

LECTURE

THE BACKLASH AGAINST MANAGED HEALTH CARE: HARD POLITICS MAKE BAD POLICY *McDonald-Merrill-Ketcham Lecture**

CLARK C. HAVIGHURST**

And there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old conditions, and lukewarm defenders in those who may do well under the new. This coolness arises partly from fear of the opponents, who have the laws on their side, and partly from the incredulity of men, who do not readily believe in new things until they have had a long experience of them.

Niccolo Machiavelli, *The Prince* (1513)¹

It is now old news that managed health care—once viewed as a highly promising, consumer-friendly movement—has encountered a serious backlash in public opinion.² Although it was predictable that the public would eventually come to question the premises of managed care, I doubt if anyone anticipated a reaction as vehement as the one we have seen. Beginning with an increasing flood of media anecdotes and editorial criticism, it seemed to culminate when movie audiences throughout the country applauded an anti-HMO expletive by the actress Helen Hunt in the 1997 film *As Good As It Gets*. At that point, it became clear that something unusual was going on and that managed care was going to provide an interesting test of the political system.

Although some of the criticism directed at HMOs was fair, cheap shots were

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** William Neal Reynolds Professor of Law, Duke University. A.B., 1955, Princeton University; J.D., 1958, Northwestern University. The author acknowledges with appreciation the comments on an earlier draft of Mark Hall and William M. Sage.

1. Quoted in RAND Corp., 1998 Calendar.

2. See, e.g., Special Issue, *The Managed Care Backlash*, 24 J. HEALTH POL., POL'Y & L. 873 (1999).

very common. Many stories did not warrant even on their face—at least for those who appreciate the problematic nature of many medical decisions and the need to take trade-offs between benefits and costs into account in health care as in other endeavors—the intended implication that health plans were acting irresponsibly in managing resources.³ Journalists were usually quick to play on people's natural concern about their health care without observing the shortcomings the old system of health care financing or the accomplishments of managed care in introducing new rationality and restraint into medical decision making. Significantly, health care's share of the nation's gross domestic product (GDP), after rising steadily at burdensome rates for many years (claiming an additional .37 of a percentage point of GDP, on average, each year from 1980 to 1993), stopped rising altogether in 1993 and remained essentially level at around 13.6 percent for six years, through 1998.⁴ How much of this relief from rising costs was attributable to better management of clinical medicine is debatable,⁵

3. One influential tale peddled by critics of managed care, for example, concerned the Kaiser-Permanente HMO in Atlanta, which sent an infant with a dire condition to a distant hospital for a middle-of-the-night emergency. Yet the sad outcome in that case apparently resulted, not from HMO profiteering at the expense of patient health, but from a simple miscommunication between the child's mother and Kaiser's nurse on the other end of the telephone. Indeed, the muckraking journalist who used a lengthy, heart-wrenching rendition of this story to lead off a book broadly attacking HMOs also revealed (136 pages later, in another connection) how a Colorado phone bank, established to field similar late-night calls to HMOs around the country, handled an identical case within fifteen seconds by instructing the mother to call 911. See GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* 1-13, 149 (1996). To be sure, all systems break down from time to time, but that is no argument against building systems. For every miscommunication like the tragic one in Atlanta, thousands of anxious parents are given help and reassurance in the middle of the night, and emergency rooms are kept clear of unnecessarily worried individuals, enabling them to treat true emergencies faster and better.

4. See Katharine Levit et al., *Health Spending in 1998: Signals of Change*, HEALTH AFF., Jan.-Feb. 2000, at 124, 125 (ending up actually lower in 1998 than in 1993, 13.5 % versus 13.7%). To be sure, GDP itself rose rapidly over this period, easily absorbing the rise in health costs that did occur. But this cause of the apparently improved performance may also be an effect. Thus, the reduction in health care's demands for new resources may itself explain some of the extraordinary growth of the overall economy in the 1990s. The savings from managed care are often denigrated as "one-time savings," and some critics of managed care take satisfaction in noting that employer costs are rising once again. Yet the six-year plateau meant that, even if health care costs now resume their earlier rate of increase (arguably a function of normally increasing demand and the appearance of new, desirable technologies), spending would still be at a lower level than it would have been, representing a recurring saving year after year. Unfortunately, people have a tendency to ask what managed care has done for them lately and not to appreciate its continuing contribution as a check on inefficient spending.

5. See, e.g., Daniel Altman et al., *Enrollee Mix, Treatment Intensity, and Cost in Competing Indemnity and HMO Plans*, NBER WORKING PAPER SERIES (Aug. 2000), at <http://www.nber.org/papers/w7832> (reporting how HMOs serving one pool of public employees in Massachusetts achieved savings almost exclusively by enrolling better risks and paying less to

but managed care was also helpful in other ways, such as in improving the accessibility and continuity of care and in making competition an effective check on providers' fees and charges. Also, despite a concern that many have expressed, no clear evidence demonstrates that HMOs have lowered the overall quality of care.⁶ If the full truth had been told, the managed care story, while not an altogether happy one, would have included more good news than bad.

But, however the benefits and costs of managed care balance out in reality, the fact remains that some very important innovators in the health care system are having an exceedingly rough time in the court of public opinion. These innovators have discovered the truth observed by Machiavelli—that introducing “a new order of things” can be “perilous.” Indeed, Machiavelli’s observation describes quite well where the managed care revolution stands today. Revanchist physician interests (“those who have done well under the old conditions” and “have the laws on their side”⁷), aided by attention-seeking journalists, opportunistic politicians, self-styled consumer advocates, and plaintiffs’ lawyers sensing HMOs’ blood in the water, have mounted what is turning out to be a very effective counter-revolution. On the other hand, consumers (“those who may do well under the new” methods of purchasing health services but “do not readily believe in new things until they have had a long experience of them”) are highly suspicious of managed care and have not rallied to its defense, even as “lukewarm defenders.” Those who advocate carrying the revolution forward—a class limited largely to major employers and the beleaguered managed care industry itself—are finding it hard to resist the counter-revolutionary tide.

In this lecture, I want to suggest why the backlash against managed care is so powerful and why the signals the public is sending to policy makers are misleading as indicators of the true nature of the problems that need somehow to be solved. After demonstrating in a somewhat formal way the likelihood that

providers, not by reducing “treatment intensity”).

6. See R. Adams Dudley et al., *The Impact of Financial Incentives on Quality of Health Care*, 76 MILBANK Q. 649, 673 (1998) (finding “little evidence of any consistent difference in clinical quality between [fee-for-service] and HMOs”); Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, HEALTH AFF., Sept.–Oct. 1997, at 7, 13–14, 20–22. According to these sources, quality improvements in some areas apparently offset adverse effects in a few areas where things are arguably worse (such as treatment of chronic conditions). On the other hand, managed care has not improved quality overall, which it might reasonably have been expected to do—and might do under a different legal regime. See *infra* text accompanying notes 39–43.

7. In suggesting that opponents of HMOs “have the laws on their side,” Machiavelli obviously failed to anticipate the Employment Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 (2000), which, by preempting certain state regulation, has sheltered much useful innovation in purchasing health services that would otherwise have been stifled by state law and associated litigation threats. In all other respects, however, Machiavelli was correct. The legal system generally embodies the professional paradigm of medical care and universally employs professionally developed standards as benchmarks for evaluating HMOs and determining patient entitlements. See *infra* note 19 and accompanying text.

legislators will enact excessive regulatory measures to appease unhappy consumers, I define the public policy challenge as one of finding nonprescriptive ways to enable managed care plans to achieve the legitimacy they so badly need in order to serve consumers well. To this end, I offer some policy suggestions for putting the managed care revolution on a somewhat different and more secure track.

I. MANAGED CARE AND PUBLIC OPINION

Throughout the 1980s, the managed care industry enjoyed something of a honeymoon with the general public. To be sure, occasional public relations problems arose, including the disclosure of the astounding compensation, during that era, of some HMO executives. But the promised cost savings, together with the enthusiasm of both employers and policy wonks, generally obscured the tensions inherent in the concept of managed care. Moreover, the number of consumers enrolled in HMOs was still relatively small, and many of them had enrolled voluntarily and retained the option of returning to the unconstrained fee-for-service system if they were dissatisfied. Under these circumstances, few complaints were heard. Managed care plans naturally came to assume that the public appreciated their efforts and accepted their methods as the wave of the future.

By the mid-1990s, however, the honeymoon was over. Predictably, the romance began to go out of the relationship once the public and the managed care industry had to face the divisive realities of health care economics. As the price gap between managed care and traditional coverage widened, more and more consumers were forced into a managed care plan because of its lower cost to their employers, without appreciating that limitations might be placed on their choices and their doctors' clinical options. Suddenly, managed care horror stories found larger audiences, and the anecdotes began to accumulate. Physicians, to say the least, did nothing to calm patients' fears.

At the same time, consumers had more and more reasons to be nervous about HMOs, as some cost-control efforts began to go beyond merely trimming fat from the edges of the system and started to cut into what might be seen as beneficial care. Initially, reducing health care costs was easy. Plans needed only to use their strategic positions vis-a-vis providers to squeeze provider incomes and to eliminate services that everyone agreed yielded no patient benefit—those undeniably on the “flat of the curve.” In due course, however, pressures from purchasers to keep costs down induced attention to benefit/cost ratios where the numerator was not obviously zero. Health plans thus seemingly began to fight the battle for cost containment in the benefit/cost no-man's land, where anyone trying to control costs is dangerously exposed to sharpshooting journalists, politicians, and trial lawyers.⁸ Indeed, while managed care stabilized health

8. For a graphic illustration of the no-man's land, see CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* 94 (1995); Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role*

care's share of GDP from 1993 to 1998, that stability became harder to maintain each passing year because of the natural tendency of health care costs to rise much faster than GDP. As expensive new technologies and treatment options continued to appear, costs could be kept in line only by imposing increasingly strict constraints. All these factors contributed to gradually increasing consumers' fear that managed care might deny them beneficial care—which they had come to see as their entitlement, whatever the cost.

It is important to ask what precisely is behind consumers' current fears. Does public opinion accurately reflect the true situation? Or is this just another case of spoiled Americans demanding entitlements for which they are not prepared to pay the cost? Most likely, people's fears reflect, more than anything else, a sense that they have had very little say in the process by which the old, reassuring health care system was replaced by something else.⁹ If such a feeling of disempowerment is indeed the source of consumer discontent, then even market-oriented policy makers should be concerned. For if consumers do not feel they have the power to choose a health plan that suits their needs, or if they feel a particular choice has been forced on them, the market cannot be said to be serving its usual democratic function. The market outcome—whatever people find themselves stuck with *ex post*—cannot plausibly be said to be validated, even presumptively, because people had an opportunity to choose *ex ante*. Lacking the legitimacy that choice, deliberately exercised, confers in a democratic system, managed care firms cannot reasonably hope to deflect criticism when their practices cause discontent.

Consumers have several good reasons for feeling disempowered in the current health care marketplace. First, even when they are offered a set of health plan options, they find it is almost impossible to distinguish between them, to know how responsive and generous each plan intends to be when a health need arises.¹⁰ Thus, it is difficult for consumers to shop for a plan that reflects their personal trade-off between the quality and cost of coverage. Today, all health plan contracts promise that the plan will pay for, or provide, all “medically necessary” care, but contemplate that the plan itself will decide just what is “necessary” in a particular situation. In 1995, I published a book suggesting the

of PSROs, 70 NW. U. L. REV. 6, 16-17 (1975) (providing same diagram with fuller elaboration).

9. See Atul A. Gawande et al., *Does Dissatisfaction with Health Plans Stem from Having No Choices?*, HEALTH AFF., Sept.-Oct. 1998, at 184 (finding substantial correlation between dissatisfaction and lack of choice); Beiyao Zheng et al., *Patients' Trust in Health Insurers: Development of an Insurer Trust Scale*, HEALTH SERV. RES. (forthcoming 2001).

10. A complexity is added by the adverse selection that can occur when a patient with a specific health need seeks the plan that provides the most generous coverage for that need. Rather than arming consumers with the ability to shop to meet a specific need, the goal should be to offer clear choices between more and less generous plans. The adverse selection problem can be ameliorated by, among other things, allowing plans to limit their coverage of “pre-existing conditions”—reserving, for example, the right, for a period of time, to invoke contractual limits in a new subscriber's previous health plan, thus discouraging consumers from upgrading their coverage as soon a specific health need arises.

rewriting of health care contracts so that they would actually tell the consumer something useful about what he could expect from his health plan and so that their terms could be enforced with some precision against one party or the other if an issue arose.¹¹ As long as contracts remain as opaque as they are today, consumers will feel unable to make informed decisions, and they will not readily accept the consequences of their choices.

Another reason consumers feel disempowered in today's health care marketplace is that most receive health benefits through their employers rather than by purchasing a plan for themselves. Group purchasing makes sense in many respects, and employers are reasonably effective agents for consumers seeking coverage. But employment groups are not the only vehicles by which individuals might obtain group health benefits. One can imagine, for example, individuals buying health care coverage through such intermediaries as professional or fraternal groups, churches, unions, or purchasing cooperatives. Indeed, it is only because the generous federal tax subsidy for health coverage applies only when coverage is purchased through an employment group that nearly all employed Americans get whatever coverage they have by that route. If the tax subsidy were made available in a different form (perhaps as a credit for coverage purchased by any means), consumers would have less reason to feel oppressed by choices made by their employers.¹²

Consumers' dissatisfaction with health coverage purchased through employment groups can be further understood as an especially troublesome instance of a significant difficulty encountered in most collective decision making. In any collectivity, some individuals' preferences will diverge significantly from the group norm. Some will be forced by a group purchasing decision to pay more than they would choose to pay for the good or service in question, while others will receive less of the collectively provided item, or lower quality, than they would willingly pay for. Some degree of unhappiness is therefore inevitable. In the case of employer-purchased group health coverage, however, people who in fact are paying more than they would choose to pay are not likely to complain because they are unaware how much they are paying or how costlier coverage affects their take-home pay.¹³ On the other hand, those who sense they are receiving less health protection than they desire *can* be expected to complain. Moreover, in addition to those prepared to pay for Cadillac coverage and fearing they are getting something less, there is another

11. See HAVIGHURST, *supra* note 8 (arguing that, although the difficulty is undeniable, better contracts could be written and probably would be if judges were more even-handed in interpreting and enforcing contracts that are less generous than they would like them to be).

12. See Stuart Butler & David B. Kendall, *Expanding Access and Choice for Health Care Consumers Through Tax Reform*, HEALTH AFF., Nov.-Dec. 1999, at 45; Mark Pauly et al., *Individual Versus Job-based Health Insurance: Weighing the Pros and Cons*, HEALTH AFF., Nov.-Dec. 1999, at 28; see also *infra* note 25.

13. It is common knowledge among economists that the cost of fringe benefits falls mostly on employees, not employers. See Linda J. Blumberg, *Who Pays for Employer-sponsored Health Insurance?*, HEALTH AFF., Nov.-Dec. 1999, at 58.

group of complainers—probably a very large one—who feel their coverage is less than ideal but who would not in fact be willing to pay the higher price of better coverage. These latter malcontents cannot see, and thus do not appreciate, the substantial cost savings they have derived from managed care—which accrue to them, unlabeled, in larger paychecks. Instead, they see only what they fear (with or without a substantial basis in fact) is a drastic diminution in the health coverage they previously enjoyed. As typical Americans, a substantial number of them will think they are being shortchanged. And there are plenty of people (physicians, consumer advocates, politicians, and journalists) who will encourage them in that belief.

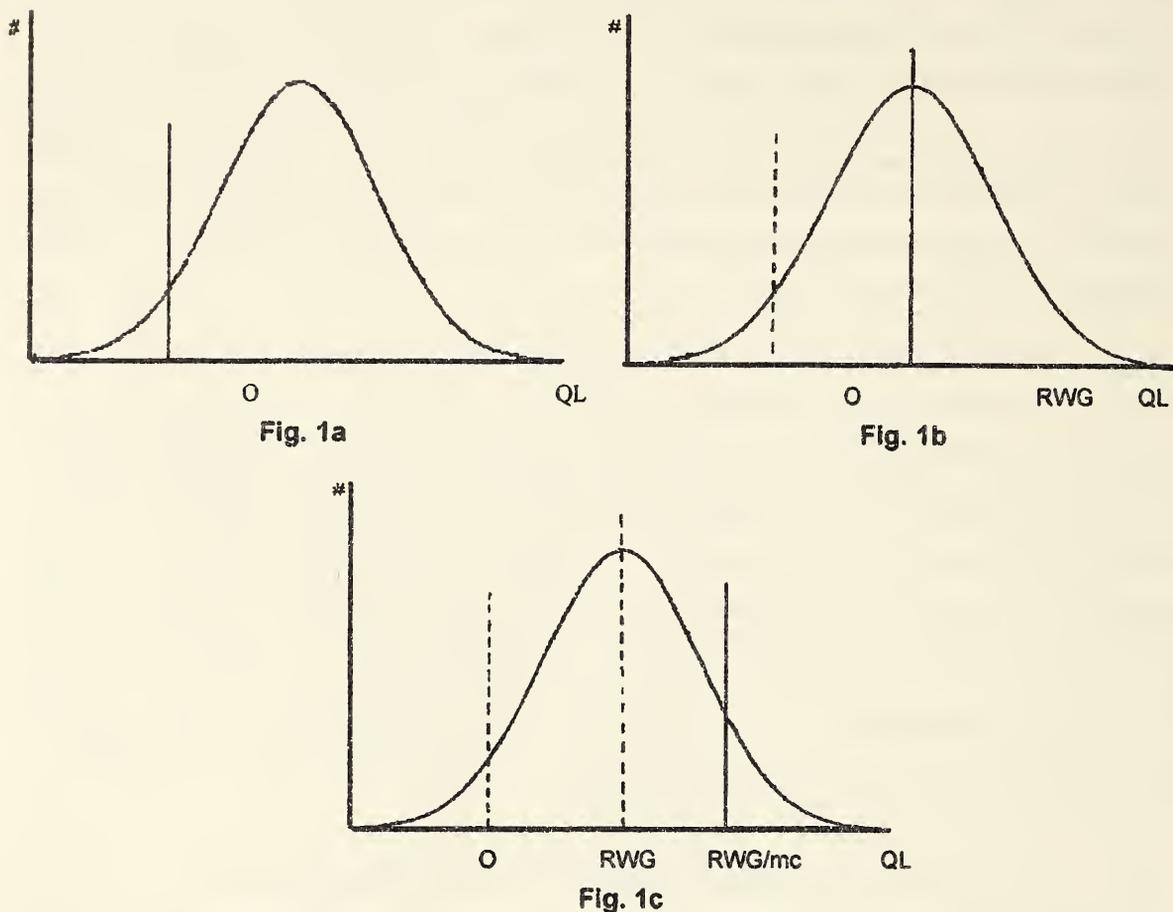
The latter two groups of dissatisfied consumers—both those willing to pay more but denied the opportunity and those who feel entitled to Cadillac coverage even though they are not prepared to pay for it—focus their grievances on the poor managed care plan or on the employer who opted for managed care in providing self-insured coverage. More importantly, these disgruntled consumers are also contributing to the strong political pressure on legislatures and other arms of government (from state attorneys general to insurance commissioners to courts) to “do something” about managed care. This pressure reflects not only well-founded consumer dissatisfaction but also grievances arising only from consumers’ poor information, unrealistic expectations, and lack of direct involvement in purchasing their own health care. Government’s most natural response to this backlash is to impose new regulatory burdens—overregulation—on HMOs and other managed care entities.

II. THE POLITICAL ECONOMY OF MANAGED CARE REFORM

The current pressure on government to dictate generous terms and costly administrative requirements for private health coverage is heightened by the same kinds of problems in collective decision making that I have identified as a source of discontent over employer-financed health coverage. Once again, the costs of the choices to be made—in this case by legislators or regulators rather than employers—are effectively hidden from the voters, who as consumers must ultimately pay them. In addition, any collective decision will inevitably, just as in the employment setting, override the preferences of many members of the group—in this case the polity itself. Those who would be ill-served by the regulatory choice include both those wanting to buy economical coverage of the kind that regulation would preclude and those wanting even stricter regulation—to reduce or eliminate the risk that any health coverage they (or their employer) might purchase would be below the level of quality they desire. As in the case of employer-purchased coverage, the preferences of consumer-voters will be distorted by their poor awareness of what incremental improvements in health coverage actually cost.

A simple model can illustrate the pernicious potential of collective decisions affecting, directly or indirectly, the quality of health coverage—that is, its scope, generosity, and dependability. Consider the bell curve pictured in Figure 1.

Figure 1. The Distribution of Quality in an Unregulated Market and Some Regulatory Possibilities



This bell curve hypothetically illustrates the number of units (x-axis) of each level of quality (y-axis) that consumers of any product might choose (with good information) to purchase in an unregulated market—high quality (BMW's) to the right, lower quality (Yugos) to the left. Regulation can be seen as eliminating certain low-quality options from the market—everything to the left of the line drawn at point *o* in Figure 1a, for example. There is, in theory, an optimal cut-off point below which some consumers could appropriately be denied their first choice. Thus, the line at point *o* might be the regulatory standard under which the aggregate savings to all consumers, both from (1) reducing their costs in searching the market (to avoid making an erroneous purchase) and (2) preventing the occasional injuries that low-cost products would cause, would most exceed the costs attributable to regulation. The costs of regulation that must be compared to its benefits include not only the administrative costs of the regulatory program itself but also the costs to those consumers who are forced to pay more than they would have chosen to pay. More ominously, an additional cost of regulation must also be counted—namely, the adverse consequences to those consumers who, instead of paying the higher price, choose to forgo the item altogether. One study of occupational licensure, for example, showed that setting minimum standards for licensing electricians caused an increase in the number

of accidental electrocutions—as some do-it-yourselfers paid the ultimate price.¹⁴ All these costs of regulation need to be taken seriously, since they may easily outweigh the gains from ensuring that no goods or services of a quality below the regulatory floor are delivered.

Even though it is possible to set as a point *o* a regulatory minimum standard under which consumers in the aggregate would enjoy a net welfare gain, that fact alone does not justify such standard-setting, command-and-control regulation. One must also consider whether real-world governments can be expected to choose anything close to the optimal cut-off point on the bell curve. Unfortunately, it is likely, even predictable, that the cut-off actually chosen by democratic government would be close to the standard signified by the line drawn at point *RWG* (for “real-world government”) in Figure 1b. The reason, obviously, is that, at least in democratic theory, the majority rules. Specifically, the political majority of would-be purchasers to the right of point *RWG*—persons who prefer (and are able to pay for) high quality—would almost certainly demand a higher regulatory cut-off than would be optimal, thus saving themselves even more search and other costs than they would save if the regulatory standard was set at point *o*. Indeed, there are reasons why the standard actually set might be higher still. Consumers on the right-hand side of the preference distribution are, after all, the most aware, affluent, influential, and politically active members of the population in addition to being well represented in the media and in policy-making elites. There would also undoubtedly be, in most cases, politically influential industry or professional groups that also prefer, and can fight effectively for, high standards as a way of increasing demand for their services and eliminating low-cost competitors.¹⁵ Even if other interest groups provide some countervailing pressure against high regulatory standards, the coalition of upper-middle-class voters and other special interests pressing for such standards may be powerful indeed.

Now let us look at Figure 1 in light of the managed care debate itself to see

14. See Sidney L. Carroll & Robert J. Gaston, *Occupational Restrictions and the Quality of Service Received*, 47 SO. ECON. J. 959, 965 (1981).

15. Although professional influences are usually blamed for excesses in occupational licensing, a classic 1963 article on medical economics observes as follows:

The general uncertainty about the prospects of medical treatment is socially handled by rigid entry [i.e., physician licensing] requirements. These are designed to reduce the uncertainty in the mind of the consumer as to the quality of product insofar as this is possible. I think this explanation, which is perhaps the naive one, is much more tenable than any idea of a [medical] monopoly seeking to increase incomes. No doubt restriction on entry is desirable from the point of view of the existing physicians, but the public pressure needed to achieve the restriction must come from deeper causes.

Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 966 (1963) (citation omitted). See also *id.* at 953 (“[I]t would usually happen in a competitive market that many qualities will be offered on the market, at suitably varying prices, to appeal to different tastes and incomes. Both the licensing laws and the standards of medical-school training have limited the possibilities of alternative qualities of medical care.”).

why the threat of overregulation of managed care by “RWGs” is especially severe. We have already seen that the middle-class majority is actively demanding regulatory protection against what they perceive (mostly misguidedly) to be poor-quality health coverage. Many of these voters are apt to believe that the cost of the coverage they wish to have guaranteed by regulation will be paid by their employers rather than themselves. It is therefore possible, even probable, that the regulatory line that upper-middle-class voters (with strong support from the medical profession and other supply-side interests) would encourage legislatures to draw would be well to the right of even the already inefficient point *RWG*. Indeed, because these dynamics have been at work for a long time, existing law and regulation (and the powerful litigation threats associated with them) probably already put a supermajority of consumers in a position where, without realizing it, they are forced by law, and by the professional standards of practice that the law incorporates,¹⁶ to pay for much more and more costly health care than they would purchase if they had clear and meaningful choices and were spending their own money (even with appropriate public subsidies). There is thus good reason to believe that managed care and personal health care generally are already being regulated even more inefficiently than is “normal” for RWGs, which will in any event tend to set high regulatory standards to suit upper-middle-class consumers and professional interests, leaving the lower-income minority to fend for themselves. The recent political backlash against managed care threatens to push RWGs to raise regulatory standards further still—to, say, the line drawn at point *RWG/mc* in Figure 1c.

Perhaps the most suggestive evidence for my claim that health care law and regulation have already drawn prescriptive lines well beyond even the line at point *RWG* in Figure 1b is that the level of spending on health care in the United States, even after stabilizing for several years after 1993, still exceeds spending in any other nation by several whole percentage points of GDP.¹⁷ With U.S. GDP approaching \$10 trillion, each of these three or four percentage points represents nearly \$100 billion in arguable overspending. Moreover, the absence in the United States of universal health insurance comparable to that found in other nations further underscores how the United States disproportionately allocates resources to providing mainstream health care for the middle class. As I have tried to show, the content, intensity, and cost of this care are dictated less by true consumer preferences than by legal and regulatory standards favored by upper-middle-class voters and professional interests. Although advocates of still more regulation can usually claim that their new prescriptions will not cost the public very much, they are counting only the incremental costs that the new rules would lay on top of costs already mandated by pervasive overregulation. It is

16. For observations and materials relating to professional standards as (costly) legal standards, see CLARK C. HAVIGHURST ET AL., *HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS* 191-204, 999-1070, 1228-38 (discussing malpractice law and coverage issues) (2d ed. 1998). See also HAVIGHURST, *supra* note 8, at 111-17.

17. See Gerard F. Anderson & Jean-Pierre Poullier, *Health Spending, Access, and Outcomes: Trends in Industrialized Countries*, *HEALTH AFF.*, May-June 1999, at 178.

remarkable how little political or academic concern is expressed about the possibility that the nation is misallocating hundreds of billions of dollars each year to health care at the expense of people's other needs and aggregate welfare.¹⁸

Advocates of regulation also never seem to recognize the impact of their proposals, or of the heavy expectations already built into American law and regulation, on the more than forty million Americans who lack any form of health coverage. Like regulating electricians, however, using regulation to marginally improve the services the political majority can expect to receive from managed care plans can have disastrous consequences for those who find it difficult to provide for their families.¹⁹ Moreover, in addition to putting the cost of health coverage out of reach for many citizens, overregulation also effectively precludes public provision of a universal entitlement. The well-off majority, content with their own high-quality care, have long proved themselves unwilling to be taxed at the level necessary to finance an entitlement to similar care for the millions who lack it. An unfortunate feature of American health policy is that the people who most bemoan the plight of the uninsured are also apt to insist on maintaining the high regulatory standards that make it politically impossible to finance a basic entitlement for all. Even if these advocates are personally prepared to pay substantial taxes to finance the same high-quality coverage for everyone, their twin commitment to both ideals—high standards and egalitarianism—does them no credit if, because it is politically impossible to realize both ideals, many lower-income people are left with no coverage at all.

18. See HAVIGHURST, *supra* note 8, at 91-92:

[I]t is cost increases, not the attained level or character of spending, that occasion most complaints and most political pressures for government intervention to control costs. Even if all spending were undeniably appropriate, the complaints about rising costs might be no less loud. Conversely, if costs were stabilized, there might be no overt complaints, even if the industry were wasting a significant portion of [the nation's] GDP on activities yielding too few benefits to justify their costs.

19. See the following observation by Judge Richard Posner, dissenting from a denial of a hearing en banc in *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), an ERISA preemption case allowing a state to require HMOs to provide reviews by independent physicians of the plan's coverage denials:

The Illinois law thus adds heavy new procedural burdens to ERISA plans. These burdens do not come without cost. The expense of an arbitration by the independent physician could easily equal the expense of the medical treatment that the HMO had refused to authorize. Piling on costs in the administration of ERISA plans will shrink benefits and deter some employers from offering health insurance at all. In addition, the Illinois law obviously is intended (responding to the recent torrent of criticisms of HMOs) to tilt the administration of those plans in favor of participants by giving them an additional remedy

Id. at 173-74. Note that Judge Posner focuses only on the administrative costs of the regulatory requirement and not on its delegation of final responsibility to medical professionals having no responsibility for the cost of the coverage they are in a position to mandate.

The burdensome impact of majoritarian overregulation of the health care sector on citizens whose circumstances and preferences are illustrated by the left-hand portion of the bell curve in Figure 1 does not stop with the uninsured. After all, when individuals accept employment without health coverage as a fringe benefit, they have in some sense made a market choice to take their full compensation in cash (and their chances with respect to health care). On the other hand, those who choose employment that does carry health benefits, although they may make the rest of us feel better, are not themselves necessarily any better off than the uninsured. Instead, they are likely to be sacrificing many other good things of life in order to pay for coverage that, because of either employer choice or law and regulation, is substantially more costly than adequate health coverage has to be.

To appreciate the magnitude of the burden that upper-middle-class health coverage places on low-income employees, consider the example of my own employer. At Duke University, an hourly-paid worker earning \$30,000 a year can obtain health coverage that costs, nominally at least, \$6535 for a family (that is, \$545 each month or eighteen percent of the worker's total pretax compensation, excluding other fringe benefits).²⁰ Although even more costly options are available, Duke employees do not have the opportunity to spend any less on health care and take the full savings in increased take-home pay. Most low-income employees therefore accept health benefits that were designed principally to meet the needs of the university's faculty and administrators. The situation at Duke is in many respects a microcosm of the national situation, in which regulatory prescriptions, professional standards, tax subsidies, and employer-dictated terms of coverage all ensure that health plans are designed to suit the preferences of the privileged minority and the interests of health care providers, thereby denying ordinary people the freedom to spend their limited incomes in ways that maximize their welfare.

There is a final insult added to this injury. Even though high standards set by law and contract appear to benefit all health plan enrollees equally, equal entitlement does not guarantee equitable allocation of benefits. Indeed, regressive cross subsidies would result if more educated, articulate, and demanding upper middle class enrollees consistently obtained more and better services than lower-income persons paying the same premiums.²¹ Although there

20. This is the sum of the employee's monthly payroll deduction and what Duke quotes as its own contribution. For a younger worker at least, this quoted cost is somewhat overstated, both as an actuarial matter and in terms of the wages the employee actually forgoes in order to have health coverage. See Pauly et al., *supra* note 12, at 32 (citing research showing that some younger individuals switching to employment without health coverage did not receive compensating increases in their wages equal to the per-employee cost of the first employer's coverage).

21. Some years ago, Duke merged its health plan for its hourly personnel with its plan for faculty and staff. Although this was generally perceived as a progressive move, its effect, ironically, was to lower premiums for the latter employees and increase the premiums for hourly workers. Obviously, the high utilizers in the faculty-staff plan enjoyed a windfall at the expense of the lower-paid employees, a situation that may continue unrecognized to this day.

appear to be no studies establishing whether inequity of this precise kind is pervasive under managed care, it seems likely that any system can be “worked” better by some patients than by others. Moreover, some of the inequities that have been observed in medical care are consistent with the hypothesis that physicians and administrators, rather than distributing services strictly according to patients’ medical needs, systematically treat some patients as more equal than others.²² Although commentators usually attribute any inequity to racism or intentional discrimination against low-income persons, unfairness in the allocation of funds pooled by consumers to pay for health services might result simply from a natural tendency to accommodate the expectations of individual patients—higher or lower, expressed or perceived, as the case may be.²³ In any event, any greater ability of higher-income individuals to get more out of their health plans than ordinary people do exacerbates the inequity previously observed in the limitations placed by law and regulation on the health care options of low-income consumers.

Observe again how political elites keep the cards stacked against the low-income consumer. Politicians, journalists, lawyers, and academic observers can all be expected to blame the system whenever discrimination of any kind comes to light and to advocate strong legal sanctions and regulatory controls to eliminate it. An obvious alternative to enforced egalitarianism, however, would be to offer those consumers who can expect to receive fewer services from their health plans (whether by their own preference or otherwise) the option of joining a cheaper plan—one whose premiums do not reflect the greater, or more effective, demands of other participants. But the elites who influence health policy have a stake in maintaining egalitarian appearances. Most of them, after all, are high-income employees of large employers and confident of their own ability to manipulate their own health plans and physicians.²⁴ Their interests help

22. See Stuart E. Sheifer et al., *Race and Sex Differences in the Management of Coronary Artery Disease*, 139 AM. HEART J. 848 (2000). This review of earlier studies attributes inequitable treatment of racial minorities to a combination of socioeconomic differences, black patients’ greater reluctance to undergo cardiac procedures, and a residue of racial bias.

23. Legal fears may also induce treatment and coverage decisions resulting in higher-income patients receiving a disproportionate share of services at the group’s expense, simply because they are perceived as being more likely to assert legal rights. Far from correcting for this problem, the legal system may even frustrate efforts by health plans to resist paying for services demanded by especially assertive patients. For a notable instance in which state regulation and a federal court, giving effect to a litigious patient’s exceptional demands, forced an HMO to pay for an expensive treatment that few other plan enrollees could have obtained for the same medical condition, see *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000) (patient found out-of-state provider of costly, unusual treatment, paid nearly \$100,000 for it out of pocket, and eventually got external reviewer to approve coverage).

24. That elite observers support only ostensible egalitarianism is obvious in the objections they raise whenever a managed care plan resists an individual patient seeking arguably desirable services. Critics of managed care virtually never acknowledge that a plan may be merely seeking to ensure that the pool of premiums it administers is allocated in a truly egalitarian manner.

to explain why the political system remains wedded to providing health coverage primarily through regressive tax subsidies,²⁵ employment-based groups, and highly regulated health plans, all mechanisms through which the expensive tastes of upper middle class consumers are invisibly subsidized by persons with either lower expectations or less ability to command attention to their health problems.

It is not uncommon to discover situations in which the best is the enemy of the good. In this case, however, it is the best and the brightest—a political and policy-making elite—who are the enemies of the common (man's) good. It is especially objectionable for academic experts and self-styled "consumer advocates" claiming to represent the interests of all consumers to support the use of the judicial system and state power to deny fellow citizens alternative kinds of health care that would better meet their respective needs—not only for health care but for other things as well. To satisfy their own needs (including their need to demonstrate their symbolic aspirations for others), the political majority, other special interests, and elite movers and shakers of health policy are content to design things so that lower-income consumers have only a Hobson's choice—either pay the high cost of upper-middle-class medical care or go without any health coverage at all.

III. STRATEGIES FOR LEGITIMIZING MANAGED CARE PLANS AND THEIR CONTRACTS WITH CONSUMERS

This is not the place to review specific regulatory proposals before Congress and state legislatures. Although many of them seem reasonable enough and not especially onerous on their face, I have just presented reasons to believe we are already well beyond the point where there is much chance that *any* additional prescriptive regulation is cost-justified even for the average consumer. Nevertheless, there is an arguable need for Congress to close some loopholes created by the Employee Retirement Income Security Act of 1974 (ERISA).²⁶ Not only has ERISA been construed, under some circumstances, to exempt managed care organizations from state law and regulation, but it supplies little consumer protection of its own in the area of health benefits. It is notable for present purposes that the 106th Congress failed to enact a so-called "patient's bill of rights" because a joint conference committee could not reconcile the House- and Senate-passed versions of the long-promised legislation. It is ironic that,

25. Because exclusions from taxable income are more valuable to persons in higher tax brackets, they can be seen as regressive in their effect on tax burdens. The more important observation for present purposes, however, is that, in its present form, the tax subsidy reduces disproportionately the resistance of higher-income persons to spending marginal dollars on health coverage. To the extent that the preferences of these individuals influence employers to choose more costly coverage, lower-income persons are burdened further still. Although these effects are softened by the exclusion's effect of reducing payroll as well as income taxes paid by lower-wage workers, the tax system still appears to add to the pressure on employers to select costlier coverage than lower-income persons would choose for themselves.

26. See 29 U.S.C. § 1001 (2000).

despite all the political reasons for expecting Congress to add to HMOs' regulatory burdens in 2000, election-year politics prevented it. Just when many Republicans were concluding that they could enhance their re-election prospects by agreeing on a bill, their Democrat counterparts were becoming increasingly uncompromising, seeing a greater political advantage in running against Republicans on an anti-HMO platform than in finally passing a law. Compromise was also inhibited, no doubt, because both sides could see lucrative fund-raising possibilities in keeping the issue alive for another year. (So much for predicting imminent political outcomes on the basis of simple models like Figure 1.)

In any event, the new Congress, which is even more closely divided than the last one, will again seek a way to deal with the crisis in managed care. Fortunately, promising alternative strategies exist, besides more government prescription and micro-management, for putting the derailed managed care revolution on an appropriate track. Although at the outset of these remarks I observed some of the managed care industry's arguable successes, managed care has generally failed in its mission to offer consumers, even within the limits of existing law and regulation, an appealing variety of arrangements for obtaining reliable health care of appropriate quality at proportionately varying cost. Congress, therefore, faces a serious problem of public policy, not just the political problem I have described. The heart of this policy problem, however, no less than the political one, is the crisis in public confidence in managed care, which has significantly delegitimized even responsible and lawful efforts by health plans to rationalize spending on health services. So the question is: Just how are HMOs and other health plans to achieve the legitimacy they must have to tackle the cost-containment job they are so badly needed to do? Where—to whom and to what institutions—do we look for help in conferring that legitimacy?

My remaining remarks will address the problem of legitimacy in what I hope is a constructive way. My idea is that the crisis of confidence in managed care needs to be addressed, not from the top down by still more prescriptive regulation, but from the grass roots up. Legitimacy is a problem for managed care plans in large part for the reason I have already identified—consumers' feelings of powerlessness in the market for health coverage. As long as consumers lack the power to choose for themselves and to know with some certainty what they are choosing, they will be easily aggrieved even if their HMO complied with all government regulations, operated according to industry standards, had good intentions, and measured up under the experts' criteria. Fortunately, there are several ways in which consumers' confidence in their health plans might be substantially restored. The goal would be simply to empower consumers, giving them enough control and creating enough plan accountability to overcome their current feeling that they are being—or are in danger of being—significantly abused.

In my view, an agenda for legitimizing managed care should include changes in the form of tax subsidies for health coverage so that consumers have

alternatives to employer-purchased benefits.²⁷ It should also contemplate action in the three additional areas explored in the following paragraphs.

A. Information

Although the role of employers in selecting health plans for their employees is one source of the legitimacy problem, a larger, arguably overriding issue is the poor quality of information available to consumers about the specific goals and methods adopted by individual health plans in their efforts to ensure appropriate spending. Extensive public and private efforts are under way, to be sure, to better inform consumers about what they are buying in health care markets. Mostly these are efforts to provide—through disclosure requirements, accreditation, “report cards,” and so forth—better information on the quality of care provided by different health plans and providers, thereby facilitating comparisons and improving the process by which health plans are selected. A policy of encouraging the collection and dissemination of better information about the past performance of plans and providers certainly makes sense.²⁸ But because information about the quality of health care is extremely hard to collect and interpret, government- or industry-sponsored information strategies alone are unlikely to make the health care marketplace work well enough to overcome the current crisis in confidence and earn HMOs all the legitimacy they need to fight the cost battle effectively in the no-man’s land of quality/cost trade-offs.

The paucity of candid information currently available about HMOs is also an issue in some important judicial forums, where some promising additional relief may eventually be obtained. Virtually all of the leading HMO companies are currently the targets of consumer class actions in which the plaintiffs allege that the defendant plan failed to give them what they were promised in the way of high-quality health coverage.²⁹ A few of these cases have been dismissed because the plaintiffs’ lawyers elected to litigate them as all-out substantive attacks on the legality of HMOs and their business methods.³⁰ Lawyers in the remaining cases, however, may achieve more success by somewhat refocusing their claims. Instead of arguing, or insinuating, that HMOs’ standard operating methods are inherently corrupt, anticonsumer, and borderline illegal, lawyers for a plaintiff class can focus their attack more narrowly, not on the defendant’s practices themselves but on its failure to tell its subscribers clearly and directly—in its advertising, plan descriptions, and contracts—about both the specific methods it planned to employ and its intention to control spending even at the possible expense of some marginal quality. In fact, HMOs, presumably

27. See *supra* note 12 and accompanying text.

28. See William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1713-43 (1999).

29. See Clark C. Havighurst, *Consumers v. Managed Care: The Class Actions*, HEALTH AFF. (forthcoming July-Aug. 2001).

30. See, e.g., *Maio v. Aetna, Inc.*, 221 F.3d 472 (3d Cir. 2000); *Weiss v. Cigna Healthcare, Inc.*, 972 F. Supp. 748 (S.D.N.Y. 1997).

taking their cues from their marketing departments rather than their lawyers, have uniformly portrayed themselves as benign facilitators of improved health care, carefully obscuring their intentions to restrict physicians' autonomy, to pay physicians in ways that create incentives potentially inimical to patient welfare, and to deny coverage for services they deem unjustified under some (undisclosed) benefit/cost test. Legal attacks on the quality of disclosures made could result in significant improvements in consumers' understanding of the limitations of the particular health coverage they are buying.

Legal challenges to HMOs' misrepresentations, nondisclosure, and systematic fudging on their apparent contractual undertakings may well be cognizable under ERISA, which specifies that employer-sponsored health plans have certain fiduciary duties.³¹ In its recent decision in *Pegram v. Herdrich*,³² the U.S. Supreme Court rejected the use of ERISA as a predicate for putting substantive legal limits on the kinds of incentive arrangements that HMOs may employ with physicians. In a footnote, however, the Court acknowledged that HMOs, as ERISA fiduciaries, may be "obligated to disclose characteristics of the plan . . . if that information affects beneficiaries' material interests."³³ This dictum signifies that misrepresentation claims may succeed where direct legal attacks on HMO methods have failed. It is at least possible, therefore, that the pending consumer class actions will result in prospective remedies increasing the candor and clarity with which individual HMOs and other health plans explain themselves to consumers. Alternatively, of course, Congress might legislate to achieve the same objective. In any event, better disclosure (including more explicit health care contracts and more explicit acknowledgment that health care needs to be, and is to be, rationed under contractual standards) is an essential step in making the market for health care work as well as it can. Indeed, candid disclosure is a *sine qua non* of the consumer consent that alone can confer on HMOs the political and legal legitimacy they obviously need to carry out their vital mission of giving consumers good value for money in health care spending.

B. Suing HMOs for Breach of Contract

The other missing ingredient, besides full disclosure, in HMOs' quest for legitimacy in the eyes of the public and of policymakers is accountability. Accountability can exist in the marketplace if consumers have information about what they can expect from a given health plan and can exit the plan if they have doubts about what is being delivered.³⁴ But, in these circumstances, a more important form of accountability is the kind enforced by the legal system, to which Americans generally expect to be able to take their serious grievances.

31. See 29 U.S.C. § 1004 (2000).

32. 120 S. Ct. 2143 (2000).

33. *Id.* at 2154 n.8.

34. Exit can create more problems than it solves, however, if plans can induce individual patients to leave the plan as soon as they present a major health problem. Nevertheless, the freedom of group purchasers to take their business elsewhere provides valuable accountability.

The most prominent issue in the debate over the so-called patient's bill of rights has been ERISA's preclusion of personal-injury lawsuits charging plans and their administrators with negligence or bad faith in the administration of coverage. As things now stand, ERISA plans cannot be sued to recover damages for personal injuries caused by erroneous coverage decisions. Current proposals to open HMOs to such suits have been controversial—more so than the added regulatory burdens in the patient's bill of rights, which health plans have little reason to resist if all are impacted equally. Such proposals would either repeal ERISA preemption outright, permitting state remedies to be pursued against employer-sponsored plans, or amend ERISA itself to allow a federal cause of action of a similar, though perhaps more circumscribed, nature.

The arguments for amending ERISA are hard to resist. The idea that a health plan can walk away from the consequences of its erroneous coverage decisions offends many people, including many judges, and their outrage has contributed strongly to the current backlash. And just as a matter of policy, without regard to the political climate, the preemption of normal legal remedies is not easy to defend. Nevertheless, amending ERISA is serious business. Its preemption provisions have been a distinct blessing in sheltering employers and health plans from some burdensome state regulation, thus permitting them to experiment usefully with innovative methods and cost controls. There is also a serious risk in subjecting employers and health plans to second-guessing by juries in personal injury cases triggered by plans' efforts to hold costs down. In the *Pegram* case, Justice Souter rejected one version of the plaintiff's claim partly because, whenever a bad result occurred, "[i]t would be so easy to allege, and to find, an economic influence . . . [that] a factfinder [might] convert an HMO into a guarantor of [a good medical outcome]."³⁵ Liability fears could easily lead HMOs to practice timid ("defensive") utilization management, resulting in inappropriately higher costs. For these reasons, Congress should seek a way to give health plan enrollees appropriate legal remedies without opening the door to unbridled hindsight and to a large jury award in every case where a bad outcome occurs.

Perhaps the best way to make HMOs appropriately accountable would be to allow personal injury suits for contract breaches, but only by patients who appealed the plan's initial decision unsuccessfully. Under this proposal, a patient who was given a clear and fair opportunity to challenge the original coverage determination and chose not to do so would be precluded from raising the issue with the benefit of hindsight at a later date. Under such a regime, although a patient could not sue if he neglected to pursue an available internal appeal from the initial denial of coverage, he would not be bound by the decision on that appeal, nor would he have to pursue his appeal beyond the first level. So, while patients would have to give the plan a chance to make a final, definitive decision with good information about the case, they would still have substantial remedies for plan errors and breaches of contract. The availability of such remedies would

35. 120 S. Ct. at 2157.

both legitimize active utilization management and improve its quality.³⁶ Indeed, if health plans and administrators faced liability on these terms, they would have strong incentives to pursue contractually authorized rationing of financing in an open and honest way, using procedures that enhance the accuracy and consistency of contract administration.³⁷

A major challenge in making HMOs reasonably and appropriately accountable for their coverage decisions, without introducing even more costly prescriptive regulation, is to ensure that the standards to which they are held on appeal and in court are contractual, not regulatory, ones. The Norwood-Dingell Bill, one of the leading compromise versions of the patient's bill of rights in the 106th Congress, would have treated many plan decisions as so-called "medically reviewable determinations" and subjected them to mandatory review by independent medical practitioners.³⁸ Although the bill was less than clear, it seemed to contemplate that most coverage determinations would be deemed "medically reviewable" and would be reviewed for consistency, not with the plan's contract with its subscribers, but with professional standards. Even though such standards are routinely invoked by the legal system for prescriptive regulatory purposes in malpractice cases as well as in coverage disputes, they are apt to be very costly. Moreover, in many cases they are far from uniform, varying substantially from place to place and practice to practice. In addition to neglecting benefit/cost trade-offs, such standards have never been examined by legislators to determine whether they constitute sound public policy appropriately enforced in all cases in coercive, regulatory ways. They should therefore not be made mandatory unless the health plan affirmatively embraces them as the standards by which it wishes to be bound. If Congress were to legislate in such a way as to make professional standards the norms applicable to all HMO

36. Regulatory oversight and remedies for breach of the duty of good faith and fair dealing would also be essential to protect against a plan's pursuing policies resulting in too many initial denials' being reversed on initial appeal. Without such oversight and remedies, the suggested regime would tempt a plan not to be consistent and evenhanded in administering its benefits but instead to adopt restrictive policies in the first instance, providing generous treatment only to "squeaky wheels" who, having appealed an initial denial, would be in a position to sue at a later date in the event of a bad result. Though not widely recognized as such, such discrimination in favor of articulate, assertive, and potentially litigious patients is already a problem, perhaps of scandalous proportions, in organized health plans. See *supra* notes 21-25 and accompanying text.

37. Health plans could also be protected against excessive exposure to liability based on hindsight by preserving the doctrine of *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). In that case, the Supreme Court held, under ERISA, that health plan contracts could give plan administrators substantial discretion in administering the plan, having their interpretations of contract terms overturned by courts only if they were arbitrary or capricious. Thus, unavoidable contractual ambiguities could not be construed against the plan so long as its interpretations were not unreasonable and were applied consistently in similar cases. For court-suggested language for clearly disclosing (and thus legitimizing) the existence of such discretion, see *Herzberger v. Standard Insurance Co.*, 205 F.3d 327, 330 (7th Cir. 2000).

38. H.R. 5628, 106th Cong., 2d Sess. (2000).

coverage determinations (other than those made pursuant to purely categorical exclusions), it would have effectively reinstated the old professional paradigm of medical care, which is precisely the problem that managed care was designed to solve by introducing new opportunities for consumer choice. It was fortunate that political gridlock defeated the Norwood-Dingell Bill and similar legislation in the 106th Congress, leaving the possibility that the nation will ultimately adopt a less prescriptive approach to resolving the crisis in managed care.

C. *Vicarious Liability for Provider Torts*

There is one more form of legal accountability—one that, unfortunately, is currently found only on academic policy agendas³⁹—that is at least equally important if HMOs are to achieve enough legitimacy in the public eye to perform their cost-containment tasks effectively. At this stage in the managed care revolution, corporate health plans have assumed extensive responsibility for the cost of care without accepting more than nominal responsibility for its quality. Only a moment's reflection should suggest that this situation is unlikely to be satisfactory as a matter of public policy. Nor can the managed care industry's public relations problems be overcome as long as it prevails. Before health plans can reasonably expect to be tolerated by the public as administrators of cost controls, they must bear some substantial legal responsibility whenever the quality of care provided under their auspices falls below appropriate standards—regulatory or contractual, as the case may be.

The current crisis of confidence in the managed care industry results in large part because, despite what individual health plans may say or imply in their advertising, they have accepted little real responsibility for the quality of care. Virtually all health plans include in their contracts a disclaimer of all legal responsibility for the care that their physicians provide, saying to enrollees in effect: "Don't sue us. Sue your doctor." In this respect, health plans have found it convenient to adhere to the convention that physicians alone are accountable to patients for the quality of care. The effect of adhering to this principle,

39. For expositions of the concept, which have also been marketed under the name "enterprise liability," see Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7 (2000) [hereinafter Havighurst, *Vicarious Liability*]; Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587 (1997); William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROBS. 159 (1997); William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1, 1-2 (1994) (joining a "chorus of voices that proposes to refocus liability for medical malpractice on the organizations that will increasingly bear practical responsibility for providing health care services"); David M. Studdert & Troyen A. Brennan, *Deterrence in a Divided World: Emerging Problems for Malpractice Law in an Era of Managed Care*, 15 BEHAV. SCI. & L. 21, 48 (1997) (concluding that enterprise liability, though "no panacea for achieving sharp deterrence in the malpractice sphere[,] . . . [is] capable of correcting some aspects of the incompatibility between malpractice law and new organizational models").

however, is to cut health plans entirely out of the picture at precisely the point where quality comes into view. Good policy, however, would require that liability fall on the party in the best position to compare the costs and benefits of measures to prevent injuries and to take, or induce others to take, the indicated precautions.⁴⁰ This criterion for policy points strongly to vicarious liability. If this principle were clearly fixed in law, it would also ameliorate HMOs' public relations problem, adding substance to their claim that they are dedicated to serving consumer interests.

For these reasons, a crucial step in restoring the legitimacy of the managed care industry—and also in improving its performance—would be to establish as a “default rule” (operating in the absence of an alternative contractual arrangement) the principle that a health plan is vicariously, and exclusively, liable for medical malpractice and other torts committed by the health care providers it procures to treat its enrollees. In time, courts would probably impose something like vicarious liability on HMOs as a matter of law, just as they have gradually moved toward making hospitals liable for the torts of emergency room physicians.⁴¹ But the need to reassign responsibility clearly and decisively is great enough in my mind that I have proposed legislation to make a clear break with the old professional paradigm.⁴² Although my proposed legislation would make vicarious liability the default rule, it would also permit patients and physicians to maintain traditional doctor-patient relationships under certain limited conditions. It also contemplates that many plans would routinely pass liability on to subcontractors, which would in most cases not only bear financial risks for the care to be delivered but also be better positioned to monitor and

40. See GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* 135-73 (1970) (classic study recommending general deterrence approach to accident liability, including assignment of liability to induce appropriate attention to quality, targeting in particular parties who, given transaction costs, are apt to be in the best position to control quality or influence others to do so).

41. E.g., *Simmons v. Tuomey Reg'l Med. Ctr.*, 533 S.E.2d 312 (S.C. 2000) (holding hospital has nondelegable duty to render competent service to patients in emergency room, if patient sought care from hospital, not individual physician). See also *Petrovich v. Share Health Plan, Inc.*, 719 N.E.2d 756, 770-75 (Ill. 1999) (denying summary judgment to HMO on vicarious liability claim because its various ways of influencing physicians might be found to amount to sufficient control to justify finding implied agency, despite independent contractor relationship). Many observers will be inclined to believe that common law courts, in holdings like that in *Petrovich*, which make it relatively easy for a plaintiff to establish an HMO's vicarious liability, are making HMOs appropriately accountable and that legislation of the kind suggested here is unnecessary. Yet the *Petrovich* decision clearly imposes vicarious liability only as a penalty for the HMO's interfering with medical decisions in the interest of cost containment and not as an inducement to encourage all plans to take a more active and constructive role in improving quality. See *id.* at 763-64, 770-76. Perversely, the *Petrovich* signal to health plans is to take less, not more, responsibility for the quality and cost of care.

42. See Havighurst, *Vicarious Liability*, *supra* note 39, at 29 (setting forth proposed statutory language establishing vicarious liability).

improve quality than was the plan itself.

The argument for legislation making health plans legally accountable, in the first instance, for the quality of care delivered to patients rests on the logic and likely beneficial consequences of assigning responsibility for both cost and quality to the same entity. Until health plans and their subcontractors are forced—either by the market or by the legal system—to be substantially accountable for the quality of care, the managed care revolution will remain unfinished, and health plans will continue to lack the kind of close integration of financing and delivery that was originally expected to be the hallmark of managed care. To be sure, few of today's health plans are ready as a practical matter to assume managerial responsibility for the quality of care, and a good deal of restructuring would be required to put them in a position to exercise meaningful influence or control. Nevertheless, making health plans presumptively liable whenever their selected providers breach legal duties to their patients would induce desirable moves toward finally realizing the efficiency potential of managed care and allowing health plans to directly address concerns that have recently been voiced about the frequency of medical errors and the overall quality of care.⁴³ A definitive shift to vicarious liability would also eliminate much of the current destructive tension between health plans and physicians. Indeed, finally bringing HMOs' and physicians' obligations to patients into some alignment would weaken one of the main subversive impulses fueling the current backlash against managed care and impeding realization of its immense promise.

CONCLUSION

In conclusion, then, I suggest responding to the backlash against managed care by focusing attention, not on devising new forms of command-and-control regulation, but on finding ways to confer political and legal legitimacy on organized health plans. The key to legitimacy is accountability, both in the marketplace and in the courts. Accountability has three essential elements: first, fuller and more candid disclosure of the goals, intentions, and methods of individual health plans; second, limited, but substantial, legal accountability of HMOs for errors or bad faith in the administration of health coverage; and third, presumptive vicarious liability of HMOs for the negligence and other torts of their various subcontractors. Once health plans provide good notice of what they are undertaking to do for consumers and can be held accountable in court when they fail to deliver on those undertakings, the market for health care financing and health services will begin to stabilize, enabling the managed care revolution to proceed in accordance with its democratic premise.

Unfortunately, the political fight over the patient's bill of rights has been fraught with peril for the generally enlightened policy of leaving to consumers and their selected agents the fundamental choice about how much and what kinds

43. See, e.g., INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., 1999).

of health care individual patients should receive. Instead of subjecting HMOs to more regulation, government should create conditions under which trade-offs between quality and costs can, to the extent possible, be accurately reflected in consumers' purchasing decisions and memorialized in private contracts rather than prescribed in law. To be sure, converting health care into a true consumer good that people purchase according to their preferences and their resources (including substantial public subsidies) is a immensely difficult undertaking, and it is currently encountering intense resistance from professional interests, political leaders, and legal institutions, which systematically refuse to step aside and yield power to consumers and their private agents in the marketplace. But it is still open for legislatures and courts to reject micro-managing of managed care plans and to focus instead on two things: empowering consumers with information that will enable them to know with reasonable certainty what they can expect from various health plans, and giving them well crafted legal rights to enforce those expectations against the health plans they choose.

Today's backlash against managed care is fully warranted by the failure of health plans to market themselves honestly and to accept appropriate legal responsibility both for honoring their contracts and for the quality of services provided under their auspices. This crisis in public confidence is providing an extremely interesting test of our political and legal systems. It remains to be seen whether those institutions can find ways to respond to legitimate public concerns, not by further undermining the democratic marketplace, but by devolving more authority to consumers, assisting them in finding trustworthy agents, and enforcing the obligations of those agents when they breach their contracts and their trust.

