is this circumstance that will finally allow us to conclude that the United States is indeed wasting resources on medical care.

B. Health Insurance: How Much Apparent Inefficiency is Efficient?

In Figure 1, point o was labeled "optimal" on only a provisional basis. Taking that label literally would call into question the entire system of health care financing, which almost inevitably—because of moral hazard—causes a great deal of consumption beyond point o. But even though public financing and private health insurance undeniably contribute to increased societal spending on health services, that fact alone does not establish that society is spending "too much." The inefficiencies apparent in the naive diagram above do not invalidate health insurance as an institution. The vital financial protection that insurance provides may more than justify the higher costs it induces people to incur.

It is important in judging the performance of the health care market to recognize that there are two conflicting objectives: protection of individuals against unpredictable medical costs and efficiency in the allocation of resources to and within the health care sector. Both are desirable goals, but neither can be obtained without some sacrifice of the other. Some overconsumption, therefore, is an inevitable, and therefore tolerable, part of the cost of pooling financial risks. This insight is important in establishing policy. Private insurance and public third-party financing may be efficient even if they cause substantial apparent inefficiency in the market for health services. The search for a reason to fear serious inefficiency in the health care market thus requires a more critical examination of the intermediaries through whom national health care is paid.

In looking for the still elusive evidence that health care costs are in fact out of control, it is necessary to ask whether public and private payers are doing all that efficiency demands to counter the distortions that third-party payment introduces. If they are, it could be strongly argued that no problem exists and that rising spending on health care should be no more alarming than increased spending on cellular technology. If they

offs in Medical Care: The Role of PSROs, 70 NW. U. L. Rev. 6, 17-20 (1975).

4. For a full statement of this rarely appreciated point, see PAUL JOSKOW, Controlling Hospital Costs: The Role of Government Regulation 20-31, 36-43 (1981).
are not, however, we may be on the trail of a final definition of the cost problem as well as on the trail of some solutions.

In theory, there are many things that payers could do to ensure that only economically justified services are rendered at the expense of the common fund and that competitive prices are paid for these services. In practice, however, many of the potential remedies may not be worth undertaking because they cost more than they save or because they produce other unwanted consequences. Nevertheless, at least until recently, the prevalent perception of waste and overspending in the health care system was based, in large part, on a sense that payers were unduly passive or ineffective in confronting their cost-containment task. Therefore, a critical issue is effectiveness and performance of financing intermediaries. Do they have the incentives and the cost-containment tools they need to act as effective agents of their customers or the public in seeking the optimal mix of financial protection, quality care, and administrative safeguards for the funds entrusted to them?

The health care sector experienced some deregulation in the early 1980's, partly in response to policy arguments supporting market reforms, increased competition, and decentralized decision making in health care. Advocates for these policies argued that payers could be activated and empowered to perform the cost-containment task more effectively. Until almost the end of the 1970's, however, health care cost control was considered by nearly everyone as a job for the government. Public regulation was employed to limit the growth of hospitals and the proliferation of unnecessary services; additional types of regulation, most notably federal restrictions on the rate at which hospital revenues could grow, were proposed. During this period it was also generally assumed that government would adopt shortly some form of national health insurance with universal cost controls included. Because government initiatives, actual and proposed, appeared to obviate the need for cost-containment efforts by private purchasers of health care, the private sector—employers and insurers—simply stood around waiting for government to act. Legal obstacles and the medical profession's opposition to many of the promising innovations also prevented third-party payers from assuming the duty of discouraging wasteful spending.

Beginning in the late 1970's, however, federal policy changed dramatically. Stepped-up antitrust enforcement made it more difficult for providers to suppress competition and to resist by collective action cost-control initiatives disliked by providers. In 1979 the Carter Administration's hospital-revenue controls were defeated in Congress, and a spate of bills designed to encourage private-sector initiatives were introduced. The 1980's brought to Washington a new administration that disclaimed any interest in regulating privately financed medical care or in imposing national health insurance. The Reagan Administration did, however, direct its attention to controlling the costs of the federal government's own health care programs. Among other things it stopped paying hospitals on the basis of their costs, allowed Medicare beneficiaries to join HMOs at program expense, and gave state Medicaid programs new freedom to in-
novate in controlling costs. Its policy toward the private sector, on the other hand, was one of benign neglect, on the premise that private health care costs are a private, not a public, responsibility.

As intended, these changes in federal policy triggered significant innovation in health care delivery and financing. Employers, recognizing the need to fend for themselves in cost containment, began to offer more health plan choices to their workers, on the theory that competition would stimulate efficiency. As a result, HMOs enjoyed much faster growth than in the 1970's, when, despite available federal subsidies, regulation kept their costs high and most employers chose to wait for government guidance. Traditional insurers responded to the new competitive pressures by offering opportunities and incentives for consumers to patronize lower-cost "preferred providers." For the first time payers began to contract selectively with providers, steering patients to those who granted price discounts and cooperated in cost-control efforts. New techniques for managing the utilization of services were introduced by payers. The term "managed care" was coined to describe the wide variety of techniques that developed to ensure that, even though price was not a central consideration in the decision to consume services, inappropriate services were not provided. Although trial and error produced some frustrations, it could no longer be said with the same assurance that payers were simply conduits for transferring funds from taxpayers or consumers to providers without appreciable oversight. Thus, the dangers of moral hazard had at least come under attack.

In many people's judgment the policy of relying less on government regulation and more on market forces failed to have the desired effect of controlling costs. Nevertheless, introducing new forms of price competition and utilization management and new incentives for consumers to patronize preferred providers lowered some unit prices and imposed some discipline on providers. Once the gains from these one-time reforms were realized, however, the cost trend resumed its upward course, leaving employers, consumers, and government still frustrated. Nevertheless, it is possible that the new cost-containment tools of the 1980's are now controlling utilization of services to the optimal extent. Until we know otherwise, at least, we cannot conclude that health care costs, while still rising at inconvenient rates, are not under appropriate control.

An ironic development in the health care cost controversy is the recent outcry over the high administrative costs incurred in the United States health care system. A large fraction of these costs are incurred by payers in efforts to bargain with providers and manage utilization. Such efforts, although precisely the kind of cost-containment actions that the policies of the 1980's were designed to stimulate, are necessarily costly. From the complaints being heard today about the magnitude of these costs and the burdens they impose on providers, one could infer that some kind of equilibrium may have been reached and that additional administrative efforts by payers would not yield savings exceeding their costs. Additionally, the market is now relatively open to the formation and growth of integrated health plans—staff-model and group-model
HMOs—which depend for cost control less on enforcing bureaucratic rules against providers and their patients and more on consensus and cooperation among plan physicians. Since consumers have not widely demanded these alternatives to conventional insurance, it may be that they do not find the administrative costs associated with cost-controlling measures instituted by traditional payers to be too high a price to pay for the freedom of choice and more personalized care the traditional fee-for-services arrangement provides.

Under the hypothesis that a certain amount of apparent inefficiency is efficient, it might be claimed that, because payers appear to be doing everything administratively feasible to control costs, the remaining spending on apparently wasteful care (that is, care to the right of point o) is no cause for concern. The current level of spending could be deemed optimal, however, only if payers do indeed have all the tools they need to control costs and if they operate under no inappropriate legal or practical constraints on their freedom of action. In addition, consumers would have to make choices according to proper incentives. Verifying whether these conditions exist, while necessary to establish whether we have a serious policy problem or instead live in the best of all possible worlds, points our inquiry in entirely new directions. Eventually, this study will focus on the legal and practical problems that payers and providers face in trying to find and use the tools necessary to tailor spending to consumers’ pocketbooks. Before zeroing in on these targets, however, it is necessary to focus on a significant problem affecting incentives on the demand side of the market for health coverage. Here we find the first solid basis for concluding that the United States indeed engages in a great deal of unnecessarily wasteful spending on health care.

III. A Taxing Problem?

For many years, federal and state tax laws have allowed employees to escape income and payroll taxes on group health insurance premiums paid on their behalf by their employers. The exclusion of such premiums from taxable income has been a valuable tax break for consumers. More importantly, it has given them a strong inducement to pay as many of their health bills as possible through employer-provided insurance rather than out of pocket. Purchasing in this way allows services to be paid for with untaxed dollars, representing a very large discount—over 40 percent for much of the population—from the cost of paying for the same care from after-tax income. Consumers have therefore purchased health coverage not just for the limited purpose of protecting themselves against catastrophic expenses (the usual object of insurance) but also to receive government help in paying routine health bills.

In taking optimal advantage of this tax scheme, consumers have sub-

stantially overinsured themselves. For example, tax considerations have excessively deterred them from accepting coverage with large deductibles and substantial coinsurance—which would have to be paid with after-tax dollars. The generous coverage thus chosen lacks vital constraints on inappropriate consumption. Furthermore, consumers seeking tax relief have likewise purchased coverage that is much more comprehensive than otherwise would be optimal. By insuring against such relatively predictable and manageable expenses as routine doctor visits and routine dental care, they have appreciably widened the realm in which the moral hazard associated with health insurance holds sway, inviting spending that would not otherwise occur.

The tax subsidy has distorted the nature of health insurance coverage in other ways. Although health plans are employing managed-care techniques more than ever before, they still have good reasons not to control the spending of the funds that consumers entrust to them as rigorously as they otherwise might. Indeed, a dollar saved by an employer’s health plan is nowhere near a dollar earned once the saved dollar is shared with the employees in the form of taxable wages. With incentives for effective cost containment thus systematically diluted, it is certain that payers are doing less than they should be doing—although not necessarily less than their customers want them to do—to offset the effects of moral hazard.

Thus, it is clear that, with unwise, unlimited tax subsidies distorting the design of private health insurance in cost-increasing ways, a great deal of preventable overspending on health care indeed occurs in the United States. In addition to its specific effects on the kinds of insurance people purchase, the tax subsidy has also had adverse consequences of a more general kind. The long experience with employee health benefits used as a tax-favored form of compensation, rather than as essential protection against unbearable risks, has contributed in some measure to the creation of a pervasive entitlement mentality among American consumers of health care. The prevalent attitude which appears to view state-of-the-art medical care—however it evolves and whatever it costs—as a virtual birthright of every citizen severely hampers both public and private actions to address the problems of the health care sector. To the extent that current tax policy has helped to create a political, institutional, and legal climate hostile to economizing on health care, it also has contributed to problems in the health care marketplace that are more fundamental than any we have yet discovered. Certainly, it has made the political task of establishing sensible health policy much more difficult.

Proposals to cap the tax subsidy at an appropriate level have not fared well over the years. (Such a “tax cap” is the most obvious and widely advocated reform idea even though income-related tax credits or vouchers would probably be a wiser and more progressive way to subsidize basic coverage.) The current movement for health reform, however, would seem to offer a new opportunity to correct this fundamental flaw in national health policy. Reform efforts could in one stroke eliminate incentives to overinsure and generate new tax revenues with which to extend
coverage to the uninsured. Nevertheless, even though health insurers and some important business groups recently dropped their previous opposition to limiting the subsidy, consumers still object to “taxing health benefits.” Indeed, most voters probably expect health reform to make it easier, not harder, for them to afford the generous benefits to which they have become accustomed. It therefore remains doubtful whether the tax subsidy will be altered. Moreover, the Clinton administration in its definitive proposal for major health reform failed to address the tax subsidy in a serious way, recommending its repeal (with a substantial lag time for collectively bargained plans) only insofar as it applies to coverage outside the statutory comprehensive benefit package.

If changing the tax subsidy proves politically infeasible, must the nation by necessity then turn to government regulation, global budgets, or other centrally imposed remedies for overspending? What we have uncovered here is a political failure, not a market failure, and it might strike some people as unseemly for government to use its own ineptitude in making tax policy as an excuse for expanding its regulatory authority. Moreover, there is no political reason why the nation should not simply accept the higher spending resulting from an unwise tax policy. After all, people live quite comfortably (literally) with the excess spending that results from heavy tax subsidies for home ownership. The deductibility of home-mortgage interest and the nontaxability of nonmonetary returns from investments in owner-occupied dwellings, although offset somewhat by local property taxes, divert substantial resources from higher-valued uses to overly spacious and lavish housing, yet no move has been made to curb that overspending by regulatory means. On the contrary, growth in the housing market is universally regarded as a good thing because of the jobs and shelter it creates. It is an interesting question why tax-subsidized growth in the health care sector should not be regarded with similar equanimity.

One thing seems clear: However socially destructive the tax subsidy for private health insurance may be, it is something other than the subsidy itself or its immediate consequences that is causing the current political discontent about the cost of health care in the United States. Indeed, as the case of residential housing tellingly illustrates, a tax subsidy is insidious precisely because, in addition to being an off-budget public expenditure, it can misallocate huge amounts of societal resources yet be entirely painless at the level of individual producers and consumers. Since the affected interests simply adjust their behavior to the incentives created, they have no occasion to complain or call for political attention.

Thus, in the abstract, capping the tax subsidy is a notion that only a “policy wonk” could love, a meritorious policy idea with no natural political constituency. Even so, some important insurer, employer, and provider interests have recently reversed their position and are now actively advocating a tax cap in the current health reform debate. Ironically, their reason for doing so is not unhappiness with the tax subsidy as such. Indeed, they are among its main beneficiaries. Having been forced into a larger political game, however, they have embraced a tax cap as a policy
alternative preferable to other measures that government might take in response to the political pressures it is feeling to "do something" about the high cost of health care. That the tax subsidy itself is not the source of these pressures suggests that people's grievances, and perhaps the cost crisis itself, may have some other root cause. Because any complaints government is hearing from the private sector about the cost of health care may betoken some market failure unconnected to tax policy, it is necessary to look further for evidence that health care costs in the United States are truly out of control, as conventional wisdom would have us believe.

IV. Is Health Care Spending Out of (Purchasers') Control?

Although the tax subsidy undoubtedly induces more inappropriate spending on health care than consumers would tolerate merely as one of the costs of having health insurance, the private sector may be reasonably efficient in controlling for moral hazard after discounting for tax effects. Because many elements of an efficient market are now in place, we must ask whether there is any good nontax reason to doubt that the nation is putting increasing resources into health care—as it is into cellular telephones—simply because people like what they are getting in return. A clue to possible problems may be found in the helplessness that some employers and consumers purport to feel in the face of forces they cannot control. That helplessness and the appeals it induces for political action may betoken a market failure of substantial magnitude. If major purchasers (including government itself, both as an employer and as the sponsor of entitlement programs) feel that they are not in control, the market is unlikely to be functioning well.

Complaints of health care purchasers such as employers and government may reflect, of course, only the special problems they face because of past commitments made to workers and program beneficiaries. In the last analysis, however, some of their frustration may stem from a lack of opportunities to economize in purchasing health care. A possible hypothesis, therefore, is that the nation overspends on health services because the marketplace offers an inadequate range of options to purchasers of all kinds, preventing them from choosing anything other than first-class, state-of-the-art, American-style medical care. Instead of being able to choose among a variety of offerings designed to appeal to persons in different economic circumstances, consumers and taxpayers may be the victims of a kind of tying arrangement under which, in order to obtain vital basic services, they must buy additional, unwanted services as well. Although purchasers of health care can reject some frills and can exclude some categories of service altogether, employers and employees may be unable to respond to the rising cost of health care as they normally respond when other costs increase—by cutting back on the quantity purchased, by making small compromises on content and quality, or by
assuming slightly greater risks. Similarly, when government is forced to make cuts in its health programs, it may have to be arbitrary because it lacks the means to be selective.

Whether health care spending is as voluntary as efficiency would require is ultimately an empirical question. There is at least some factual support, however, for the hypothesis that the United States health care system offers only a kind of Hobson's choice, requiring consumers either to purchase some version of a health care Cadillac or to take their chances with the safety net that more or less exists for those without health insurance. Whereas most people simply pay the price of one of the Cadillac models available in the marketplace, a large number of people have chosen to go without health coverage. These people appear to be some evidence that the market has failed to meet consumer demand for low-cost care. Government's long-standing unwillingness to finance universal coverage is also, in part, a function of the market's lack of low-cost options—which, however inadequate they might seem in the abstract, would certainly be preferable to no coverage at all. The widely discussed recent effort to design a package of basic benefits in the State of Oregon illustrates strikingly both the market's lack of models for bare-bones coverage and the need for economizing tools capable of putting resources to their best uses.

The exact nature of the market's apparent failure in offering economizing options can be forcefully demonstrated by referring again to Figure 1. Recall that no consumption to the right of point o in that diagram can be justified solely on the basis of the medical benefit derived. (After point o, derived from the slope of the cost curve, the benefits of adding inputs are less than the cost of those inputs.) Most spending beyond point o is thus an artifact, not of the strength of people's preferences, but of the moral hazard associated with health insurance. All such care is therefore a legitimate potential target for cost-containment efforts.

Recall also, however, that some care falling to the right of point o in Figure 1 may be (despite its inappropriateness in benefit/cost terms) a necessary cost of the valuable financial protection that health insurance provides. Because the costs that would have to be incurred to prevent or deter such spending would in many cases exceed the net saving, it would often be better—i.e., more efficient—to incur the costs of such marginally beneficial care than to attempt to eradicate it. Nevertheless, all health

6. An especially poignant indication of the inefficient kinds of economizing in which people have been forced to engage is the inadequacy of most employees' employment-based coverage with respect to renewability and portability. Forced to pay a high price for short-term benefits, employees have accepted large risks with respect to their future care. Although much has been made in the current reform debate of the insecurities of current coverage, the reasons why employees have not voluntarily obtained more reliable protection have not been fully explored. The argument here is that consumers have been restricted by law and circumstance in the kinds of economizing they can undertake, forcing them to economize in inefficient ways.

services falling to the right of point o should be regarded as legitimate targets for economizing efforts if a health plan can devise cost-effective means to attack them. Indeed, if health plans are not taking such measures, then the market can be judged to be malfunctioning and allocating excessive resources to health care.

Under the plan/subscriber contracts in use today, all health plans (including HMOs) generally commit themselves, explicitly or implicitly, to pay for or provide all care to the left of point x, rather than covering only care up to point o. These contractual undertakings reflect, in part, a natural disinclination to fight the cost battle in the metaphorical benefit/cost no man’s land, where the cost controllers would come under heavy fire—including possible legal liability for denying medically beneficial care. This reluctance to economize even where it would be efficient to do so is partly a consequence of the tax subsidy, which weakens economizing incentives. It is also, however, a consequence of a legal system whose unrealistic expectations of payers and providers artificially raise the costs of economizing in the treacherous territory of benefit/cost trade-offs. Therefore, a real possibility exists that, because consumers are systematically denied desirable opportunities to economize, the market as a whole is failing to control costs optimally.

Many observers might disagree with the hypothesis that the health care market does not offer consumers an adequate range of choice. In their view, employers, particularly self-insured ones, have many options for providing bare-bones coverage to their workers. These skeptics would point to increased use of substantial patient cost sharing and to recent shifts by employers from open-panel fee-for-service plans to closed-panel HMOs in which utilization management, gatekeeper arrangements, and financial incentives are employed to discourage inappropriate spending. Proponents of the managed-competition strategy are among those who are apparently satisfied with the range of cost-containment tools available in the current market. In their view, to facilitate all of the economizing that consumers should want, all that is needed is more of the same—more integration of financing and delivery in cost-conscious HMOs. The Clinton Administration’s proposed Health Security Act reflects a similar premise.8

Many of those who profess not to be concerned about consumers’ lack of choice are not, however, merely making an empirical judgment about the efficacy of the cost-containment tools currently available. Instead, they are making an essentially political judgment that it is not necessary, feasible, or desirable to carry the battle into the benefit/cost no man’s land. For example, Paul Starr, a prominent health policy advisor to President Clinton, has written, “[T]he challenge of health reform is not to persuade the public to give up beneficial care but to reduce the costs that have no benefit, thereby freeing up the resources needed to include

the uninsured within a mainstream standard of health coverage. Other commenters similarly seek voter support for impending reforms by denying that the time for "rationing" health care has arrived. Thus, ethicist Arthur Caplan says, there "are things we can do before we have to talk about rationing." Dr. Paul Ellwood, a sponsor of the original managed-competition proposals, likewise believes that, by focusing on the flat of the curve, "we can avoid or at least delay rationing." Dr. Robert Brook, whose research leads him to believe that as much as a third of the care we consume lies, in effect, beyond point x in Figure 1, thinks "we have at least 10 years before we have to think about rationing."

Other influential observers, including economist Victor Fuchs and Dr. William Schwartz, are more candid, however, and insist on getting away from the any-benefit test that point x symbolizes. Schwartz, for example, identifies specific targets to the left of point x that should, he thinks, be addressed immediately—such as a policy in prescribing magnetic resonance imaging for head injuries which clearly saves an occasional life, but at a cost of about $2 million dollars for each machine. These observers are quite vague, however, about the specific mechanisms that should be deployed to attack targets in the no man's land. Indeed, in virtually all discussions, "rationing" implies some form of government control and at the least an implicit valuation of the lives of individual citizens. It is thus understandable why so few commentators are willing to embrace rationing. The question under consideration here, however, is only whether consumers have, or should be given, better opportunities to economize in purchasing their own care—with whatever subsidies the government provides to ensure that consumers are not forced to make unacceptable choices. Essentially, the question being asked is whether consumers can consent today to accept some limits on their entitlement to marginally beneficial services that they may arguably need tomorrow.

Those who believe that only unnecessary, nonefficacious care should be targeted immediately in the war against health care costs are making a grave miscalculation in at least one respect. The targets they do believe can be attacked immediately will be much harder to attack successfully if the benefit/cost no man's land remains a privileged sanctuary rather than being viewed as a legitimate part of the battlefield. As long as the appropriateness of a service is deemed to turn on whether it has any benefit

12. **Id.**
13. See id.; see also William B. Schwartz, M.D., **The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief**, 257 JAMA 220 (1987) (discussing the need to limit technological innovation or ration beneficial services).
(that is, falls to the left or right of point x) rather than on whether it is likely to be worth its cost (that is, falls to the left or right of point o), the burden of proof in challenging a particular expenditure will be much harder to meet than it should be. Many battles that should be won will be lost—including many battles against spending on the flat of the curve (that is, between point x and point y).

Another reason that some observers give for not worrying about consumers’ economizing opportunities is the doubt that consumers would enroll in health plans that threaten to deny beneficial care. However, this empirical judgment is based on nothing more than consumer behavior in the present market and the assumed immutability of the entitlement mentality apparent in opinion polls and labor/management disputes. There is no empirical basis, however, for skepticism about a policy of capping the tax subsidy, exposing consumers directly to cost burdens now borne by their employers, and ensuring that the market is not artificially prevented from offering an adequate range of choices. Sooner or later, such a policy would induce economizing that consumers may now resist.

Other resistance to expanding consumers’ market options is rooted in a preference for the any-benefit test (point x) as the criterion for making health care choices. Industry interests naturally prefer this liberal standard. Public officials give it at least lip service because they are hesitant to deny, in the face of public opinion, the government’s responsibility to ensure that everything feasible is done for the health of every individual. Most academic observers similarly prefer not to be associated with politically unpopular ideas. In the political world that these influential players inhabit, point x represents moral high ground, a position that conveniently spares them both criticism for being insensitive and the need for long explanations about trade-offs. Yet, despite the safety of overlooking the benefit/cost no man’s land, point x cannot be morally defended, even by using the moral assumptions of those who adhere to it. A policy that puts excessive public and private resources into financing Cadillac-style care for everyone has only symbolic merit. In reality, it is likely to result in the continued neglect of other, more pressing national needs in fields such as education, crime control, environmental protection, and job-creating capital investment. Because the aggregate cost of avoiding cost-containment skirmishes in the benefit/cost no man’s land could possibly exceed one or more whole percentage points of the nation’s GDP, it is irresponsible to deny consumers the means to carry on the battle against wasteful spending wherever the enemy is found.

If we can conclusively establish that the market for health care systematically denies consumers opportunities to economize in reasonable ways, we will finally have a solid basis for concluding that United States health care costs are out of control—in the literal sense of being beyond the influence of those who ultimately pay costs. If a substantial amount of health care spending is in fact involuntary in the sense that consumers (or taxpayers) do not assume the payment burden willingly, then rising societal investments in health care can be distinguished from healthy economic growth. Society could not then reasonably presume—as it does in
the case of cellular telephones and other commodities—that people buying increasing amounts of ever more costly goods and services derive benefits from their purchases at least equal to their outlays, thus justifying the increase in aggregate spending. Having established a solid basis for doubting the dependability of the current health care market as a forum for making crucial trade-offs, we can now proceed to examine more closely the functioning of private contracts—the instruments by which consumers on the demand side of the market might be expected to signal their preferences to those on the supply side. The following discussion will suggest and demonstrate that health care contracts have yet to be put to effective use in the battle against moral hazard and excessive spending.

V. CONTRACT FAILURE IN HEALTH CARE

Ordinarily when purchasers contract for the future delivery of complex goods or services, the sales contract contains detailed specifications of the purchaser’s requirements. Health care contracts, however, do not; contracts between patients and the actual providers of care are usually unwritten and rarely say anything specific about the provider’s undertaking. Even more significantly, subscriber contracts for private health plans employ only the most general terms in defining the services that subscribers are, in effect, purchasing on a prepaid, pre-need basis. Indeed, there appears to be a general assumption—detectable not only in health care contracts but in virtually all thinking about health care in America—that health care is not something that can or should be purchased in measured quantities of agreed-upon quality. Instead, “health care” is apparently viewed, within broad categories, as a familiar, fungible commodity that a purchaser identifies simply by pointing to the shelf on which are stacked the desired products. Thus, health plan subscriber contracts generally define coverage by including (or excluding) services in blocks. These blocks are variously defined by reference to a type of service (e.g., acute hospital services), a particular disease (e.g., temporomandibular joint syndrome), conditions (e.g., mental health care), procedure or therapy (e.g., autologous bone marrow transplants), treatment modality (e.g., outpatient rehabilitation services), or a type of provider (e.g., clinical psychologist services). Public policymakers are also accustomed to using such categorical terms in defining the coverage of public health plans—as if each category were self-explanatory.

Under the health care contracts in use today, the nature, quality, and precise content of the future possible services are generally not defined in the contract itself. Such variables are left instead largely to the discretion of the providers of care and plan administrators, subject to any legal constraints. Indeed, if one judges only from the terms of the actual contracts, providers of care and private health plans enjoy very wide discretion with respect to the quantity and quality of the services they provide and the style and manner in which those services are delivered. This lack of specificity concerning the quantity and quality of services to be provided re-
fects not an inevitable or unavoidable failure of contract as a practical tool, but a set of conventions in the health care industry that lie at the heart of the inability of purchasers to control the cost of the care they are buying. Under these conventions health care providers, individually and collectively, exercise almost exclusive responsibility for defining the entitlements of patients.

Of course, most health plan contracts are more in the nature of insurance policies than contracts for the future delivery of services. The actual function of health care contracts is not to prescribe the services that providers will eventually supply. Instead, it is to curb moral hazard by limiting the services that insureds can purchase at the plan's expense. Yet, today's health plan contracts are crafted to counteract moral hazard only on the fringes of the problem—that is, beyond point x in Figure 1. Thus, they impose few explicit limitations (other than categorical exclusions and limited cost-sharing requirements) on the obligation of the plan to pay for whatever services a physician prescribes. Under the test of "medical necessity," which serves almost universally as the contractual touchstone of plan coverage, the criteria used to check the spending discretion of providers are almost exclusively medical, not economic. Omission of cost considerations from the coverage calculus obviously neglects a principal concern of consumers. More ominously, the medical-necessity test perpetuates the values and preferences of health care providers—to prescribe for patients everything that may be beneficial, and nothing but the best. Thus, today's health plan contracts are generally shaped in accordance with a convention, or paradigm, under which health care is not regarded as a consumer good that people are free to purchase according to their preferences and economic circumstances. Health care contracts are written primarily to create individual entitlements to whatever care providers competently and in good faith prescribe; the contracts simply are never thought of as mutual undertakings by which individuals pool their funds to cover their future health needs and, in so doing, accept reciprocal limitations on their future right to make claims on the common fund.

The shortcomings of today's health care contracts are striking evidence of a failure of societal desire to carry the war against inappropriate spending into the no man's land illustrated in Figure 1. Thus, sanctuary is provided, in the war against excessive spending, to many services that would be indefensible against benefits to costs comparison. Weapons designed for only limited purposes will not succeed against a powerful enemy. The contract failure found in the health care sector today is significant precisely because it reflects explicit or implicit acceptance of medical efficacy alone—the any-benefit test—as the sole criterion for deciding what care should be financed. Economic considerations enter only

15. Even integrated HMOs—the only plans that assume any responsibility for actually providing care rather than merely financing it—make no special contractual commitments about the nature or content of the care they will deliver. Indeed, the subscriber contracts of such HMOs are even less informative with regard to plan policies and practices than the typical health insurance policy.
in the form of a requirement that care be “cost-effective”—no more costly than another equally effective mode of treatment. It should be noted that this economic concession also embodies the any-benefit criterion.

Serious consequences have flowed from the ineffectiveness of health care contracts as instruments either for dictating terms to providers or for combatting moral hazard in the benefit/cost no man’s land. The inadequacy or absence of crucial terms in such contracts has meant that all concerned—patients, providers, plan administrators, and courts—have had to look elsewhere for rules and definitive decisions concerning the specific services to be provided in each case. In the bundle of rights belonging to each consumer of health services, much of the content is, therefore, ultimately established by judges, juries, and medical expert witnesses—arbiters unlikely to share, or implement, consumers’ concerns about costs. As so construed, patients’ entitlements include the right to demand, at little or no direct cost, many health services that are of dubious benefit or marginal value. Another implicitly conferred entitlement is the right—also of questionable value—to obtain legal redress for whatever the law (not the contract) defines as medical malpractice. Instead of serving as instruments of consumer choice and empowerment, health care contracts put consumers and their pocketbooks at the mercy of other actors with agendas of their own.

The adverse cost and legal consequences of inadequate health care contracts have become increasingly serious. With consumers and their agents poorly armed in the fight against overspending, the nation’s physicians, technology suppliers, and hospitals have been free for nearly a generation (certainly since Medicare and Medicaid) to invent and sell ever more costly goods and services with little reference to cost considerations. The nation thus gradually came to incur health care costs now regarded as unbearable. At the same time the courts, myopically misunderstanding consumer welfare, picked up the costly professional standards and customary practices that evolved in the dysfunctional marketplace and used them to define the specific coverage obligations of health plans and to detect substandard care in malpractice suits. The health care industry has thus operated for many years under a legal regime that threatens physicians, hospitals, and health plans with severe sanctions if they are caught violating standards that have increasingly lost touch with economic reality. By drawing its standards from industry custom and professional practice, the legal system has exacerbated waste in a system that was already out of control. In addition to inducing risk-averse doctors to practice “defensive medicine” going beyond even what courts would probably require, the law has also served as a ratchet preventing standards that have gone up from ever coming down. Courts have also impeded reliance on private contracts as a means of escaping the tyranny of inefficient standards.\(^6\)

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16. Professing skepticism about the voluntariness of private contracts by which consumers waive rights they later desire to assert, courts are frequently reluctant to enforce the contracts or to construe them against patients. See Havighurst, supra note 14, at 1765-72,
Because it operates largely under centrally prescribed rather than privately prescribed standards, the health care industry can usefully be thought of as a regulated industry. Whatever one thinks of government regulation in general, public regulators are at least accountable to elected officials and are potentially capable of serving the overall public interest by balancing competing values such as benefits and costs. Unfortunately, the same cannot be said about the regulatory regime under which the health care industry operates. Neither the courts nor the professional sources from which the courts borrow standards are accountable to either voters or consumers. Moreover, courts tend to focus on individual cases, not issues of public policy, and tend to consider only benefits to individuals, not costs to consumers or to the economy as a whole. Although government regulation is often criticized for stemming too much from the interests being regulated, actual industry capture of a regulatory program is presumably exceptional. The health care industry, on the other hand, has been effectively empowered to regulate itself. Under industry conventions strongly supported by the legal system, health care providers have broad powers, both individually and collectively, to decide without substantial cost constraints or effective oversight what services patients should receive. Recent innovations in managed care and utilization management, although significant, do not invalidate these assertions. Without contracts that expressly authorize their cost-control efforts, HMOs and other managed-care plans can economize only sub rosa and not—because of legal constraints—to the full extent that cost-conscious consumers might approve.

For present purposes, the most important consequence of the defective regulatory regime under which the health care industry currently operates is that consumer choice is largely illusory in health care markets. Although the marketplace offers many apparent options, including a variety of managed-care plans, the real range of consumer choice is limited by the need for all plans to conform to ill-considered, often vague, but potentially demanding standards emanating from the same central source—the legal system which borrows standards as necessary from providers themselves. Consumers are thus denied, beyond a certain point, the freedom to benefit themselves by economizing choices. Specifically, they lack opportunities for prospective self-denial—that is, they are not free to contract today to accept voluntarily a degree of health care rationing tomorrow.\(^\text{17}\) Thus, the same consumers who are free to buy small, arguably less safe cars (or used cars or cars without air bags or antilock brakes) cannot make comparable economizing choices in purchasing health care. Unable to save money for other uses by assuming a small degree of risk—risks that would almost certainly be near-negligible, judging from the doubtful value of so much of today's health care spending—purchasers of health coverage face essentially a choice only among

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1783-89.

17. See generally Havighurst, supra note 14 (discussing the principles of and problems associated with consumer choices of health care).
different versions of the same health care Cadillac. Of course, American consumers have always had the option of going without health coverage altogether. The very large number of persons who have made that choice, however, is itself mute testimony to the need for intermediate alternatives.

In sum, the reason for the huge margin by which the United States leads other nations in per-capita health care spending is that its political and legal institutions have given it the worst of both worlds—regulation and the free market. On one hand, the centrally prescribed, legally enforced standards that the nation has allowed to guide health care spending have never been evaluated as public policy or formally adopted as such. On the other hand, the private health plans to which the nation has entrusted great responsibilities have been either unwilling or unable to define effectively by contract private rights and obligations. Not only have the good intentions underlying the medical-legal system's insistence on high standards for everyone undercut the ability of market forces to determine the appropriate level of spending on health service, but the good intentions have tragically impeded efforts to guarantee universal access to health care. The same regulatory system that has priced so many individuals out of the health insurance market has also made prohibitive the cost of providing for those individuals at public expense. Once again, the best has proved to be an enemy of the good.

The obvious implication of the analysis here is that the United States must finally come to terms with its schizophrenic nature and choose which way to go—whether to give more meaningful choices to consumers or to confer upon government all the powers necessary to give the people the health care the government decides is good (enough) for them. Contract failure, even though it has long prevailed in the health care sector, is not necessarily a sufficient reason to introduce heavy-handed public regulation to prescribe or otherwise limit the health care that people can receive. Before adopting a government-dominated, choice-denying remedy for the problems of the health care industry, policymakers should consider whether contract failure might be overcome by a combination of private initiatives and legal change. It is submitted that private contracts offer policymakers a whole new avenue for effecting health care reform.