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Can Consumer-Choice Plans Satisfy Patients?

PROBLEMS WITH THEORY AND PRACTICE IN HEALTH INSURANCE CONTRACTS*

Wendy K. Mariner[†]

I. INTRODUCTION

The managed care industry has historically relied on contracts to manage patients' access to medical care, primarily to control costs. Nevertheless, health care costs and insurance premiums are rising.¹ The contractual model appears to have

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¹ Jon Gabel, Gary Claxton, Erin Holve, Jeremy Pickreign, Heidi Whitmore, Kelley Khont, Samantha Hawkins & Diane Rowland, *Health Benefits in 2003: Premiums Reach Thirteen-Year High As Employers Adopt New Forms of Cost Sharing*, HEALTH AFFAIRS, Sept./Oct. 2003, at 117; Paul Fronstin, *National Health Spending Up 8.7 Percent Between 2000-2001: Spending for Health Care Will Continue to Grow*, 24 EBRI NOTES 1 (June 2003); Bradley C. Strunk & Paul B. Ginsburg, *Tracking Health Care Costs: Trends Stabilize But Remain High in 2002*, HEALTH AFFAIRS, June 11, 2003, at W3-266, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.266v1.pdf>; *Survey of Employers Sees Big Increase Coming for Costs of Health Care in 2003*, BNA HEALTH CARE POLICY REPORT, Oct. 7, 2002, at 1340; Jon Gabel, Larry Levitt, Jeremy Pickreign, Heidi Whitmore, Erin Holve, Diane Rowland, Kelley Dhont & Samantha Hawkins, *Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats*, HEALTH AFFAIRS, Sept./Oct. 2001, at 180; INSTITUTE OF MEDICINE, COVERAGE MATTERS: INSURANCE AND HEALTH CARE (2001).

Both managed care and managed competition were advocated as the solution to rising costs. See, e.g., Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990's: Universal Health Insurance in a System Designed to*

failed.² The question is, why? Contracts have been used to define rights and responsibilities for centuries.³ Everyone agrees that unlimited rights to care regardless of cost – based on patient demand and physician willingness to provide – would bankrupt the system.⁴ But, if today's contracts do not work, what will?

This Article examines the role of health insurance contracts in defining and enforcing access to medical care. It focuses primarily on employment-based group health benefit plans, although much of the discussion may apply to government programs and individual insurance policies. Part II describes how contracts are used to control health care costs, and briefly recaps contrasting attitudes toward the role of private contracting in proposals for health insurance reform. Contracts are likely to remain an essential tool for defining rights to care in any future health care financing system. Yet they are often the source, rather than the resolution, of

Promote Quality and Economy, 320 NEW ENG. J. MED. 94 (1989). Drew Altman and Larry Levitt graphed health expenditures from 1961 to 2000 to demonstrate that no policy measure has controlled the rise of costs over the long run. Drew E. Altman & Larry Levitt, *The Sad History of Health Care Cost Containment as Told in One Chart*, HEALTH AFFAIRS, Jan. 23, 2002, at W83, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.83v1.pdf>. Henry Aaron responded that he, like Chief Renault in "Casablanca," was "shocked, shocked" at the numbers. Henry J. Aaron, *The Unsurprising Surprise of Renewed Health Care Cost Inflation*, HEALTH AFFAIRS, Jan. 23, 2002, at W85, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.85v1.pdf>. Aaron has correctly predicted intractable cost increases for years. See Henry J. Aaron, *A Funny Thing Happened on the Way to Managed Competition*, 27 J. HEALTH POL. POL'Y & L. 31 (2002); Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 SCIENCE 418 (1990). Forces little affected by the policy measures tried so far continue to exert upward pressure on the prices and use of health care: new technology added to the medical armamentarium, an aging population that uses more services, and perhaps even what Professor Annas calls a culture in which many people believe that death is optional. See, generally, GEORGE J. ANNAS, *SOME CHOICE: LAW, MEDICINE AND THE MARKET* 73-77 (1998).

² Altman & Levitt, *supra* note 1, at W84 (noting that many believe that we will not control costs unless we ration medical care). See also GEORGE J. ANNAS, *STANDARD OF CARE: THE LAW OF AMERICAN BIOETHICS* 211-217 (1993); DANIEL CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* (1987); Aaron & Schwartz, *supra* note 1. Others argue that health care is already rationed to some degree by price in the United States. See EMILY FRIEDMAN, *THE RIGHT THING: TEN YEARS OF ETHICS COLUMNS FROM THE HEALTHCARE FORUM* (1996); Wendy K. Mariner, *Rationing Health Care and the Need for Credible Scarcity: Why Americans Can't Say No*, 85 AM. J. PUB. HEALTH 1439 (1995).

³ E. ALLEN FARNSWORTH, *CONTRACTS* (3d ed. 1999).

⁴ See generally *MEDICINE AND SOCIAL JUSTICE: ESSAYS ON THE DISTRIBUTION OF HEALTH CARE* (Rosamond Rhodes et al. eds., 2002); THOMAS H. RICE, *THE ECONOMICS OF HEALTH RECONSIDERED* (1st ed., 1998); GEORGE J. ANNAS, *SOME CHOICE: LAW, MEDICINE AND THE MARKET* (1998); THEODORE R. MARMOR, *UNDERSTANDING HEALTH CARE REFORM* (1994); DANIEL CALLAHAN, *WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS* (1990).

disputes between patients and insurers. Without a better understanding of why patients resist contractual limits, efforts to control health care costs by attempting to enforce contractual limits are likely to continue to fail.

Part III notes differences between consumers who purchase health plans and patients who seek medical care, and why contract and insurance rules developed for consumers may not wholly suit the individuals in their roles as patients. Part IV then describes consumer-choice health plans, which conform health insurance more closely to a consumer good and expand the use of contractual obligations to control health care costs by shifting more responsibility for choice to consumers. Part V discusses the advantages and disadvantages of such plans for employers, consumers, and patients, as well as their implications for expanding health insurance coverage and controlling health care costs. Part VI expands the analysis, exploring the difficulties of using the consumer model to constrain future choices about health care, and concludes that efforts to force health insurance into a consumer model are not likely to avoid the disputes over coverage that have bedeviled patients in managed care. For all its appeal, the consumer-choice approach ultimately fails to confront or solve a fundamental problem contributing to the rise in health care costs today – disputes over benefit coverage.

Part VII questions whether rules designed for consumer transactions can satisfactorily resolve disputes between insurers and patients. I hypothesize that the most intractable disputes between patient and insurer might be classified into several categories, a hypothesis that calls for empirical testing. A brief overview of normally applicable contract rules highlights instances in which current doctrines and rules may fail to resolve disputes in these categories in a manner that generally satisfies both parties. Several assumptions underlying consumer-oriented contract rules do not easily fit the relationship between health insurer and patient and may exacerbate resistance to their enforcement. Ultimately, this Part concludes that modified or new rules that better fit that relationship may be needed to minimize opportunities for dispute. This Article does not purport to develop any new rules itself. Rather, it suggests the questions that require deeper analysis before we can begin to develop, interpret, and enforce contracts that better calibrate the relationship between insurer and patient. Where that is not possible within the contract rubric, it may be better to pursue alternative mechanisms for

specifying future health insurance obligations and entitlements, mechanisms that can both gain willing acceptance by all concerned and ameliorate the rising costs of care.

II. THE USE OF CONTRACTS IN HEALTH REFORM

Few people question the utility of contracts in their daily lives, whether it be for buying consumer goods like cars, renting an apartment for a year or a hotel room for a night, opening a bank account, or hiring employees. In theory, contracts embody a voluntary agreement. Yet contracts that attempt to define legal rights to medical care and the concomitant responsibility for providing that care have often become the source, rather than the resolution, of disagreement. In the 1990s, consumer opposition to contractual limits on care fueled a popular backlash against managed care.⁵ Additionally, health insurers have been inconsistent in enforcing contractual limits, sometimes succumbing to legal, political, or personal pressure to provide care that is not covered by the contract, and sometimes denying care that appears covered and appropriate. Contractual limits cannot control costs as long as one or the other party does not abide by – or agree with – the limits. When it comes to health care, the fact that limits are set forth in a contract does not appear to be sufficient reason, by itself, to make those limits acceptable.⁶

⁵ See Uwe E. Reinhardt, *Consumer Choice Under "Private Health Care Regulation,"* in REGULATING MANAGED CARE: THEORY, PRACTICE, AND FUTURE OPTIONS 91-116 (Stuart H. Altman et al. eds., 1999) (noting that resistance to managed care arose in part from employees' perception that private insurers were limiting their access to what had been essentially free care at the point of service); Marc A. Rodwin, *Backlash as Prelude to Managing Managed Care*, 24 J. HEALTH POL. POL'Y & L. 1115 (1999) (issue dedicated to discussion of the managed care "backlash"); Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365 (2003).

⁶ There are many plausible reasons why managed care contracts have given rise to disputes. Consumers may not have an adequate understanding of managed care in general or their health plan in particular. Lois A. Vitt, Jurg K. Siegenthaler, Linda Siegenthaler, Deanna M. Lyter & Jamie Kent, *Consumer Health Care Finances and Education: Matters of Values*, EBRI ISSUE BRIEF, No. 241, Jan. 2002. But even extensive education – not likely to be forthcoming – may not be enough to gain willing agreement to all the terms of a contract. Many people feel entitled to medical care, at least when they are ill or injured. NORMAN DANIELS, *JUST HEALTH CARE* (1985). Contrary to market theory, consumers do not always want their contracts to be enforced. See generally Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (1993). When consumers get sick, they become patients and are likely to demand whatever care they or their physicians believe they need, regardless of what the contract says. See Wendy K. Mariner,

More than half of all Americans obtain health care with private insurance provided through employers or unions.⁷ The vast majority, about 145 million in 2001, are employed by private, non-government employers.⁸ Exactly what these individuals are entitled to, and how much it costs, depends on the terms of a contract. Most of these contracts still provide for “managed care” to some degree, in a variety of structures,⁹ but others offer indemnity insurance, flexible benefits, and increasingly, consumer-driven and defined contribution plans.¹⁰ New forms of insurance are being developed and consumers may increasingly participate in negotiating contracts for their

Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care, 15 J. CONTEMP. HEALTH L. & POLY 1 (1998) [hereinafter Mariner, *Standards of Care*].

⁷ Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2001 Current Population Survey*, EBRI ISSUE BRIEF, No. 240, Dec. 2001 (reporting that 163.4 million people in 2000 – 67.3% of all non-elderly Americans – had employment-based health insurance). Numbers declined slightly in 2001, with 162.3 million non-elderly workers and their dependents, 65.6% of the total, covered by employment-based coverage, including 145 million private sector and 17.7 million public sector employees and dependents. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2002 Current Population Survey*, EBRI ISSUE BRIEF, No. 252, Dec. 2002 [hereinafter *Fronstin 2002*].

⁸ *Fronstin 2002*, *supra* note 7. There were about 247.5 million Americans under age 65 in 2001. Those not included in private, non-government, employment based plans were: 17.7 million in government employee group plans; 16.4 million with non-employer, individual insurance coverage; 37.9 million in public benefit programs, and 40.9 million uninsured. *Id.* See also Craig Copeland, *Nonelderly Individuals with Employment-Based and Individually Purchased Health Care Coverage*, 20 EBRI NOTES 3 (2000) (reporting that 125.7 million Americans were covered by private, non-government employer plans in 1998).

⁹ The most familiar models include health maintenance organizations (HMOs), which offer a closed panel of providers and no coverage of services by non-participating providers; preferred provider organizations (PPOs), which offer a contracted network of participating providers typically paid on a fee-for-service or discounted fee-for-service basis; point of service plans (POSs), which cover services from participating providers and also allow patients to obtain care from non-participating providers upon payment of larger deductibles or co-payments. In general, premiums for these plans are lowest for HMOs and highest for POSs or general indemnity plans. Each model has variations and include “OWA’s,” Allison Overbay and Mark Hall’s joking acronym for Jason Adkin’s “other weird arrangements.” Allison Overbay & Mark Hall, *Insurance Regulation of Providers That Bear Risk*, 22 AM. J.L. & MED. 361, 361 n.2 (1996).

¹⁰ See *Defined Contribution Health Plans Emerge as Employers Face Double-Digit Cost Hikes*, BNA HEALTH CARE POLICY REPORT, Feb. 25, 2002, at 307 [hereinafter *Defined Contribution Health Plans*]; *Consultant Survey Says Employers Unlikely to Make Dramatic Changes to Rein in Costs*, BNA HEALTH CARE POLICY REPORT, July 15, 2002, at 962. See also Robert D. Reischauer, *Choice and Social Insurance*, in SOCIAL SECURITY AND MEDICARE: INDIVIDUAL VERSUS COLLECTIVE RISK AND RESPONSIBILITY 19 (Sheila Burke, Eric Kingson & Uwe Reinhardt eds., 2000) (arguing that rising costs also led to exploring defined contribution elements for Social Security).

own care. Managed care contracts may be an inadequate model for the future.¹¹

Professor Clark Havighurst has argued that contracts can be an effective tool of health care reform, especially when used to encourage consumers to make better bargains with managed care organizations (MCOs), and when focused on the quality of care.¹² Other scholars argue that if insurers, employers and consumers are free to make their own agreements, without significant regulation of the health insurance market, they will voluntarily control costs more effectively than government.¹³ Rising costs and a backlash against managed care suggest that the managed care contractual model has not met those expectations.¹⁴ More important, a pure market approach rarely takes into account whether the terms of a contract are fair to consumers as well as insurers.¹⁵

Other scholars concerned with equitable access to care for all Americans more often recommend legislation to restructure health care financing and delivery.¹⁶ However,

¹¹ Victor R. Fuchs, *What's Ahead for Health Insurance in the United States?*, 346 NEW ENG. J. MED. 1822 (2002).

¹² Clark C. Havighurst, *Freedom of Contract: The Unexplored Path to Health Care Reform*, in AMERICAN HEALTH CARE: GOVERNMENT, MARKET PROCESSES AND THE PUBLIC INTEREST 145 (Roger D. Feldman ed., 2000); CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995).

¹³ This was the premise of earlier proposals for managed competition. See Enthoven & Kronick, *supra* note 1; Paul M. Ellwood, Alain C. Enthoven & Lynn Etheredge, *The Jackson Hole Initiative for a Twenty-First Century American Health Care System*, 1 HEALTH ECONOMICS 158-59 (1992). The scholarly debate on this issue has followed the lines of the debate over whether private contracting is preferable to or more just than tort standards and regulation in health care. For those in addition to Havighurst who favor private contracting, see RICHARD EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? (1997); Mark A. Hall, *Law, Medicine and Trust*, 55 STAN. L. REV. 463 (2002); MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING DECISIONS (1997); MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE (1994); E. HAAVI MORREIM, HOLDING HEALTH CARE ACCOUNTABLE: LAW AND THE NEW MEDICAL MARKETPLACE (2001); David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 SO. CAL. L. REV. 221 (2000).

¹⁴ Another managed care proponent, Paul Ellwood of the Jackson Hole Group, was reported to say, "Under managed care, we were going to let the market decide – the best delivery system would emerge from that. . . . I no longer believe that." *"Pioneer of Managed Care" Proposed New Generation of Health Care Delivery*, 11 BNA HEALTH CARE POLICY REPORT 167 (2003).

¹⁵ Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11 (1999).

¹⁶ Most of these scholars are skeptical of or frankly oppose unconstrained private contracting as the sole mechanism for distributing health care. See, e.g., M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919

political support for major health system change has not yet materialized.¹⁷ Insurers, employers and patients are still left to their own devices to arrange for health care within affordable limits. These devices will undoubtedly continue to be contracts. The relatively recent so-called “consumer-choice” health plans rely on contracts to make consumers more aware of health care costs.¹⁸ Even incremental reform legislation, like the stalled Senate and House of Representatives versions of a Bipartisan Patient Protection Act, assumes that private parties will use contracts to determine what care is available to whom.¹⁹ Thus, contracts appear to be an inevitable part of any future health care financing system. Yet, we do not fully understand where private contracting does and does not work to further the goals of equitable access to affordable care.

III. PATIENTS AND CONSUMERS

Various terms describe people covered by health insurance. Insurance texts prefer “insureds” as a generic term for anyone who is insured.²⁰ Managed care organizations often speak of “enrollees” or “members.” Today, most everyone refers to all these people as “consumers.”²¹ Does the shift in terminology have any substantive import for health policy or

(2002); Uwe E. Reinhardt, *Reforming the Health Care System: The Universal Dilemma*, 19 AM. J.L. & MED. 21 (1993).

¹⁷ See generally Robert J. Blendon, John M. Benson & Catherine M. DesRoches, *Americans' Views of the Uninsured: An Era for Hybrid Proposals*, HEALTH AFFAIRS, AUG. 27, 2003, at W3-405, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.405v1.pdf>; Uwe E. Reinhardt, *Is There Hope for the Uninsured?*, HEALTH AFFAIRS, Aug. 27, 2003, at W3-376, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.376v1.pdf>; Robert J. Blendon & John M. Benson, *Americans' Views on Health Policy: A Fifty-Year Historical Perspective*, HEALTH AFFAIRS, Mar./Apr. 2001, at 33.

¹⁸ Consumer-choice models are described in Part IV, *infra*.

¹⁹ Bipartisan Patient Protection Act of 2001, S.1052, 107th Cong. (2001); H.R. 2563, 107th Cong. (2001).

²⁰ See, e.g., ERIC M. HOLMES & MARK S. RHODES, *HOLMES'S APPLEMAN ON INSURANCE* (2d ed. 1996 & Supp.); LEE R. RUSS & THOMAS F. SEGALLA, *COUCH ON INSURANCE* (3d ed. 1995); ROBERT H. JERRY II, *UNDERSTANDING INSURANCE LAW* (2d ed. 1996); ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES* (1988).

²¹ The use of “consumer” was emphasized by the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry. See CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES, REPORT TO THE PRESIDENT OF THE UNITED STATES (Nov. 1997), available at <http://www.hcqualitycommission.gov/cborrr/>. The managed care industry has used the term, often interchangeably with “member,” in its public statements. See also NATIONAL COMMISSION FOR QUALITY ASSURANCE, *STANDARDS FOR ACCREDITATION OF MANAGED CARE ORGANIZATIONS* (2002).

law? Dr. Edmund Pellegrino argues that terminology can in fact change public perceptions, especially in health care.²² Professor George Annas argues that transforming patients into consumers could deprive patients of important traditional rights.²³ This is because the laws generally applicable to consumers differ in significant respects from those applicable to patients.²⁴

A. *The Balance of Information*

Historically, laws governing patient rights and provider responsibilities have been based on the patient's disadvantage relative to medical professionals.²⁵ Although in the nineteenth century Sir Henry Maine characterized "the movement of progressive societies [as] a movement from Status to Contract,"²⁶ the rights of patients in the twentieth century developed because of their unequal status in a relationship with a medical professional.²⁷ Today, this inherent imbalance in knowledge and skill remains a defining characteristic of the physician-patient relationship. Laws typically attempt to

²² Edmund D. Pellegrino, *Words Can Hurt You: Some Reflections on the Metaphors of Managed Care*, 7 J. AM. BOARD FAM. PRAC. 505 (1994).

²³ George J. Annas, *A National Bill of Patients' Rights*, 338 NEW ENG. J. MED. 695, 696 (1998); George J. Annas, *Reframing the Debate on Health Care by Replacing Our Metaphors*, 332 NEW ENG. J. MED. 744 (1995).

²⁴ Mariner, *Standards of Care*, *supra* note 6 (outlining differences between consumers and patients and emphasizing that consumers are buyers of care, while patients are recipients of care without regard to any source of payment). The discussion in this Part is based largely on that article.

²⁵ GEORGE J. ANNAS, *RIGHTS OF PATIENTS* (3d ed. 2004); ELEANOR D. KINNEY, *PROTECTING AMERICAN HEALTH CARE CONSUMERS* (2002).

²⁶ SIR HENRY SUMNER MAINE, *ANCIENT LAW 168-70* (Thoemmes Press 1996) (1861)

The movement of the progressive societies has been uniform in one respect. Through all its course it has been distinguished by the gradual dissolution of family dependency and the growth of individual obligation in its place If then we employ Status . . . to signify these personal conditions only, and avoid applying the term to such conditions as are the immediate or remote result of agreement, we may say that the movement of the progressive societies has hitherto been a movement *from Status to Contract*.

Id.

²⁷ Not all law governing modern relationships are left to contract. Like laws protecting patients, laws prohibiting certain types of discrimination recognize the need to protect individuals who are vulnerable because of personal characteristics, or status, such as race, color, ethnicity, gender or disability. See generally ANDREW KOPPELLMAN, *ANTI-DISCRIMINATION LAW AND SOCIAL EQUALITY* (1996); HAROLD S. LEWIS & ELIZABETH J. NORMAN, *EMPLOYMENT DISCRIMINATION LAW AND PRACTICE* (2002); CATHARINE A. MACKINNON, *SEX EQUALITY* (2002). Thus, it might be said that the hallmark of progressive twentieth century societies has been a selective move from contract to status to preserve individual integrity.

counter this imbalance and protect patients from mistreatment by physicians whose actions patients cannot independently evaluate.²⁸

In contrast, consumers are presumed to have equal bargaining power with sellers. Voluntary choice and willingness and ability to pay are the hallmarks of consumer purchasing, especially in a competitive market.²⁹ Ability to pay constrains consumer choice, however, and consequently limits a product's consumer base to those people who can afford to buy that product. In addition, consumers may not have adequate information about a product or service to make wholly rational and voluntary choices. Consumer protection laws seek to redress this information imbalance by requiring sellers to disclose material information that is not generally available to the public, thereby supporting the consumer's ability to make an informed choice.³⁰

In the medical context, one might compare consumer disclosure laws to the physician's duty under the tort doctrine of informed consent to disclose sufficient information to permit informed consent to medical care. The physician's duty arises from the patient's personal right of self-determination, which entitles the patient to whatever information she needs and wants to make medical care decisions. In contrast, consumers have no comparable personal right to information by virtue of their status as consumers. Consumer disclosure laws are designed to fill gaps in general knowledge in a population of undifferentiated consumers, and the seller's duty is imposed to protect fair commercial exchanges.

²⁸ Traditional laws protecting patients include legislation and common law principles requiring physicians to provide care in accordance with professionally accepted standards of care and to act in the patient's best interest; requiring physicians and hospitals to keep personal medical information about patients confidential; the doctrine of informed consent to medical care (and research); the right to privacy and dignity in patient care; and the right to emergency care. *See* ANNAS, *supra* note 25. Advances in medicine may have increased the need for laws to protect patients, particularly the doctrine of informed consent to medical treatment, because diagnostic methods and treatment options are rarely within ordinary citizens' general knowledge. *See generally* Wendy K. Mariner, *Informed Consent in the Post-Modern Era*, 13 *LAW & SOC. INQUIRY* 385 (1988).

²⁹ *See* RICE, *supra* note 4 (arguing that none of the assumptions necessary to an efficient, competitive market are met in health care markets).

³⁰ Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals and Trade-Offs*, 32 *HOUS. L. REV.* 1319 (1996) (comparing consumer protection approaches from other sectors to managed care).

B. *Legal Obligations and Their Sources*

In general, tort law governs the physician-patient relationship, while contract law governs the relationship between consumers and sellers. Consumer protection laws sometimes impose product standards on manufacturers of goods,³¹ which can be seen as amendments to the contract of sale. The general duty of physicians to conform their behavior to accepted medical standards is almost never translated into specific statutory standards for particular clinical services.³² Instead, professional consensus, sometimes in the form of guidelines adopted by professional specialty organizations, establishes the standard of care.

In addition to adhering to accepted medical standards, physicians have a quasi-fiduciary duty to act in the patient's best interest.³³ Sellers have no comparable fiduciary duty, either to act in the consumer's best interest or to sell only what the consumer needs.³⁴ Consumers are presumed to be the best judge of their own purchases, whereas patients are presumed to need the expert assistance of physicians to identify their own medical needs. Where medical needs are obvious, individuals can often buy remedies like aspirin over the counter, in which case the individual acts more like a consumer than a patient.

The differences between patients and consumers are summarized in Figure 1 below. Individuals can be both consumers and patients, although they are rarely both at the same time. People act like consumers when choosing what

³¹ For example, the Food and Drug Administration sets specific standards for drugs, biologics, medical devices, food, and cosmetics. 21 U.S.C. §§ 353, 371 (2000). The Consumer Products Safety Commission also sets product specifications for certain consumer products. 15 U.S.C. §§ 2056, 2058 (2000). State insurance licensure laws requiring certain insurance policies to include specific provisions can also be viewed as setting product standards. Common law may also protect consumers by subjecting manufacturers of defective products to liability in tort for negligence or defective products. See AMERICAN LAW INSTITUTE, *RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY* (Tentative Draft, 1994).

³² The most visible exception is legislation prohibiting specific procedures for abortion. See *Partial Birth Abortion Ban Act of 2003*, Pub. L. No. 108-105, § 2, 117 Stat. 1201 (2003) (codified at 18 U.S.C. § 1531); *Stenberg v. Carhart*, 530 U.S. 914 (2000) (holding that a similar Nebraska law violated the Due Process Clause of the Fourteenth Amendment).

³³ See generally Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241 (1995).

³⁴ See Wendy K. Mariner, *Business v. Medical Ethics: Conflicting Standards for Managed Care*, 23 J.L. MED. & ETHICS 236, 238 (1995) (noting that for-profit corporations have a fiduciary obligation to their investors).

health plans to buy and like patients when deciding what treatment to undergo. In addition, some elements of managed care and other health plans, such as choosing physicians, combine both consumer and patient functions.³⁵ Nevertheless, it is useful to keep the distinctions in mind when considering whether disputes arising out of health plans should be addressed as a matter of common law contract or tort principles, or by legislation. The more health care is perceived to be a consumer good, the more likely it is that contract principles will supersede tort principles in defining both access to care and rights and obligations in care.

Figure 1: Differences Between Consumers and Patients

Consumer Characteristics	Patient Characteristics
Buyers of goods and services	Recipients of health care
Purchases dependent on financial resources	Independent of payment source
Purchases based on voluntary choice	Seek care based on need
Presumed equal bargaining position with sellers	Unequal skill and knowledge of health care
Sellers have no fiduciary duty to buyer	Provider has quasi-fiduciary duty to patient

IV. CONSUMER-CHOICE HEALTH PLANS

Current health care reforms encourage patients to become consumers and ask them to control costs by choosing cheaper health plans³⁶ and also assuming a larger share of the

³⁵ For a more complete discussion of the categories of consumer, patient, and mixed consumer/patient functions in managed care, see Mariner, *Standards of Care*, *supra* note 6. See also KINNEY, *supra* note 25, at 9 (recognizing both the distinctions and the overlapping functions).

³⁶ Jon R. Gabel, Anthony T. Lo Sasso & Thomas Rice, *Consumer-Driven Health Plans: Are They More Than Talk Now?*, HEALTH AFFAIRS, Nov. 20, 2002, at W395, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.395v1.pdf>; *Defined Contribution Health Plans*, *supra* note 10; Bill Brubaker, *Co-Pay, or You Pay? Firms Hope Worker-Directed Health Plans Will Curb Rising Costs*, WASH. POST, July 28, 2002, at H1.

cost.³⁷ Health plans are easing away from managing individual patient care and shifting more decision-making responsibility onto providers and patients, while incorporating more elements of traditional indemnity insurance into their “new” plans.³⁸ The animating idea is to inject market concerns into consumer choices – to make the cost of care and its trade-offs more visible to the individuals who experience them. These consumer-choice trends reduce insurers’ involvement in personal treatment decisions and emphasize their role in financing care. Although insurers still make determinations about what premium they will charge for any given package of benefits and whether a particular condition or treatment is covered, consumers are asked to assume more responsibility for deciding what benefit package to buy and what treatment to obtain. All of these choices rely on contracts to structure the financial relationship between insurer and patient and to define the cost/benefit trade-offs. However, if this shift in structure seeks to both control costs and make individuals more comfortable with their health plans, it may be expecting too much of contracts.

Managed care had to say “no” to patients to save costs for unnecessary expenditures. This is, of course, precisely what patients disliked. Consumer-choice plans shift responsibility for cutbacks from the insurer to the consumer, taking the onus off both the insurer and the employer. In effect, they ask the consumer to say “no” to herself – exactly what many advocates of market solutions to rising health care costs have recommended.³⁹ But will it work? Will consumers say no to their future selves as patients? If so, will patients be willing to abide by the choices they made as consumers?

Before addressing the question of efficacy, a few words about terminology. New plans that give consumers more say or responsibility in structuring plan elements have been called “consumer-driven,” “consumer-directed,” and even “defined

³⁷ See generally James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, HEALTH AFFAIRS, Mar. 20, 2002, at W139, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.139v1.pdf>; REGINA E. HERZLINGER, MARKET-DRIVEN HEALTHCARE: WHO WINS, WHO LOSES IN THE TRANSFORMATION OF AMERICA'S LARGEST SERVICE INDUSTRY 245-81 (1997).

³⁸ *Aetna Expands Product Line Offerings with Choice of Providers in 'Health Fund'*, 10 BNA HEALTH POLICY REPORT 956 (2002) [hereinafter *Aetna Expands Product Line*].

³⁹ Gabel et al., *supra* note 36, at W396 (“Managed care . . . was placed in the role of saying no to patients [C]onsumer-driven health care is an effort to put patients in a position to say no to themselves”).

contribution” plans, although terms are not always used consistently. For purposes of this Article, to distinguish between the structure and financing of plans and also among different plan structures, I lump all plans that give consumers the right to buy medical care directly or to design their own health benefit structures under the generic term “consumer-choice plans.”

The term “defined contribution” has a more specific meaning in the employee benefit world. It refers to an employer’s financial method or strategy for calculating how it pays employee benefits.⁴⁰ An employer with a defined contribution plan pays a fixed or “defined” amount (in dollars or percentage of wages, for example) toward employee benefits. These dollars can be used to fund a self-funded plan under the Employee Retirement Income Security Act (ERISA),⁴¹ or to purchase health insurance policies from insurance companies or managed care organizations. Alternatively, the dollars can be paid to an employee (or to a designated employee account, like a medical savings account) so that the employee can use the dollars to purchase benefits or services of his own choosing. The employer discharges its obligation with this payment. The employer does not guarantee any particular benefits or medical care. Defined contribution plans contrast with defined benefit plans, which guarantee employees a specific benefit or package of benefits, for a fixed premium, regardless of what it costs to provide those benefits in the future. Employers who fund their own health plans (as in self-funded ERISA employee welfare plans) must use their own assets to pay whatever the promised benefits cost.⁴² Some defined contribution plans allow an employee to use some or all of the contribution to purchase a defined benefit health insurance policy, which offers some guarantee of specific covered services, but in that case, the responsibility for providing any guaranteed benefits lies with the insurer or MCO. Some defined contribution plans function,

⁴⁰ Paul Fronstin, *Defined Contribution Health Benefits*, EBRI ISSUE BRIEF, No. 231, Mar. 2001 [hereinafter Fronstin, *Defined Contribution Health Benefits*] (describing defined contribution plans for retirement and health benefits).

⁴¹ 29 U.S.C. §§ 1001-1461 (2000).

⁴² Jon R. Gabel & Gail A. Jensen, *Self-Insurance in Times of Growing and Retreating Managed Care*, HEALTH AFFAIRS, Mar./Apr. 2003, at 202, 205-06 (reporting that most self-funded employer plans, especially those from small employers, rely on indemnity insurance, although some large organizations have created managed care plans).

at least in part, like a medical savings account or like a 401(k) retirement plan.

“Consumer-driven” or “consumer-directed” health plans are characterized by consumer involvement in structuring plan components, rather than by the way they are financed. There are several models, just as there are many models of managed care plans.⁴³ An employee may use designated funds to buy health care or to purchase the package of benefits with the providers she prefers. Such plans are most often financed by employer-defined contributions, a financing method that can also be used by public entities.⁴⁴

It is too early to say whether any of these consumer-choice plans are the wave of the future, a niche market product, or a flash in the pan. As of 2001, an estimated 1.5 million Americans were members of some type of consumer-choice health plan.⁴⁵ That represents 0.9 percent of all Americans under age 65 in employment-based plans, and 0.6 percent of the total non-elderly population in the United States.⁴⁶ The number of companies that offer these plans to employers remains limited,⁴⁷ and few employers have more

⁴³ Fronstin, *Defined Contribution Health Benefits*, *supra* note 40, at 11.

⁴⁴ In theory, a consumer-driven plan could be financed like a defined benefit plan, but would not be attractive to sponsors who seek to limit their health care expenditures, because it would encourage consumers to create an expensive package of benefits using expensive providers.

⁴⁵ Gabel et al., *supra* note 36, at W404 (noting that supporters' predicted groundswell of enrollment has not materialized, but that enrollment has grown more than skeptics predicted). *See also* Jon B. Christianson et al., *Defined-Contribution Health Insurance Products: Development and Prospects*, HEALTH AFFAIRS, Jan./Feb. 2002, at 49.

⁴⁶ *Fronstin 2002*, *supra* note 7.

⁴⁷ Lumenos (Alexandria, Virginia), Definity Health (Minneapolis, Minnesota), and MyHealthBank (Portland, Oregon) offer health reimbursement-type plans. *See* discussion *infra* Part IV.B. General descriptions of their plans are available at their websites. *See* Lumenos, Inc., at http://www.lumenos.com/Lumenos_Program/At_a_glance (last visited Jan. 30, 2004); Definity Health Corporation, at <http://www.definityhealth.com/marketing/productsServices.html> (last visited Jan. 30, 2004); MyHealthBank, Inc., at <http://www.myhealthbank.com/corp/products/unify.jsp?cat=pd> (last visited Jan. 30, 2004).

Vivius (Minneapolis, Minnesota) offers consumer-directed customized packages. *See* discussion *infra* Part IV.C. *See also* Vivius Inc., at <http://www.vivius.com/public/consumers/index.asp> (last visited Jan. 30, 2004).

Lumenos and Definity are not licensed as insurers to date, but instead, administer self-funded employer plans, often taking a percentage of the monthly plan premium as a fee for administration. Gabel et al., *supra* note 36, at W397. For example, Definity takes ten percent. Zina Moukheiber, *Give Them a Stake*, FORBES MAGAZINE, May 13, 2002, at 171. Vivius and MyHealthBank have licensing agreements with HealthNet and Blue Cross/Blue Shield, respectively. *Id.* at W399.

than one or two years of experience with them.⁴⁸ Therefore, one might argue that consumer-choice plans are a fad that need not be taken seriously.

The contrary view is that regardless of their low prevalence, consumer-choice plans may represent a shift in thinking that could influence the structure and operation of all health plans for the near future. Several large health insurance companies are developing consumer-choice plans – an indication that these companies consider consumer-choice plans to be a potential competitive force in the future.⁴⁹ Many insurers and managed care companies have already incorporated more consumer choice into the structure of their managed care and insurance products. Even if consumer-choice is not the dominant model, its effects may be significant. HMOs – in the narrowest sense of closed panel organizations – remain a minority organizational structure in the health benefits market, but managed care issues drive the health policy debate nevertheless. Thus, even if consumer-choice plans only attract a minority of the population, their emphasis on consumer participation in choosing and designing health plans may reshape health insurance and the health policy debate in general.⁵⁰

⁴⁸ Gabel et al. mention about 50 companies that offer consumer-directed plans. Gabel et al., *supra* note 36.

⁴⁹ Aetna, Humana, UnitedHealth Group, Blue Cross/Blue Shield and Tufts Health Plan in Boston announced that they have or will create plans to meet the competition. See *Aetna Expands Product Line Offerings*, *supra* note 38. Some industry representatives predict that consumer-choice plans could occupy 20% of the market by 2005, and perhaps 50% by 2007. Gabel et al., *supra* note 36, at W405. That may be optimistic. A similar prediction was made for Medicare managed care plans, but fewer Medicare beneficiaries than expected moved into managed care plans and many plans dropped out of the Medicare market. In 2003, only about 4.6 million of Medicare's 40 million beneficiaries were enrolled in Medicare managed care plans. Reed Abelson, *Private Plans Again Seen as Aid to Medicare*, N.Y. TIMES, July 5, 2003, at A1.

⁵⁰ Because most Americans get their health coverage through employment, health insurance policy is often disproportionately targeted to and influenced by employers and employees, as well as Medicare beneficiaries. Enron executives aside, most employees and their dependents rely entirely on their health insurance to pay for their medical care, because they cannot afford to pay out of pocket for non-nominal care. This large population forms what Uwe Reinhardt called the middle tier of the United States three-tiered health system. Uwe E. Reinhardt, *Turning Our Gaze From Bread and Circus Games*, HEALTH AFFAIRS, Spring 1995, at 33, 34. The top tier includes the wealthy who can afford to pay out of pocket for health care; the middle tier includes employees, their dependents, and most Medicare and Medicaid beneficiaries; the bottom tier includes the uninsured and underinsured who depend on public hospitals and clinics and free care pools and often go without basic and preventive care. The large middle tier population includes the majority of voters, and when they are squeezed, they complain, often to their legislators. *Id.*

The following subsections describe the general categories of consumer-choice health plans.

A. *Consumer Choice Among Selected Plans “On Offer”*

The simplest form of consumer-choice health plans are cafeteria plans that have been in operation for many years.⁵¹ Employer-based plans give employees a choice of two or more health plans (HMO, PPO, POS, or indemnity) offered by the same or different insurers.⁵² Benefit plans for government employees, like the Federal Employees Health Benefits Program (FEHBP)⁵³ and the California Public Employees Retirement System (CalPERS),⁵⁴ offer government employees a wide choice of plans offered by different companies, which can encourage competition that may improve the price or quality of plans, or both. A wide array of different plans is likely to be attractive to consumers. Nonetheless, by itself, merely offering a choice of plans does not guarantee significantly lower costs, better quality or patient satisfaction. Premiums for most plans are not dramatically different. Moreover, most of the plans on offer are defined benefit plans, which do not give consumers much say in directing their own health care. An employer can control the cost of employee health benefits to some extent by selecting the health plans on offer and by limiting the amount or percentage of its contribution to premiums. Employers gain the greatest financial advantage by using a defined contribution to cap the cost of their premium payments.

B. *Health Reimbursement Arrangements or Plans*

The current prototypical consumer-choice plan gives employees a fixed dollar amount (or percentage of wages) with

⁵¹ Fronstin, *Defined Contribution Health Benefits*, *supra* note 40.

⁵² Most employers offer plans sold by the same insurer or managed care organization. Different plans offered by the same company may not actually produce much difference among the choices. As Alain Enthoven points out, “they do not provide the competition among delivery systems that motivates improvement” in quality or cost. Alain C. Enthoven, *Employment-Based Health Insurance Is Failing: Now What?*, HEALTH AFFAIRS, May 28, 2003, at W3-237, W3-240, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.237v1.pdf>.

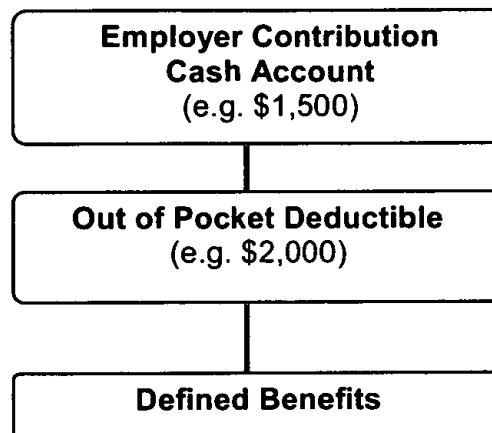
⁵³ 5 U.S.C. §§ 8901-8914 (2000). For a general description of the program, see Office of Personnel Management, at <http://www.opm.gov/insure/health/> (last visited Jan. 31, 2004). The FEHBP covers about 8 million federal employees and their dependents.

⁵⁴ For a general description of the program, see CalPERS, at <http://www.calpers.ca.gov/health/> (last visited Jan. 31, 2004).

which to purchase health care directly from providers and/or buy an insurance policy or managed care plan. The package appears similar to a medical savings account plus a managed care or indemnity (defined benefits) insurance policy. Often referred to as a health reimbursement arrangement (HRA), these plans have been granted favorable tax status by the Internal Revenue Service, which may encourage employers to adopt them.⁵⁵

Since HRAs are relatively new, only a small proportion of employers offer them. However, several national insurance companies, including Aetna and some Blue Cross/Blue Shield organizations, are developing HRA plans.⁵⁶ Although there is no uniform structure for HRAs, which are still evolving, existing plans follow a general template of two or three tiers like the structure shown in Figure 2.

Figure 2: Health Reimbursement Arrangements



In the top tier, an employer contributes a fixed dollar amount, perhaps one or two thousand dollars, to each employee's designated medical savings account, which the employee can use to purchase medical care from anyone.⁵⁷ Some plans place restrictions on the type of services an employee can purchase with these "banked" account funds. For example,

⁵⁵ The IRS ruled that this employer contribution is not taxable if paid solely by the employer and not taken from an employee's salary, and is used for substantiated medical payments including premium payments. Rev. Rul. 2002-41, 2002-28 I.R.B. 75.

⁵⁶ See Gabel et al., *supra* note 36, at 399.

⁵⁷ In this discussion, in the case of employees who purchase coverage for their families, the term "employee" includes covered dependents who select specific medical services for themselves.

some plans might limit purchases to particular types of care and prescription drugs. Others might prohibit expenditures for cosmetic surgery or custodial care. Most plans permit employees to choose any provider in order to maintain the advantage of consumer choice. However, employers may contract with provider groups to offer discounted fees to employees, so that employees who use these providers will spend a smaller proportion of their account funds. In order to encourage employees to remain healthy, more generous plans may permit expenditures for preventive care, like immunizations, well-baby care, and smoking cessation or fitness programs, without counting them as account expenditures. Some plans may allow unexpended account funds to roll over to subsequent years.

When the initial “banked” amount has been expended, plans often require employees to pay out of pocket – up to a maximum amount, such as two thousand dollars – for subsequent medical care. Not all plans have this middle tier, however. Those that do could structure it in different ways, such as a co-payment for additional contributions by employers. This tier may also contain restrictions on the type of services that would qualify as middle tier expenditures.

Once the maximum has been paid by or on behalf of the employee, remaining medical expenses are financed through some form of health insurance, typically a defined benefit plan – the third or final tier. In these cases, the initial and middle tiers function as a deductible. The employer may purchase a managed care plan or indemnity policy for the employee group, with a package of defined benefits. In a self-funded plan, the employer may begin paying directly for medical care, with or without a cap on per capita or total expenditures. Alternatively, the employer may provide the employee with a fixed contribution that the employee can use to buy a health insurance policy or membership in a managed care plan. To negotiate lower premiums than would be available for individual policies, the employer or HRA plan ordinarily creates a benefit plan or selects the choice of plans from which an employee can choose. This third tier offers something like catastrophic coverage, and may appear in the same variety of plan structures that exist for regular group insurance plans.

In view of the possible variations in each tier, no single description will capture the details of every HRA.⁵⁸ Nonetheless, the general structure has two characteristic attributes: cash or its equivalent goes to the employee to buy medical care, and some form of health insurance benefit plan covers medical care expenses above a certain minimum.

C. Consumer-Directed Plans

Consumer-directed or consumer-driven plans offer the most consumer involvement in structuring health benefits. Consumers design their own customized health plans by selecting its components – provider network, benefit package, cost-sharing requirements, conditions and limitations – from choices offered by a commercial company or employer.⁵⁹ Figure 3 illustrates categories of options, which can be varied in many ways, with consumers choosing differently priced components in each category:

Figure 3: Consumer-Directed Plan

PREMIUM LEVEL	CONSUMER-CUSTOMIZED PLAN COMPONENTS				
	Physician Network	Hospital Network	Benefit Package	Cost Sharing	Other Limits
High \$\$\$	Open	Open	Broad	Low	Few
Medium \$\$	PPO	PPO	Average	Medium	Average
Low \$	Closed Panel	Fixed	Limited	High	Many
	+	+	+	+	= \$ Total Premium

Ideally, there should be several options for each component. For example, provider options might include the

⁵⁸ The Pacific Business Group on Health (PBGH) partnered with Definity to offer what it calls the Breakthrough Plan and received “a small share” of Definity stock in return. See Pacific Business Group on Health, *Breakthrough Strategy – Promoting Consumer Choice and Reengineering of Health Care Delivery*, at <http://www.pbgh.org/programs/breakthrough> (last visited Jan. 31, 2004). PBGH states that the plan is not managed care and it is not a defined contribution plan, yet the description suggests it may be both. See News Release, Definity Health, Pacific Business Group on Health Unveils Groundbreaking Alternative to Managed Care, available at http://www.definityhealth.com/marketing/newsroom/pressreleases/2001/Breakthrough_Release_11052001.pdf (last visited Jan. 31, 2004).

⁵⁹ Companies that have created and offer consumer customized packages include Vivius and MyHealthBank. See *supra* note 47.

choice of any physician, a fixed network of physicians, or a physician network with the possibility of referral outside the network. Each of these options is priced separately, with greater freedom of choice and more generous benefits generally priced higher. A premium is calculated based on the total cost of the components. Employees who find that their choices yield a premium that is unacceptably high will have to select less expensive components.

These plans are designed to – and do – force the consumer to face the cost of health care choices in far more detail than is possible when the choice is among health plans as a whole. Consumer-directed plans are most often financed by defined contributions, although they need not be. A fixed contribution forces the consumer to make explicit trade-offs between the premium amount and the scope of services covered, freedom to choose physicians and hospitals, provider locations, the size of deductibles and co-payments, dispute resolution procedures, and other plan elements. For example, a consumer who wishes to use a teaching hospital, because it offers a higher quality of care, might have to pay a higher premium or a large co-payment.

V. IMPLICATIONS OF CONSUMER-CHOICE HEALTH PLANS

A. *Advantages for Employers*

The most obvious advantage that consumer-choice plans offer employers is cost savings.⁶⁰ However, this advantage primarily derives from financing the plan with defined contributions, which caps the cost of benefits and protects the employer from rising medical costs. It may also reduce the cost and burden of administering a health benefits plan, although any savings will depend on the employer's previous experience with plan administration or how much outside companies charge to administer self-funded plans.

Consumer-directed plans also shift some, if not all, of the financial and personal risk to employees. Since consumers decide what medical care to buy – at least in the first two tiers – they assume responsibility for how much to spend, what provider to use, and what kind of care they obtain. This

⁶⁰ Alan Lyles, Jonathan P. Weiner, Andrew D. Shore, Jon Christianson, Leif I. Solberg & Patricia Drury, *Cost and Quality Trends in Direct Contracting Arrangements*, HEALTH AFFAIRS, Jan./Feb. 2002, at 89.

responsibility carries with it an implicit assumption of the risk of error, so that consumer-employees are less able or likely to complain to employers about their choices or unfortunate outcomes of treatment. By the same token, it distances the employer from decisions about benefit coverage and liability for negligence or wrongdoing on the part of providers or plan administrators.

B. Advantages and Disadvantages for Consumers

Consumer-choice plans should appeal to consumers. A consumer-choice plan company homepage features as its slogan: "Whoever holds the money writes the rules. With Lumenos, health care consumers hold the money."⁶¹ This is a clear statement that health benefits are a consumer good and that purchasing power determines one's health benefits. It also emphasizes the idea of consumer choice as the foundation for medical care, appealing to the American passion for choice in general and consumer choice in particular.⁶²

An HRA offers consumers considerable freedom of choice in the first two plan tiers. Individuals can shop for physicians and services without the constraints imposed by a gatekeeper system. Most people would appreciate saving the time and bypassing the bureaucracy of obtaining referrals to specialists, for example.⁶³ The ability simply to make an appointment with any physician one likes for routine procedures, like a mammogram or a wart removal, would remove some of the aggravation associated with managed care.

Freedom of choice also provides some measure of control. Consumer-directed plans give consumers more control over the kinds of services included in their insurance coverage. Ideally, consumers could put together a package of services tailored to their own needs and preferences. An insurer's ability to construct flexible packages at a reasonable premium

⁶¹ See Lumenos, Inc., *The Lumenos Program*, at http://www.lumenos.com/Lumenos_Program/At_a_glance (last visited Jan. 31, 2004).

⁶² ANNAS, *supra* note 4.

⁶³ Some managed care plans have all but eliminated the requirement of preauthorization for referrals after finding that preauthorization produced little, if any, cost savings. For example, UnitedHealthcare abandoned its program requiring preauthorization of certain specialty care in 1999. See News Release, UnitedHealth Group, UnitedHealthcare Introduces Care Coordination (Nov. 9, 1999), available at <http://www.unitedhealthgroup.com/news/rel1999/1109ccoord.htm>.

Similar prerequisites to care in network managed care plans may be on the wane. See Robinson, *supra* note 37, at W143.

may be limited, however, since the premium reflects the size and risk profile of the entire consumer pool for that coverage scheme. And, as noted above, consumers assume responsibility for the care they purchase directly, as opposed to care selected and provided by a managed care organization, a responsibility that flows from and counterbalances the gain in control.

For consumers, the benefits of freedom of choice and increased control are contingent and in some instances unavailable. Whether consumer-choice plans actually expand consumers' choices depends upon the type of plan offered. If the plan supplements a menu of health plans offered by an employer, it may increase employees' options. If the plan replaces another plan that the employer would otherwise offer, the effect on choice depends on the content of the old and new options. Employment-based plans still give the employer the ultimate say in which choices are available. There is some evidence that the majority of employers pay more attention to the cost of premiums than to the quality of care or the operation of health plans.⁶⁴ As Marc Pauly and Marc Berger point out, employment-based plans necessarily cater to the average employee – especially the average employee who is more likely to change employment when unhappy – and may ignore the concerns and preferences of employees who have little bargaining power.⁶⁵ This focus on the average mobile employee typically results in considerable uniformity of health plans, so that employees are forced to accept conditions they do not like in order to obtain more important benefits they want.

Consumer-choice plans should be attractive to people who are relatively healthy or free from chronic diseases or conditions that require expensive, ongoing treatment. They may also appeal to people who need specialized treatment that does not cost very much per unit, such as asthma medication, which rarely exceeds the first tier of banked funds in an HRA. Those types of consumers can avoid seeing a primary care provider to get a referral each time they need a prescription

⁶⁴ JON R. GABEL, KELLY A. HUNT & KIMBERLY HURST, WHEN EMPLOYERS CHOOSE HEALTH PLANS DO NCQA ACCREDITATION AND HEDIS DATA COUNT? (Commonwealth Fund, Sept. 1998) (reporting that employers vary in their knowledge of health plans and whether they emphasize premium price, quality, provider networks or other factors in selecting plans for employees), *available at* http://www.cmwf.org/programs/health_care/gabel_ncqa_hedis_293.asp.

⁶⁵ Mark Pauly & Marc L. Berger, *Why Should Managed Care Be Regulated?*, in *REGULATING MANAGED CARE: THEORY, PRACTICE, AND FUTURE OPTIONS* 53 (Stuart H. Altman et al. eds., 1999).

refilled. Similarly, parents can schedule a well-child visit with little fuss. However, people with more expensive problems, like chronic illnesses, who can expect to spend the full amount of any banked account and/or deductible, may find these plans more expensive than an ordinary defined health benefits insurance policy. Accordingly, they may be unable to assemble an affordable package of benefits that covers their needs.

Additionally, consumers face high and even prohibitive information costs regarding consumer-choice plans. In order to decide what she wants in a consumer-choice health plan, a consumer needs better-than-average knowledge of health benefits and plan structures, as well as how to read and interpret a contract, and access and analyze health information.⁶⁶ Many companies post information about consumer-choice plans on their websites, enabling consumers to navigate an interactive program to assemble and compare different plan components. Using the website requires some familiarity with computer-based information systems.⁶⁷ Both defined contribution plans and consumer-choice plans are probably most attractive to young, computer-literate people who like managing their own affairs. It is not surprising, therefore, that small start-up firms, especially software companies, were among the first to offer them. People who do not have access to a computer, cannot manipulate computerized information systems, or lack the sophistication to understand the complexities of health plan structures, face a difficult time availing themselves of consumer-choice plans.

C. *Advantages and Disadvantages for Patients*

Publicly available information about consumer-choice health plans emphasizes consumer issues, largely to the exclusion of patient-related concerns, such as how patients are treated. Most of the information that companies publicly offer focuses on initial entry issues, such as the freedom to select plan components in a consumer-driven plan, or spend banked first tier amounts in an HRA. Information about how to get

⁶⁶ See Vitt et al., *supra* note 6 (discussing research finding that while some consumers may be ready to make more choices, others have little understanding of their health benefits, with some not knowing what type of plan covers them; and that the different health plan options may be “incomprehensible to the estimated 42-90 million Americans with low functional literacy”).

⁶⁷ See Gabel et al., *supra* note 36, at W401.

medical care that cannot be purchased with banked or out-of-pocket funds is harder to find. It appears that all types of consumer-choice plans rely on some form of defined benefits insurance for medical care beyond a minimum threshold, whether it be an ordinary deductible or an HRA tier. Indeed, Alain Enthoven has dismissed consumer-choice plans as a euphemism for ordinary health insurance with a high deductible.⁶⁸

Some consumer-choice plans could produce an inefficient allocation of resources, paying for the kind of care that individuals could most easily afford without insurance and limiting insurance coverage to fewer costly services. For example, employers might spend a larger proportion of their total health benefits funds for the medical savings account segment in the first tier, leaving less with which to buy the residual health insurance coverage. This would disadvantage individuals with more serious conditions or more expensive care needs.⁶⁹ In this case, patients who need significant medical care are likely to be worse off than with either indemnity insurance or managed care of almost any type. “[A] small fraction of the population accounts for a large share of health spending Overall, the top 10 percent of spenders accounted for 58 percent of all health care spending.”⁷⁰ Thus, while the majority of employees might be satisfied with consumer-choice plans, a minority might suffer disproportionately. It is patients, rather than consumers, who confront the high costs for catastrophic care, and it is in these circumstances that patients most resist limits on care.

Once the consumer becomes a patient who needs more than inexpensive out-patient care, she faces the same question of benefit coverage that has bedeviled both indemnity insurance and managed care: does the plan cover the care that she needs? The question may be postponed, but not necessarily avoided. Ultimately, therefore, consumer-choice plans are

⁶⁸ See Enthoven, *supra* note 52, at W3-239 (“The popular ‘consumer-driven’ or ‘defined-contribution’ models are no more than a cover for high deductibles, intended to make consumers cost-conscious shoppers. They offer no real solution, because health expenses are concentrated among high-cost patients whose personal expenses exceed deductibles.”).

⁶⁹ See Catherine Hoffman, Dorothy Rice & Hai-Yen Sung, *Persons with Chronic Conditions: Their Prevalence and Costs*, 276 J. AM. MED. ASS’N 1473 (1996) (reporting that 76% of direct medical care costs in the U.S. are for chronic conditions).

⁷⁰ Paul Fronstin, *Can “Consumerism” Slow the Rate of Health Benefit Cost Increases?*, EBRI ISSUE BRIEF, No. 247, July 2002.

likely to run into the same wall that damaged their predecessors. If consumer-choice plans include defined-benefits health insurance, then they will appeal only to healthy people who like to pick their physicians for preventive and routine care. More importantly, they will not solve the intractable problem of disputes over coverage of expensive treatment. From the patient's perspective, the health policy debate will have turned back on itself, into a contract dispute once again.

D. Implications for Health Policy and Regulation

Consumer-choice health plans encourage thinking about health care as a consumer good, rather than a personal service. This characterization may encourage consumers to learn more about health care in order to make good "purchases." To the extent that the public becomes more familiar with the possibilities and limits of medicine, and the qualifications of providers, society may benefit from more realistic public expectations.⁷¹

The proliferation of consumer-choice plans may also encourage providers to compete more vigorously for patients on the basis of quality as well as price. While some of this competition may improve the general quality of care, it may also divert dollars from some essential medical facilities to boutique medical practices for the carriage trade. In addition, consumers who are paying their own bills may demand more of providers, insisting on diagnostic tests and health-enhancing procedures that drive up the cost of health care. After all, if medical care is just another consumer good, consumers may feel entitled to buy whatever they can afford, regardless of personal need or a physician's judgment.

Not everyone can extensively research medical care, and bad buys in medicine can have serious negative consequences. As discussed in Part V below, it is difficult for anyone to predict the kind of care she might need in the future and, therefore, to make accurate choices about what kind of health plan is worth buying. If consumers are expected to make these choices and

⁷¹ See, e.g., CALLAHAN, *supra* note 2. There is a growing amount of information available to consumers on the Internet, including medical information about diseases and treatment from the National Institutes of Health and non-profit organizations advocating for patients with specific diseases and conditions, and information about physicians from state medical boards and about hospitals and managed care organizations from accrediting organizations.

accept responsibility for them, then they may require considerable assistance. Consumer protection legislation imposing broad disclosure duties on providers and insurers would be most apt for a consumer model, but generic disclosures may not be sufficient to answer questions from the patient's perspective.

Consumer-choice plans also may affect the patient-doctor relationship. To some extent, managed care already has altered the way patients think about physicians and other health professionals. Many patients have expressed fears that physicians would be persuaded or forced to deny them needed treatment because of their financial arrangements with managed care organizations, especially capitated payment arrangements.⁷² A consumer-choice plan that insulates physicians from an insurer's financial influence might restore trust in the physician-patient relationship.⁷³ A patient who buys care directly from a physician – without the need to seek insurer approval – is likely to have confidence that the physician will advise the patient about all available treatments. This gives physicians freedom to make treatment decisions solely in the interests of their patients. It also leaves responsibility for those decisions, including liability for malpractice, with the physician alone, without implicating insurers or employers.

The behavior of consumers and patients will influence the effect of consumer-choice health plans on national health care expenditures. Consumer-choice health plans may force consumers to recognize the costs of their health care, as intended. In theory, consumers may respond by choosing lower cost care, which would lower overall health costs. However, if people forego needed care because of cost, their problems may simply be delayed or exacerbated, affecting their lives and possibly requiring more expensive care in the future. Depending upon the structure of the plan, costs will be shifted

⁷² Patients have brought actions against managed care organizations claiming that their compensation arrangements with physicians created incentives to deny necessary care to patients. *See, e.g.,* *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997), *cert. denied*, 552 U.S. 914 (1997). The decision in *Pegram v. Herdrich*, 530 U.S. 211 (2002), may have foreclosed many future claims.

⁷³ Incentive-neutral payment systems are difficult to design. *See* Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 240 (1996) (describing variables in physicians' organizational structure and compensation elements such as amount, timing, and intensity that create and counteract incentives to offer treatment).

to consumers or among groups of consumers. Costs that are not covered by the plan could also affect the public fisc if the government becomes the payer of last resort. This could drive health care costs higher because at least some of these last resort costs would be additions to, rather than substitutes for, private health plan expenditures.

Consumer-choice plans might encourage fragmentation of risk pools, which could have serious negative consequences for those pools with the sickest patients.⁷⁴ If healthier people enroll in consumer-choice plans, competing health insurance and managed care will have a higher proportion of sicker individuals in their insured populations. This adverse selection can initiate an insurance death spiral. Insurers or plans with higher-risk populations charge higher premiums, which drive healthier individuals out and into competing, lower-premium plans.⁷⁵ The cycle continues until the higher-risk individuals cannot afford actuarially adequate premiums and insurers or plans collapse. Here again, the government may pick up the remnants, either because they become eligible for public programs like Medicaid, or by expanding government benefit programs or creating high-risk insurance pools.

Consumer-choice plans may also alter how health insurance is distributed. To the extent that consumers have a direct insurer-insured relationship with a health plan they choose, the health plan should be more directly accountable to the insured. This could uncouple health benefits from employment.⁷⁶ Employers may find that their role in organizing and administering benefits is sufficiently reduced to encourage them to abandon it entirely, leaving employees to deal directly with plans.

Severing the link between employment and health benefits may not be financially attractive to employers, however. They may save labor costs by offering health benefits instead of higher wages.⁷⁷ Employers may perceive other

⁷⁴ See Robinson, *supra* note 37, at W151.

⁷⁵ See, e.g., RUSS & SEGALLA, *supra* note 20, § 144:7.

⁷⁶ For a critique of current employment-based health insurance, see Uwe E. Reinhardt, *Employer-Based Health Insurance: RIP*, in *THE FUTURE U.S. HEALTHCARE SYSTEM: WHO WILL CARE FOR THE POOR AND UNINSURED?* 325-52 (Stuart A. Altman et al. eds., 1997).

⁷⁷ See Alan B. Krueger & Uwe E. Reinhardt, *The Economics of Employer Versus Individual Mandates*, *HEALTH AFFAIRS*, Spring 1994 Supplement, at 34 (arguing that health insurance costs come out of employee wages), at <http://content.healthaffairs.org/cgi/eprint/13/2/34.pdf>.

advantages of controlling health plans, including ensuring that their employees are covered for illnesses that affect productivity.⁷⁸ From the employee's perspective, there are advantages to having an employer act as broker for health insurance.⁷⁹ Employers have resources to analyze plan characteristics, such as quality and price, synthesize information, and present it in a comprehensible format for employees. Even more importantly, large employers have bargaining power to negotiate lower premiums than are available for individual policies. Insurers favor "natural groups" – those formed for reasons unrelated to health risks – because the population avoids adverse selection. Groups formed as a result of employment are good natural groups, which can qualify for lower premiums. In addition, insurers save on the costs of marketing, because they need only negotiate with the employer, not with each individual employee.⁸⁰

⁷⁸ Ellen O'Brien, *Employers' Benefits from Workers' Health Insurance*, 81 MILBANK Q. 5 (2003) (arguing that health economists often do not consider and rarely evaluate firms' returns stemming from health-related investments and suggesting that health benefits may benefit employers by improving recruitment and retention of highly competent employees and increasing productivity, in addition to reducing absenteeism).

⁷⁹ Paul Fronstin & Ruth Helman, *Findings From the 2000 Health Confidence Survey*, 22 EBRI Notes 1 (April 2001) (noting that some employees appreciate their employer's ability to negotiate from a position of strength). On the other hand, not all employers are effective agents for their employees. See Mariner, *supra* note 34. Enthoven argues that the employer-based system of health insurance is failing and recommends a revival of managed competition, by which he means real competition among insurance carriers, to control rising costs. See Enthoven, *supra* note 52, at W3-237. He says this requires employers to give their employees a real choice among plans having different provider groups, which are offered by different insurance carriers or companies. *Id.* at W3-243. Enthoven's proposal would require regulating insurance carriers to prevent them from selecting risks, but allow them to price according to the risk of enrollees. *Id.* at W3-243 to 244. Exchanges would act as brokers that bring together employers and carriers so a large enough pool of employees can choose a plan. The exchange would adjust premiums for risk after enrollment and sets common rules for all. *Id.* at W3-244. His recommendation for exchanges sounds a lot like the Clinton health plan, except that it would be voluntary (but probably require some amendment of ERISA and state insurance law). It assumes that employees will choose voluntarily and carriers can actually compete for their choice. Since the exchange itself has expenses and profit, it is not clear how much of this would merely replace current carrier expenses and how much would be an addition. Employers may resist this array of choices if it is easier to deal with only one or two carriers. Many self-insure and don't want to buy policies, or do not want to pay premiums based on a population that includes people in addition to their own employees because such "outsiders" may have more health risks and raise premiums, although it is possible to risk-adjust premiums so that employers pay only for their own employees.

⁸⁰ Consumer-choice plans may forfeit some savings in marketing costs if they engage in direct-to-consumer marketing or plan development.

If health benefits were separated from employment, a new set of issues would arise. The first would be whether to depend on insurers issuing individual policies or to encourage or require the formation of groups of prospective insureds. In the absence of rate control, of course, non-group insurance would ordinarily produce higher premiums, thereby defeating much of the purpose of consumer-choice plans, that is, to save money for both consumers and the nation as a whole. Alternatively, insurers could offer fewer benefits for the same premiums, probably disappointing consumers and patients.

Whether employers would abandon their sponsorship of health benefits to the government or even to privately insured groups is hard to predict. Fragmented risk pools appear to destroy one advantage of employment-based insurance groups. However, employers might prefer to continue sponsoring health benefit plans, while reducing benefits and shifting more costs to employees, rather than paying additional wages to permit employees to buy into external plans.⁸¹ Currently, there does not appear to be much support among employers or benefit managers for decoupling health insurance from employment, but the change could occur if a critical mass of employees opted for consumer-choice plans and made their own choices independent of their employer.⁸²

Such a shift would return a large proportion of the population to the status it had before the rise of employment-based health insurance and the adoption of Medicare and Medicaid. It also would require a sea change in insurance regulation to govern millions of individuals, many of whom could not afford individual health insurance policies. A move toward individual policies could set the stage for expanded regulation of insurance to create large enough risk pools –

⁸¹ There might be a role for employers in offering marketing or information about plans offered by independent insurers. Some employers provide this service to employees without creating an ERISA benefit plan, but there appears to be little interest in paying workers higher wages to enable them to buy health insurance in the commercial market. The tax benefits of having an ERISA plan with benefits that count as employee compensation are likely to remain an incentive for employers to retain control over employee benefits. Moreover, employer-sponsored plans may be favored as one means of encouraging employees to remain with the employer. See HERZLINGER, *supra* note 37, at 250-52.

⁸² Gabel et al., *supra* note 36 (reporting results of survey on benefit managers, insurers, health plan managers and benefit consultants that no one was seriously considering terminating their health plans or giving employees a fixed amount with which to purchase insurance independent of employment; also noting that the survey respondents may have an interest in employers remaining in the field).

independent of employment – to avoid adverse selection and to permit reasonable group rate premiums.⁸³ This might also accelerate other insurance reforms, such as regulating marketing practices, mandatory benefit coverage, non-discrimination requirements, standards for dispute resolution, standards of care, and even requirements for the governance of insurance companies and rate regulation to ensure fair premiums. Alternatively, it might encourage broader health policy reforms, such as expanding Medicare to include the non-elderly.

VI. WILL PATIENTS ACCEPT CONSUMER-CHOICE HEALTH PLANS?

Despite past failures, current consumer-choice proposals seek to harness market features to control costs, perhaps to return health care to its nineteenth and early twentieth century status as a consumer good. The proposals offer options to consumers in the hope that consumers will make choices that result in lower total health care spending. In turn, the model shifts responsibility for controlling costs – and increased financial risk – from private sector organizations to the consumer herself. The success of consumer-choice models thus depends on the validity of two assumptions for which there is little empirical evidence. First, it assumes that the choices consumers make will be cost effective. Second, it assumes that consumers can and will make *ex ante* choices to which they will adhere without regret when they become patients.⁸⁴ Both assumptions depend upon the ability and willingness of individuals to abide by contractual limitations on their future access to medical care. This part critically examines these assumptions and their underpinnings.

Americans value choice – both as a general principle and as applied to medical care.⁸⁵ Indeed, public demand for choice induced many MCOs to offer POS and other plans that allow consumers to choose from among a larger group of

⁸³ Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification* (Working Paper, June 2002), available at http://papers.ssrn.com/paper.taf?abstract_id=322581.

⁸⁴ Enthoven, *supra* note 52, at W3-238 (“Any successful cost containment strategy must give doctors and patients good personal reasons to limit spending.”).

⁸⁵ See generally KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS 2003 ANNUAL SURVEY, available at <http://www.kff.org/insurance/ehbs2003-1-set.cfm> (last visited Jan. 31, 2004); ANNAS, *supra* note 4.

providers.⁸⁶ However, expanded choice within a health plan can be costly. MCOs lost bargaining power by contracting with many providers, so that POS and expanded-choice plans cost more than restricted-network HMOs. The idea that consumers would choose the least costly provider seems counterintuitive, especially in the United States, where people often associate price with quality. Indeed, consumers are most likely to associate the concept of choice with choice of physicians, not with a choice of health plans.⁸⁷

Choosing providers may not prove to be the most important determinant of health care costs. For example, it may be the number of transplants performed, not whether the transplant costs \$300,000 when performed by Dr. A at Hospital B or \$400,000 when performed by Dr. C at Hospital D, that drives up health care costs. In that case, whether the transplant is covered at all has more influence on total costs than who performs the transplant. If this is true, then the scope of covered benefits should be the most important element of a health plan. Yet, consumers may not recognize a future need for transplant coverage and therefore may purchase a cheaper plan without such coverage. When the transplant is needed, the consumer is now a patient and may resist enforcement of any contract that denies coverage. Thus, opting for a less costly plan does not mean that a patient will abide by it without challenge, thus undoing much of the expected cost-saving.

The consumer-choice model rejects a “one size fits all” approach to health insurance, encouraging different sizes or packages of benefits, providers, and prices so that consumers can choose among them. It is possible, however, that for the costly services of greatest concern to patients, one size does fit most, if not all. Most people appear to want generally the same thing – good quality care for whatever serious, expensive illness befalls them. Therefore, a major challenge to the success of consumer-choice models is the fact that consumers choose health plans, while patients choose medical care. Thus, contracts for health benefits must describe precisely what medical care will be included in covered benefits to permit consumers to accurately purchase a health plan for their future selves as patients. Moreover, consumers must be able and

⁸⁶ In some cities, almost all physicians participate in all health plans.

⁸⁷ See KAISER FAMILY FOUNDATION, *supra* note 85.

willing to predict what their future needs will be and choose accordingly.

One school of thought argues that the public should have access to enough information about a health plan to permit informed choices.⁸⁸ This is a consumer-oriented remedy for imbalances in information. The information could be provided by the health plans themselves, employers who offer them, government agencies, or independent non-government organizations.⁸⁹ The public already has access to considerable information. Most health plans distribute information brochures to prospective consumers and make information available on their websites. Employers, as well as independent organizations, offer summary comparisons of the most salient features of selected plans.⁹⁰

It is not clear, however, that the type of information disclosure currently required or voluntarily provided either meets consumers' needs or encourages cost-saving choices.⁹¹ In particular, it is not clear that information disclosure, no matter how complete, can prevent disputes over benefit coverage when a patient needs care. After all, it is almost impossible to describe the specific types of diagnostic procedures and treatments that will be covered in the case of all types of illnesses and injuries. Aside from the infinite variability of

⁸⁸ William M. Sage, *Regulating Through Information: Disclosure Laws and American Healthcare*, 99 COLUM. L. REV. 1701 (1999). Most state licensure laws have been modified in recent years to expand disclosure requirements. *Id.*

⁸⁹ Several organizations offer descriptions of different plans. *See, e.g.*, California Choice Health Insurance (company offering private employers a choice of 6 different health plans types), at <http://www.calchoice.com> (last visited Jan. 31, 2004).

⁹⁰ The Employee Retirement Income Security Act (ERISA) requires employment-based plans to give employees a summary of information about the health plan, although the required information falls short of the kind of operational detail recommended by consumer advocates or required by state laws governing non-ERISA insurance plans. 29 U.S.C. §§ 1021-1022 (2000).

⁹¹ *See Sage, supra* note 88; Rodwin, *supra* note 33. Even report card systems purporting to compare the quality of care provided by different plans may not offer the information that consumers want to know. *See, e.g.*, Huw T.O. Davies, A. Eugene Washington & Andrew B. Bindman, *Health Care Report Cards: Implications for Vulnerable Patient Groups and the Organizations Providing Them Care*, 27 J. HEALTH POL. POL'Y & LAW 379 (2002). *See also* MARY GRAHAM, *DEMOCRACY BY DISCLOSURE: THE RISE OF TECHNOPOPULISM* (2002). "Disclosure systems have been systematically oversold" as a method of helping people reduce health risks or make safe purchases. *Id.* at 157. Graham argues that, despite their theoretical value, useful disclosure systems are difficult to design. *Id.* at 153-55. She points out that disclosure requirements "to reduce risks have been products of expediency and frustration." *Id.* at 11. In disputes over whether or how to regulate risks, disclosure has been a political compromise solution that avoids complete corporate transparency and traditional governmentally imposed product standards. *Id.*

human beings, which requires tailoring medical treatment recommendations to individuals, advances in medical technology continue to add options for future diagnosis and treatment, while medical and health services research and evaluate the effectiveness of old and new techniques. A complete catalog of covered services would fill a multi-volume compendium.⁹² Even if such a catalog were available, it is not clear whether consumers would be able to select the treatment options – or even medical conditions – that they want or need to be covered, because that requires predicting one's future medical needs.⁹³ This type of projection is notoriously difficult to do even with the best information. Moreover, there may be a significant population that is not inclined to attempt it.⁹⁴

Consumer-choice proposals are predicated on the assumption consumers can decide, *ex ante* – when they must choose a health plan during an annual enrollment period – which plan they will want when they need care in the future. In principle, this type of forward-looking decision making is no different from any personal services contract in which a

⁹² Some boundaries are necessarily imposed by one-year health plan terms, which limit the time within which future technologies might become available and, therefore, the scope of coverage. In addition, most health plans exclude coverage of experimental or investigational therapies, although whether these exclusions ought to apply in an individual case is a frequent subject of dispute. *See, e.g.*, *Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196 (1st Cir. 1997), *cert. denied*, 523 U.S. 1072 (1998); *Loyola University of Chicago v. Humana Insurance Co.*, 996 F.2d 895 (7th Cir. 1993).

⁹³ People with chronic diseases are certainly aware of coverage categories or treatments, and often physicians, that they wish to have covered. However, they may in fact have less freedom of choice if the desired coverage is beyond their means. Genetic testing may also help some people predict their risks of some future illnesses, but may also subject them to other disadvantages, from increased insurance premiums to employment discrimination. *See generally* Alexandra K. Glazier, *Genetic Predispositions, Prophylactic Treatments and Private Health Insurance: Nothing is Better Than a Good Pair of Genes*, 23 AM. J.L. & MED. 45 (1997); GENETIC SECRETS: PROTECTING PRIVACY AND CONFIDENTIALITY IN THE GENETIC ERA (Mark Rothstein ed., 1997); NEW YORK STATE TASK FORCE ON LIFE & THE LAW, GENETIC TESTING AND SCREENING IN THE AGE OF GENOMIC MEDICINE (2000); ASSESSING GENETIC RISK: IMPLICATIONS FOR HEALTH AND SOCIAL POLICY (Lori B. Andrews et al. eds., 1994).

⁹⁴ A significant number of people do not designate a health care proxy or surrogate decision-maker to act in case of their future incompetence, despite surveys indicating support for such options as well as concern that patients' wishes are too often ignored. *A Controlled Trial to Improve Care of Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preference Outcomes and Risks of Treatments (SUPPORT)*, 274 J. AM. MED. ASS'N 1877 (1998). Although securing treatment for life-threatening illnesses is among the foremost concerns of health insurance, there may be psychological reasons for avoiding discussions of one's future terminal illness or death, which might not apply when making decisions about the probability of future illness or injury that is not life-threatening. *See generally* INSTITUTE OF MEDICINE, APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE (1997).

consumer contracts for personal services in the future.⁹⁵ However, the consequences of an error in prediction about one's need for medical care are often far more serious than an error in predicting one's future need for furnace repairs or even legal services.

Additionally, a person's preferences can change. What a consumer wants, or can currently afford, may not suffice when that consumer becomes a patient. The problem of inconsistent preferences across time appears to be particularly troubling in health insurance.⁹⁶ The consumer who chooses a less costly health plan today may believe that her future self will be satisfied with a limited range of benefits or providers, or that she will have enough money to pay for any health care not covered by the plan. When the future arrives, however, she may not be satisfied in fact and may not have the money after all.

Contracts are a way of binding oneself to behave more rationally or ideally in the future. Indeed, more traditional health economists and contract proponents advocate contracts as a way to force consumers to make binding economic choices. Unlike personal decisions about one's own behavior or promises to oneself, however, which one can abandon unilaterally, an insurer can enforce a bilateral contract against the insured. Such contracts could be considered a form of an Odysseus contract, in which one asks another to prevent them from succumbing to their own future desires. But while Odysseus may have been genuinely grateful for being restrained from embracing the sirens, will patients who elect limited benefit coverage be grateful for the money they saved last year when

⁹⁵ Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755 (1992).

⁹⁶ For example, one behavioral economics approach contrasts the choices that one makes today with the choices that he makes for the future or his "future self." See, e.g., JONATHAN GRUBER & BOTOND KOSZEGI, A THEORY OF GOVERNMENT REGULATION OF ADDICTIVE BADS: OPTIMAL TAX LEVELS AND TAX INCIDENCE FOR CIGARETTE EXCISE TAXATION (Nat'l Bureau of Econ. Research, Working Paper No. 8777, Feb. 2002). These "time-inconsistent" preferences represent what a person "would like for himself today and what he would like for himself tomorrow," which are often quite different. See, e.g., Jonathan Gruber, *Government Policy Towards Smoking: A View from Economics*, 3 YALE J. HEALTH POL'Y L. & ETHICS 119, 122 (2002) (arguing that people often choose pleasure over risk avoidance today in the belief that, in the future, they will be more forbearing and choose to stop taking risks, like smoking or overeating; but that people who claim or believe they will quit smoking (or start dieting) in the future often find that tomorrow never comes, because every day, one's future forbearing self becomes today's pleasure-seeking self).

treatment that may save their lives is denied this year because it is not a covered benefit?

Characterizing patients as consumers may increase demand for health care. Since the collapse of the Clinton administration's proposal for universal coverage, medical care and health insurance have been described as products – and patients as consumers. Consumers are entitled to buy whatever they want to the extent of their financial resources. Contracts can, at best, control supply. They cannot control demand. The problem of demand for medical care – and therefore resistance to contractual limits – seems insoluble, especially in a private market that encourages consumer choice.⁹⁷ Paradoxically, the more people think of medical care and health insurance as a consumer good or a matter of contract, the more care they may demand. This can also erode any sense of social responsibility for protecting everyone from devastating illness. Examples of this erosion can be seen in the rise of “boutique” medicine, which offers “consumer choice” of medical services,⁹⁸ while state Medicaid programs have insufficient funding to cover necessary expenses for people in need.⁹⁹

The foregoing examination suggests that disputes over defined benefits cannot be prevented unless health plans define and enforce limits in a way that is acceptable to patients as well as consumers. This puts a heavy burden on those who design and interpret health plan benefits, a burden that has not been met so far. The next section takes a preliminary look at the question whether the legal principles that apply to health plan interpretation and enforcement can resolve disputes over benefit coverage.

VII. PROBLEMS WITH INTERPRETING CONTRACTS FOR CONSUMERS AND PATIENTS

The drive to use contracts gains support from the idea that contracts are voluntary agreements that operate under well-known rules of law, so that enforcement should be both

⁹⁷ Wendy K. Mariner, *Patients' Rights After Health Care Reform: Who Decides What Is Medically Necessary?*, 84 AM. J. PUB. HEALTH 1515 (1994).

⁹⁸ Victoria Colliver, *Palo Alto Clinic Goes 'Boutique,'* S.F. CHRON., Mar. 25, 2003, at C3; Cindy Tumiel, *The Doctor Will See You Now – Really; 'Boutique' Medicine Offers Return of Old-Style Service, But at a Price,* SAN ANTONIO EXPRESS-NEWS (Texas), Dec. 9, 2002, at A1.

⁹⁹ Robin Toner & Robert Pear, *Cutbacks Imperil Health Coverage for State's Poor,* N.Y. TIMES, Apr. 28, 2003, at A1.

relatively straightforward and automatic. However, both the rules and their application are neither necessarily self evident nor universally accepted.

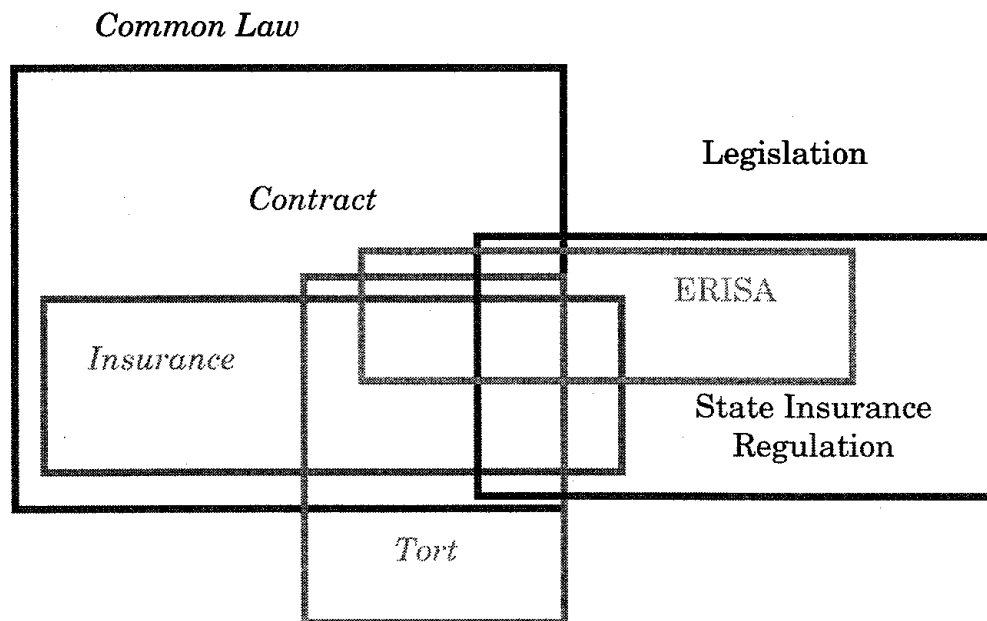
I hypothesize that health insurance contracts have both failed to control costs and instill consumer confidence because they are based on a model of consumer choice that fails to fully account for the real world of employment-based health insurance and the needs of patients. After all, it is employers, not consumers, who select the array of plans from which employees choose. And it is patients, not consumers, who demand care that increases costs. When consumers get sick, they become patients, and patients do not necessarily want contract limits enforced.

Resistance to contract limits may be exacerbated by an ill fit between the law governing the terms of an insurance contract and the substance of the contract terms: medical care. Patients who resist contract enforcement may claim, in effect, that contract or insurance law is the wrong law to govern their medical care. A more nuanced claim might be that the general rules governing insurance policies do not adequately take into account what is promised, what is expected, or what is agreed upon by parties to a group health plan. Thus, until the parties agree on how the contract should be interpreted and what rules should govern that process, they should not be expected to adhere to an agreement without complaint.

A. *What Rules Govern Health Plans?*

Legal principles provide standards for interpreting and construing contracts and supply default rules where contracts are silent or ambiguous. Yet many principles from several areas of law, including contract, insurance, and tort, compete for application to health plans, as illustrated in Figure 4 below. State insurance legislation and regulations govern the licensure and operation of insurance companies and most managed care organizations, and impose some requirements on the substance of insurance policies. ERISA, however, limits the application of state legislation and common law that “relates to” private employee group health plans that are subject to ERISA.¹⁰⁰ Simply choosing applicable rules can be a matter of dispute.¹⁰¹

¹⁰⁰ Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461 (2000).

Figure 4: Legal Principles

In theory, each promise in a contract may best fit a particular legal doctrine. Contract doctrines function well in defining what counts as an agreement and what circumstances permit the parties to agree. Contract doctrines also do a good job of defining predictable rights and duties, such as delivery of goods or services that are specifically identifiable in advance. For example, a promise to pay a fixed sum of money if an injury

See generally Karen A. Jordan, *Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution*, 65 MO. L. REV. 405 (2000); Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 NEW ENG. J. MED. 1986 (1996). The U.S. Supreme Court's jurisprudence on ERISA preemption of state laws affecting managed care has evolved significantly in the past decade. *See, e.g.*, *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *De Buono v. NYSA-ILA Medical and Clinical Servs. Fund*, 520 U.S. 806 (1997); *Unum Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999). A new test was formulated this year for determining whether state laws qualify for the exception to § 514 preemption because they regulate insurance. *See Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).

¹⁰¹ This is seen most often in disputes over whether ERISA preempts state common law liability claims and state insurance laws. *See* Wendy K. Mariner, *Slouching Toward Managed Care Liability: Reflections on Doctrinal Boundaries, Paradigm Shifts, and Incremental Reform*, 29 J.L. MED. & ETHICS 253 (2001). The Supreme Court recently agreed to hear appeals in two cases involving ERISA preemption of state claims of MCO negligence. *See Aetna Health Inc. v. Davila*, 124 S. Ct. 462 (granting writ of cert., Nov. 3, 2003); *Cigna Healthcare of Tex., Inc. v. Calad*, 124 S. Ct. 463 (Nov. 3, 2003) (granting writ of cert.).

occurs next year can be described and enforced by contract with little debate. By contrast, a promise to provide appropriate medical care if an illness occurs next year is more difficult to specify. Deciding how to fulfill the promise – and what it will cost – is far less predictable, especially in light of medical advances and variations in provider competence and patient preferences. Thus, certain kinds of promises to provide medical care may be especially difficult to define, interpret, or enforce. Indemnity health insurance mitigated the uncertainty by delegating to physicians two key elements of insurance – defining what counted as a covered loss and what counted as payment for the loss. It is commonly understood that managed care superseded indemnity health insurance because paying for whatever medical care a physician recommended became too costly. But indemnity insurance may have lasted as long as it did not only because medical care was less expensive, but also because insurers avoided the key elements that make underwriting possible: carefully predicting risks and losses.

Insurance itself does not fit neatly into the typical context of contract law.¹⁰² Professor E. Allen Farnsworth suggests that insurance law developed as a separate field because the general body of contract law did not adapt itself to handle insurance disputes.¹⁰³ Insurance law is the primary source of legal doctrine governing insurance contracts, yet insurance treatises devote relatively little attention specifically to health insurance, often placing it in a chapter on “other insurance issues.”¹⁰⁴ Most rules have been developed in the context of commercial lines of insurance, and most health insurance case law, apart from cases turning on issues of ERISA preemption, involves individual insurance policies.¹⁰⁵

¹⁰² FARNSWORTH, *supra* note 3, § 1.8 (stating that older contract treatises regarded insurance as “outside the scope of general contract law”). *See also* James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995 (1992). Standard treatises on contract law typically mention health insurance contracts briefly as examples of standardized or adhesion contracts, if at all. *See, e.g.*, CORBIN ON CONTRACTS I-108 to I-109 (J.E. Murray, Jr., ed., rev. ed. 2002 & Spring Cum. Supp.); P.S. ATIYAH, AN INTRODUCTION TO THE LAW OF CONTRACT 273 (1995).

¹⁰³ FARNSWORTH, *supra* note 3 at §1.10 (insurance law developed when contract law did not succeed in adapting to insurance transactions).

¹⁰⁴ *See, e.g.*, JEFFREY W. STEMPEL, 2 LAW OF INSURANCE CONTRACT DISPUTES § 22.10 (2d ed. 2002); MALCOLM A. CLARKE, POLICIES AND PERCEPTIONS OF INSURANCE: AN INTRODUCTION TO INSURANCE LAW (1997); HOLMES & RHODES, *supra* note 20; RUSS & SEGALLA, *supra* note 20; ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW (2d ed. 1996); KEETON & WIDISS, *supra* note 20.

¹⁰⁵ Employee group health insurance often requires binding arbitration, and

Basic principles of insurance policy construction are intended to carry out the parties' intent as expressed in the contract.¹⁰⁶ Unambiguous terms should be enforced as written. However, not everyone agrees on what is ambiguous. Where ambiguity exists, the doctrine of *contra proferentum* encourages construing ambiguous terms against the drafter and in favor of coverage.¹⁰⁷ Different interpretive approaches complicate construction.¹⁰⁸ On the one hand, courts should give contract terms their ordinary meaning. On the other hand, courts should also view each term in the context of the contract as a whole in order to determine the meaning of individual rights and duties. Thus, there is ample room for disagreement, interpretation, and even maneuvering in construing policy terms.

Employee group health insurance has unique characteristics that deviate from the assumptions underlying general insurance law doctrine, especially individual first-party insurance.¹⁰⁹ For example, the insurer and employer negotiate the contract, which the employee rarely sees.¹¹⁰ This raises questions about what an employee can be deemed to agree to and whether the employer can act on behalf of its employees when it bears some or all of the cost of insurance.¹¹¹ Group health insurance contracts are also standard form contracts, which have non-negotiable terms to simplify their application to a large population. Yet decisions about how to treat a patient are highly individual. Corbin links insurance regulation with

the resulting decisions do not necessarily include explanations of the legal reasoning.

¹⁰⁶ HOLMES & RHODES, *supra* note 20, § 5.1.

¹⁰⁷ *Id.* § 6.1. See also Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 541 (1996) (comparing judicial approaches to the doctrine of *contra proferentum*).

¹⁰⁸ Jeffrey W. Stempel, *Unmet Expectations: Undue Restrictions of the Reasonable Expectations Approach and the Misleading Mythology of the Judicial Role*, 5 CONN. INS. J. 181 (1998) (describing variations in judicial interpretations of doctrine, ambiguity, and expectations of the parties in contract construction and interpretation).

¹⁰⁹ See Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, HEALTH AFFAIRS, Nov./Dec. 1999, at 124; Mariner, *Standards of Care*, *supra* note 6, at 22-23.

¹¹⁰ Employees typically receive a summary of how the health plan operates, but not the contract between the employer and insurer or MCO. Mariner, *Standards of Care*, *supra* note 6, at 35.

¹¹¹ See, e.g., *Engalla v. Permanente*, 938 P.2d 903 (Cal. 1997) (finding that an employer might not have contracted with Kaiser Permanente had it known that the binding arbitration requirement was administered by the HMO and caused delays of 2 or more years, contrary to the expectations fostered by the contract).

the goal of remedying unfairness in insurance contracts.¹¹² For these reasons, the justifications for some legal doctrines – and therefore, the manner in which those doctrines interpret some contract terms – may not exist in the case of group health insurance. At the very least, applying insurance rules developed for first-party commercial insurance can produce anomalous results.

Particular problems arise with respect to contracts of adhesion.¹¹³ As Justice Stevens noted:

[C]ourts traditionally have reviewed with heightened scrutiny the terms of contracts of adhesion, form contracts offered on a take-or-leave basis by a party with stronger bargaining power to a party with weaker power. Some commentators have questioned whether contracts of adhesion can justifiably be enforced at all under traditional contract theory because the adhering party generally enters into them without manifesting knowing and voluntary consent to all their terms.¹¹⁴

However, most common law decisions recognize the utility of standard form contracts in many commercial contexts and review them for reasonableness.¹¹⁵ Similarly, recent Supreme Court opinions have allowed enforcement of provisions in adhesion contracts. In *Carnival Cruise Lines, Inc. v. Shute*, a Washington state couple bought a ticket for a cruise from a cruise company in Florida, through a travel agent in Washington state.¹¹⁶ The back of the ticket, received by mail, contained a “contract” that included a forum-selection clause requiring all disputes to be resolved in a court located in Florida. Mrs. Shute sued the cruise line in the United States District Court for the Western District of Washington for injuries resulting when she slipped on a deck mat and fell during a tour on the cruise. In a 7-2 opinion, the Court held

¹¹² CORBIN ON CONTRACTS § 4.14 (Joseph M. Perillo ed., rev. ed. 1993). See also HOLMES & RHODES, *supra* note 20, § 3.7. ERISA preempts enforcement of certain laws against group health insurance plans offered by private employers, in complicated ways. See *supra* notes 104-05.

¹¹³ Friedrich Kessler, *Contracts of Adhesion – Some Thoughts about Freedom of Contract*, 43 COLUM. L. REV. 629 (1943).

¹¹⁴ *Carnival Cruise Lines, Inc. v. Shute*, 499 U.S. 585, 601-02 (1991) (Stevens, J., dissenting) (citing Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173 (1983), W. David Slawson, *Mass Contracts: Lawful Fraud in California*, 48 S. CAL. L. REV. 1 (1974), and KARL N. LLEWELLYN, *THE COMMON LAW TRADITION* 370-371 (1960)).

¹¹⁵ See, e.g., *Williams v. Walker-Thomas Furniture Co.*, 350 F.2d 445 (D.C. Cir. 1965).

¹¹⁶ 499 U.S. 585 (1991).

that the forum-selection clause was enforceable and precluded suit outside Florida.¹¹⁷ It noted that “forum-selection clauses contained in form passage contracts are subject to judicial scrutiny for fundamental fairness,” but found that there were legitimate economic reasons for selecting a fixed forum for disputes and no evidence of fraud, overreaching, or discouraging passengers from bringing legitimate claims.¹¹⁸ Moreover, the Court noted that the Shutes did not deny that the ticket gave them notice of the Florida court limitation.

Justice Stevens, joined by Justice Marshall, dissented, arguing that “only the most meticulous passenger is likely to become aware of the forum-selection provision.”¹¹⁹ Moreover, he noted, “many passengers, like the respondents . . . will not have an opportunity to read paragraph 8 [the forum-selection clause] until they have actually purchased their tickets.”¹²⁰

Although forum-selection clauses likely will not trigger disputes in health insurance contracts, the Court’s treatment of such clauses holds lessons for other standard contract provisions. Certainly, Justice Stevens’s comment that the injured party may not have notice of the relevant contract provision until he has purchased a ticket also applies to provisions in insurance policies that are not delivered until premiums are paid. Of course, health insurance premiums typically are paid in monthly installments, so that, in theory, a consumer could terminate participation in the plan after reading the policy. However, there are barriers to changing plans. Most employers permit changes only once a year. Moreover, even if change is possible, most other plans available

¹¹⁷ The Court distinguished its prior opinion on forum-selection clauses, *Bremen v. Zapata Off-Shore Co.*, 407 U.S. 1 (1972), which had noted that forum-selection clauses, although not historically favored, are prima facie valid. *Id.* at 9-10. The agreement in *Bremen* was between two business corporations to tow a drilling rig from Louisiana to the Adriatic Sea off Italy, so that the parties might be expected to pay attention to a forum-selection clause. The Court said that “a freely negotiated private international agreement, unaffected by fraud, undue influence, or overweening bargaining power, such as that involved here, should be given full effect.” *Id.* at 12-13. This has led to the argument that, to be enforceable, such agreements should be freely bargained for. In *Bremen*, the Court said that a party seeking to avoid enforcement of a forum-selection clause on grounds of inconvenience of the forum has a “heavy burden of proof.”

¹¹⁸ 499 U.S. at 595. Reasons for including a forum-selection clause included the fact that the company’s principal place of business was in Florida, where some of its cruises originated, and the assumption that limiting the fora in which to sue could reduce the expenses of litigation and therefore ultimately help reduce fares.

¹¹⁹ *Id.* at 597.

¹²⁰ *Id.*

are likely to contain similar provisions. Thus, the fundamental issue is not whether a consumer had notice of the objectionable provision, but whether the substance of provision itself violates public policy.¹²¹

In *Engalla v. Permanente Medical Group*, the California Supreme Court, while confirming its endorsement of binding arbitration clauses in general, permitted a patient's estate to defend against enforcement of the arbitration clause by pursuing a claim of fraud against Kaiser Permanente.¹²² There was considerable evidence that Kaiser controlled the arbitration process and either encouraged or permitted delays, undermining arbitration's presumed advantages of speed and simplicity.¹²³ The court agreed that this evidence supported the possibility that Kaiser either misrepresented its arbitration process or acted in reckless disregard of the facts. However, the court required an additional step. Since Mr. Engalla's employer selected the health plan, it was also necessary to find that the employer relied on Kaiser's misrepresentation.

Few reported cases address the question whether "boiler-plate" provisions, such as binding arbitration, forum selection clauses, and notice of claim limitations, are reasonable in a health plan contract. Although courts no longer rotely apply the principle that an insured is bound by everything in the policy regardless of whether she read it, that remains the presumption unless mistake or fraud can be shown. However, within the particular context of health plans,

¹²¹ See, e.g., *Steven v. Fidelity & Casualty Co. of New York*, 377 P.2d 284, 298 (Cal. 1962) (refusing to enforce insurance policy limitation on liability because insured "must purchase the policy before he even knows its provisions"). In *Carnival Cruise Lines*, Stevens offered examples of contract provisions that are generally against public policy because they unduly limit a company's liability:

Complete exemptions from liability for negligence or limitations on the amount of the potential damage recovery, requirements that notice of claims be filed within an unreasonably short period of time, provisions mandating a choice of law that is favorable to the defendant in negligence cases, and forum-selection clauses are all similarly designed to put a thumb on the carrier's side of the scale of justice.

499 U.S. at 599 (Stevens, J., dissenting).

¹²² *Engalla v. Permanente Medical Group, Inc.*, 938 P.2d 903 (Cal. 1997). In *Engalla*, the plaintiffs sought to rescind the arbitration clause, claiming fraud in the inducement of the contract. *Id.* at 916. The patient filed a notice to arbitrate his claim of malpractice by failing to diagnose cancer. *Id.* at 910. Before the arbitrators were selected, the patient died, and the health plan intended to insist on limiting possible compensation to the lesser death benefit under California law. *Id.* at 914.

¹²³ An independent study reported that an average of 674 days elapsed before the appointment of a neutral arbitrator to commence proceedings, and 863 days before a hearing began. *Id.* at 913.

more scrutiny of adhesionary terms may be necessary to determine what can reasonably be expected, both of patients and insurers.

Tort law doctrines sometimes affect health insurance disputes, and the line between tort and contract law can be blurry in some circumstances.¹²⁴ A boundary-crossing example is the tort of bad faith, generally defined as an insurer's refusal to pay a contract claim that there is no bona fide cause to deny.¹²⁵ Applying this tort doctrine to enforce a contract or remedy or punish a breach of contract raises questions of when other legal doctrines should supplement contract and insurance law.¹²⁶ Tort law appears particularly apt in the case of insurance because courts often use tort law to determine responsibility for injury when a dispute cannot be avoided, especially where the harm is difficult to predict and social norms are still evolving.¹²⁷

B. *Types of Disputes and Available Principles*

One might expect disputes to arise most often in cases where the promise itself is uncertain or one party did not or could not agree to it. One would also expect that contract terms with clear definitions of publicly understandable and easily identifiable items or services, such as the amount of premiums and co-payments, or procedures for obtaining services, leave less room for disagreement. Disputes over procedural rules have arisen, however, and what appears to be a clear contractual term may not adequately express what is intended or expected.¹²⁸

Within the category of health plan provisions that give rise to disputes, significant disagreements fall into five

¹²⁴ P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 *LAW & CONTEMP. PROBS.* 287 (1986).

¹²⁵ See generally BARRY R. OSTRAGER & THOMAS R. NEWMAN, *HANDBOOK ON INSURANCE COVERAGE DISPUTES* § 12.01 (9th ed. 1998); Roger C. Henderson, *The Tort of Bad Faith in First-Party Insurance Transactions After Two Decades*, 37 *ARIZ. L. REV.* 1153 (1995).

¹²⁶ See generally Nicholas J. Johnson, *The Boundaries of Extracompensatory Relief for Abusive Breach of Contract*, 33 *CONN. L. REV.* 181 (2000); Melvin Aron Eisenberg, *The Emergence of Dynamic Contract Law*, 88 *CAL. L. REV.* 1745 (2000).

¹²⁷ See Stephen D. Sugarman, *A Century of Change in Personal Injury Law*, 88 *CAL. L. REV.* 2403 (2000).

¹²⁸ Carole Roan Gresenz, David M. Studdert, Nancy Campbell & Deborah R. Hensler, *Patients in Conflict with Managed Care: A Profile of Appeals in Two HMOs*, *HEALTH AFFAIRS*, July/Aug. 2002, at 189.

subcategories defined by the subject and degree of uncertainty:¹²⁹

1. Textual Ambiguity: Ambiguity in the contract text that permits conflicting interpretations.

2. Medical Quality/Effectiveness Uncertainty: Uncertainty about whether an unambiguous contract covers a specific item or service, such as a new technology, with the focus of dispute on the general effectiveness of the item or service itself, including whether it is investigational or experimental.

3. Provider Competence: Uncertainty about whether an unambiguous contract covers a specific physician, hospital or other provider to perform a particular service, with the focus of dispute on the provider's competence or other qualifications to do so.

4. Patient Efficacy Uncertainty: Uncertainty about whether an unambiguous contract covers a specific item or service for an individual patient, with the focus of dispute on the patient and her medical condition, including questions about whether a proposed treatment is medically necessary or appropriate to help a specific individual, regardless of whether it may otherwise be considered standard therapy.

5. Preferences: Differences in the parties' preferences for specific outcomes (such as a particular medical therapy or referral to a particular specialist or facility), in the absence of contractual ambiguity.

These "disputed" categories are likely to be found in the contract provisions that (1) define covered benefits and exclusions, including limitations on the number or dollar

¹²⁹ These categories are derived from a review of reported cases and the few empirical studies of such disputes. See Kanika Kapur, Carole Roan Gresenz & David M. Studdert, *Managing Care: Utilization Review in Action at Two Capitated Medical Groups*, HEALTH AFFAIRS, June 18, 2003, at W3-275, at <http://content.health-affairs.org/cgi/reprint/hlthaff.w3.275v1.pdf>; Mark A. Hall, Teresa Rust Smith, Michelle Naughton & Andrea Ebbers, *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055 (1996); Peter D. Jacobson, Elizabeth Selvin & Scott D. Pomfret, *The Role of the Courts in Shaping Health Policy: An Empirical Analysis*, 29 J.L. MED. & ETHICS 278 (2001); Gresenz et al., *supra* note 128; Willy E. Rice, *Judicial Bias, The Insurance Industry and Consumer Protection: An Empirical Analysis of State Supreme Courts' Bad-Faith, Breach-of-Contract, Breach-of-Covenant-of-Good-Faith and Excess-Judgment Decisions*, 41 CATH. U. L. REV. 325 (1992). Of course, reported judicial decisions are not necessarily representative of the universe of disputes, most of which never get to court. See William M. Sage, *Judicial Opinions Involving Health Insurance Coverage: Trompe l'Oeil or Window on the World?*, 31 IND. L. REV. 49 (1998); Marc Galanter & Mia Cahill, "Most Cases Settle": *Judicial Promotion and Regulation of Settlements*, 46 STAN. L. REV. 1339 (1994). Future research may identify other issues.

amount of covered items and services, and (2) specify the terms on which specific providers, including physicians and hospitals, are available to patients. These are the provisions that embody two of the three major techniques that MCOs use to control costs: controls over covered services and medical decision making, and limits on patient choice of provider.¹³⁰

In the first category, in theory, more precise drafting can correct ambiguous terms. Still, it may be impossible to define certain benefits with sufficient precision to avoid at least some vagueness.¹³¹ Then the question is whether the provision is reasonably susceptible to more than one construction.

Even when terms are clear, courts may apply different approaches to construing the contract, from a classical strict interpretation to a more equitable approach using general principles of reasonable expectations.¹³² Here again, the parties may have different expectations based on conflicting views of the purpose and function of health insurance.¹³³ Insurers may consider the contract a straightforward financial obligation to pay for specifically defined treatments in carefully delineated circumstances. Consumers may view the contract as promising whatever medical care might work. What counts as a reasonable expectation on the part of consumer? Any answer necessarily adopts a particular viewpoint as to the role of insurance in distributing health care.

The second, third, and fourth categories of disputes raise these problems with greater intensity. While provisions governing providers and treatment might be made clearer and more enforceable by contract methods, they also depend on specific circumstances arising after the contract is made. For example, categories two and three might require reference to

¹³⁰ See Laura Tollen & Robert M. Crane, *A Temporary Fix? Implications of the Move Away from Comprehensive Benefits*, EBRI Issue Brief, No. 244, April 2002; Jacob S. Hacker & Theodore R. Marmor, *The Misleading Language of Managed Care*, 24 J. HEALTH POL. POLY & L. 1033 (1999). The third technique, using provider networks and transferring financial risk to providers, is the subject of the contract between the MCO and the provider, which is beyond the scope of this discussion.

¹³¹ See Mariner *supra* note 34, at 241; M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 292 (2003). There may also be circumstances in which one or both parties may prefer vague terms to more precise definitions. See George G. Triantis, *The Efficiency of Vague Contract Terms: A Response to the Schwartz-Scott Theory of U.C.C. Article 2?*, 62 LA. L. REV. 1065, 1079 (2002).

¹³² RUSS & SEGALLA, *supra* note 20, § 21.3; 2 HOLMES & RHODES, *supra* note 20, § 5.1.

¹³³ See generally Deborah A. Stone, *Promises and Public Trust: Rethinking Insurance Law Through Stories*, 72 TEX. L. REV. 1435 (1994).

objective evidence of the effectiveness of therapies and the competence of providers, respectively. It may be possible for the parties to agree on, or at least make explicit, acceptable measures of quality and competence, where they exist. But quality of care measures are still developing and do not yet evaluate the universe of options.

Where there are no measures, deciding what the benefit covers requires judgment. Many ERISA plans grant the plan administrator the sole discretion to interpret plan terms, including whether a treatment is medically necessary for a patient. Yet in the eyes of patients, clarity about who will interpret the contract does not necessarily legitimize the exercise of that discretion. Even the Supreme Court has hinted that the deference it has shown to a fiduciary acting under a contractual grant of discretion may not be appropriate where conflicts of interest taint the decision.¹³⁴ Although all MCOs have varying financial interests that may conflict with patient care decisions, courts have not yet developed appropriate standards for weighing conflicts and judging the exercise of discretion. Thus, the scope of benefits may remain uncertain despite provisions assigning discretionary authority to the insurer.

Disputes such as those in category four, about whether a treatment is medically necessary, also may require some outside assistance. For example, an independent professional organization or panel could make an unbiased professional determination of need and appropriateness for individual patients. More than forty states have created external independent review panels to review these types of disputes.¹³⁵

¹³⁴ In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n.15 (2002), the majority opinion noted, in a footnote, "An issue implicated by this case but requiring no resolution is the degree to which a plan provision for unfettered discretion in benefit determinations guarantees truly deferential review." The majority noted that "review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised." *Id.* (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (holding that although appellate courts generally review benefit decisions de novo, where the plan grants the plan fiduciary discretion to construe plan terms, courts should give that judgment deference and review it for abuse of discretion)). Significantly, it added, "It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest." *Id.*

¹³⁵ Wendy K. Mariner, *Independent External Review of Health Maintenance Organizations' Medical Necessity Decisions*, 347 NEW ENG. J. MED. 2178 (2002) (finding that, in 2002, 41 states and the District of Columbia had legislation providing for independent external review of varying disputes, with most covering medical necessity, others also including experimental treatment, and still others covering some additional disputes). The Supreme Court held that ERISA did not preempt Illinois' narrow statute

When established and operated under transparently fair standards, independent review panels give consumers some assurance that their benefits will not be denied for financial reasons alone. However, these review panels do not prevent disputes; they are intended to resolve disputes without the need for litigation or arbitration.

Ideally, review panels can help to develop more consistent decisions about what kinds of treatment are appropriate in what circumstances. Professional opinion, however, is not necessarily dispositive. In 2001 in Massachusetts, an MCO denied coverage for a liver transplant for a patient with Hepatitis C and HIV. The denial rested on the ground that the transplant was experimental and thus excluded from coverage under the patient's employment-based managed care plan.¹³⁶ An independent external review panel confirmed the experimental nature of the procedure and thus the denial. Publicity about the case generated donations to pay for the transplant. The patient underwent two successive transplants, but died from predicted complications. Aware of publicity about that case, the Massachusetts Medicaid program agreed to pay for the same procedure for a different patient with the same medical conditions, despite similar coverage limits under Medicaid. These cases raise fundamental questions about whether it is possible to define covered benefits when medical therapies are changing, why patients or insurers consider some decisions fair and others unfair, and how publicity affects the distribution of health care and dollars.

The fifth subcategory may include disputes for which there is no obvious contractual solution. Here, threshold questions are whether preferences should carry any weight in determining coverage, and, if so, whether they should apply only in circumstances in which services of equivalent benefit (or cost) are available. Regardless of one's views on these questions, disputes based largely on preferences probably will continue to arise. Minimizing such disputes will require creative responses. For example, a contract might provide a sum of money equivalent to the cost of standard therapy that the patient could use to pay for his preferred provider or

in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).

¹³⁶ Liz Kowalczyk, *Donors and HMO Bolster Ailing Activist Funds Raised for Liver Transplant*, BOSTON GLOBE, July 21, 2001, at A1.

service. The possible options depend upon the objectives of insurers and patients and what they believe is fair.

Ideally, one would conduct an empirical study to test the forgoing hypotheses and to investigate more precisely which promises give rise to disputes, comparing those promises with available principles and rules of law to determine which promises fit the principles.¹³⁷ The kinds of questions that should be asked include: What kinds of contract terms give rise to disputes? What are the reasons for these disputes? Which reasons are based in the difficulties of predicting the cost or availability of future medical therapies? Which are based on the parties' financial needs? Which result from not understanding what the contract means or having different expectations? Which of these can be resolved by applying legal doctrines? Where legal doctrines do not fit promises, can contracts be changed to fit legal doctrine or should alternative methods be used to govern the relationship between insurer and patient? Are alternatives best suited to adoption as legislation or as common law doctrine by courts?

Answers to these questions will not remove the economic pressures on health care costs. However, they should permit a clearer definition of what contracts can and cannot prescribe in health insurance, and what people can realistically agree to. Further analysis should permit the design of more effective contracts for different kinds of health insurance, and suggest alternative methods for addressing health insurance problems that do not fit the contractual model.

C. *Supplemental or Alternative Doctrines*

The field of health law draws on a wide range of common law and legislation.¹³⁸ Thus, one might go beyond traditional insurance doctrines to find principles that could clarify the rights and duties in the context of health plans. A brief look at some potential candidates, however, reveals that they, too, have been developed largely outside the context of health plans.

¹³⁷ Some studies have begun to identify the types of disputes in a sample of health plans, *see supra* note 129 and accompanying text, but these studies do not explicitly address the relationship between contract drafting and governing law.

¹³⁸ *See generally* Bloche, *supra* note 131, at 292 (finding that different bodies of law do not take health care into account to a significant degree).

1. Requirements Contracts

Health insurance contracts are structured in much the same way as ordinary requirements contracts, in which a seller agrees to sell, and a buyer agrees to buy, all of the goods or services required by the buyer.¹³⁹ Insurance policies involve an agreement on the part of the insurer to provide goods and services to treat illness and injury as they occur to the insured, in return for the insured's payment of premiums.¹⁴⁰ Like requirements contracts, health insurance policies are illusory in the sense that one party retains complete discretion whether to perform, either by producing medical services or by paying for them. There is little risk of nonpayment on the part of the insured or buyer, because employers typically deduct amounts from employee wages to pay premiums. Thus, freedom to perform or not ordinarily belongs entirely to the insurer.

Disputes over whether a service is "medically necessary" and therefore a covered benefit mimic disputes in requirements contracts over whether goods demanded by a purchaser were "required" within the meaning of a requirements contract. Generally, the buyer who is party to a requirements contract is entitled to receive whatever amount of goods are in fact required by him for his business, and the seller is required to produce and deliver that amount, even if it increases unexpectedly.¹⁴¹ However, both parties are bound to act reasonably in making demands.¹⁴² Therefore, a seller-defendant is entitled to assert and prove that the demands were "in

¹³⁹ See, e.g., *New York Cent. Iron Works Co. v. United States Radiator Co.*, 174 N.Y. 331, 334, 66 N.E. 967, 968 (1903) (finding that "the parties left the contract open and indefinite as to the quantity of goods that the plaintiff might order from time to time").

¹⁴⁰ Of course, the insured does not pay for each unit of service as it is delivered, but instead pays an actuarially determined fixed premium.

¹⁴¹ *Eastern Air Lines, Inc. v. Gulf Oil Corp.*, 415 F. Supp. 429 (S.D. Fla. 1975).

¹⁴² One party is not necessarily entitled to increase quantities to an unlimited degree. The Uniform Commercial Code rule states that:

A term which measures the quantity by the output of the seller or the requirements of the buyer means such actual output or requirements as may occur in good faith, except that no quantity unreasonably disproportionate to any stated estimate or in the absence of a stated estimate to any normal or otherwise comparable prior output or requirements may be tendered or demanded.

U.C.C. § 2-306(1) (1977).

The parties may agree to limit the amount of variation, for example, to a certain percentage of prior years' quantities. In the absence of express agreement, one party may object to substantial changes in quantity on the ground of mistake. See *infra* note 155 and accompanying text.

excess of the plaintiff's reasonable needs and were not justified by the conditions of the business or the customs of the trade."¹⁴³ This is another way of ensuring that the parties act in good faith and in pursuit of the purpose of the contract.

What counts as "required" for purposes of a health insurance policy? Case law on requirements contracts offers little to answer this question beyond general statements of good faith and fair dealing. Patients do not have business customs of the type courts often consider to assess whether a buyer was demanding an unreasonable amount of goods. Nor are patients in a position to demand additional services for the purpose of taking advantage of unexpectedly favorable market conditions that would make it highly profitable to acquire more goods from the seller at price that is now well below market. Rather, the patient's "requirements" are entirely personal. Perhaps the only independent or external standard for judging the reasonableness of a patient's demands – whether a treatment is "required" – are generally accepted medical standards of care.

2. Personal Services Contracts

To the extent that managed care plans require the plan to determine the nature of the services to be provided as covered benefits, whether by pre-authorization or other means, they operate like contracts for personal services. Thus, disputes over the nature or quality of services for covered benefits share features with disputes over other personal service contracts. The standard assumption in personal service contracts – that specific performance is not available to enforce a contract for personal services – does not quite fit health insurance or managed care, since such contracts do not typically promise a specific provider or service.¹⁴⁴ Nonetheless, disputes over services often focus on whether what the plan is willing to offer will meet the medical needs of the patient. This brings to mind the rule concerning "comparable" offers in personal service contract disputes, most often used in cases in which a promised

¹⁴³ *New York Central Iron Works Co.*, 174 N.Y. at 335, 66 N.E. at 968 ("In other words, that the plaintiff was not acting reasonably or in good faith, but using the contract for a purpose not within the contemplation of the parties . . .").

¹⁴⁴ Exceptions to this categorization include plans that cover a specific number of procedures over a specific time period, such as mammograms, immunizations, and dental cleaning.

position does not materialize and the person to perform the service rejects a proffered alternative. The “performer” must mitigate damages, if possible, usually by accepting an offer of alternative employment. One might argue that patients should mitigate possible damages by accepting the substitute treatment or provider offered by the insurer. However, the alternative must be “comparable” or “substantially similar” to that promised by the original agreement.¹⁴⁵ What is comparable is highly fact-dependent. Substitutes that are “different and inferior” do not ordinarily qualify as comparable, and the “performer” may reject them.¹⁴⁶

The burden of demonstrating comparability could reasonably fall upon an insurer who determines what counts as “medically necessary” treatment. However, health plans rarely promise a specific treatment that could be compared with the offered substitute. In addition, if the alternative is not an acceptable substitute, the remedy is the amount of

¹⁴⁵ See, e.g., *Manuma v. Blue Hawaii Adventures, Inc.*, No. 24433, 2002 Haw. App. LEXIS 369 (Haw. Ct. App. Dec. 6, 2002). In *Manuma*, the court found the following:

[T]he measure of recovery by a wrongfully discharged employee is the amount of compensation agreed upon for the remaining period of service, less the amount which the employer affirmatively proves the employee has earned or with reasonable effort might have earned from other employment Before projected earnings from other employment opportunities not sought or accepted by the discharged employee can be applied in mitigation, the employer must show that the other employment was comparable, or substantially similar, to that of which the employee has been deprived; the employee’s rejection of or failure to seek other available employment of a different or inferior kind may not be resorted to in order to mitigate damages.

Id. at *3-*4.

Plaintiff was hired as entertainment director/musician for dinner cruises for twelve months, but terminated after eight months due to the employer’s financial difficulties and offered manual labor in a shipyard or yacht maintenance instead. *Id.* at *1-*2. The court found neither job was “substantially similar,” and affirmed an award of damages, but, oddly, found no error in the district court’s reduction of damages, which offset it by two months worth of compensation for which the plaintiff could or should have found other comparable employment in satisfaction of a duty to mitigate damages. The court did not explain why it thought he could have found two months of comparable work. *Id.* at *3.

¹⁴⁶ See, e.g., *Parker v. Twentieth Century-Fox Film Corp.*, 474 P.2d 689, 693 (Cal. 1970). In *Parker*, Shirley MacLaine contracted for \$750,000 to play the lead in a musical motion picture, “Bloomer Girl,” to be filmed in Los Angeles, with rights to approve the screenplay and director changes. The film company instead offered her the lead in a non-musical western entitled “Big Country, Big Man” to be filmed in Australia, for the same fee but without approval rights. *Id.* at 690-91. The Supreme Court of California upheld a trial court ruling that MacLaine was entitled to reject the western because it was “different and inferior” to the promised musical. The court held that MacLaine had no duty to mitigate damages and awarded her the full promised fee. *Id.* at 693.

compensation that would have been paid for the original position. However, in many health benefit disputes, the patient seeks a service that is more expensive than what the insurer offered. Therefore, if the insurer offers only the cost of its preferred, less costly, alternative, the patient is likely to remain dissatisfied and often unable to pay for the desired service.

3. Mistake

In disputes over covered benefits or qualified providers, patients might feel that there has been a mistake in the contract – or in the assumptions underlying the contract – that should be corrected in order to permit the patient to obtain the services he seeks. Mistakes do not reflect the agreement of the parties. The doctrine of mistake is rarely applied, however, and does not easily fit disputes over benefit coverage in health plans.¹⁴⁷ It is difficult to identify the agreement of the parties on a specific treatment, because health plans do not ordinarily specify the particular treatment that will be covered in an individual case of illness. Indeed, these disputes might be characterized as instances of erroneous assumptions as to the value of the health plan to the patient.¹⁴⁸

Applied to insurance contracts, which allocate risk by definition, there is little room for forcing an insurer to provide a service that it did not contemplate. Yet, here again, the rule is based on assumptions about expectations and behavior in the commercial market that do not necessarily pertain when a

¹⁴⁷ The remedy for mistakes is typically reformation of the contract. *Aluminum Co. of America v. Essex Group, Inc.*, 499 F. Supp. 53 (W.D. Pa. 1980). In *Aluminum Co. of America*, the Court held:

Courts have traditionally applied three remedial rules in cases of mistake, frustration and impracticability. In some cases courts declare that no contract ever arose because there was no true agreement between the parties . . . or because the parties were ignorant of existing facts which frustrated the purpose of one party or made performance impracticable. Restatement 2d of Contracts § 286. In some other cases the courts hold that a contract is voidable on one of the three theories. In these cases the customary remedy is rescission. In both classes of cases where one or both parties have performed under the supposed contract, the courts award appropriate restitution in the light of the benefits the parties have conferred on each other. The aim is to prevent unjust enrichment. The courts in such cases often call this remedy 'reformation' in the loose sense of 'modification.'

Id. at 78.

¹⁴⁸ Corbin notes that the law should ordinarily enforce agreements despite variation in the value of the agreement. CORBIN ON CONTRACTS § 28.35 (Joseph M. Perillo ed., rev. ed. 1993).

patient seeks treatment for severe illness. Patients may not stoically “swallow their losses and disappointments,” because such losses are not merely financial and are not business as usual.

Related doctrines of frustration and impracticability, most often relevant to commercial contracts, do not seem pertinent to health insurance, unless one could argue that it would be financially impractical for an insurer to provide an expensive service because the expenditure would threaten the insurer with insolvency. However, relief from performance is not ordinarily granted unless a supervening post-contract event renders performance impossible.¹⁴⁹ In the case of unexpected cost increases, few courts have allowed relief unless the increase was at least twice the expected costs of performance.¹⁵⁰ Finally, since the remedy for frustrated or impracticable performance is discharging the insurer from performing, as by excusing it from providing or paying for the service, it offers no advantage over general rules of insurance policy construction. Indeed, these doctrines would only seem to apply where there is no dispute as to coverage and where providing the concededly covered benefit would bankrupt the company – a rather remote possibility.

There is some support for the idea that where an event is unforeseeable in a commercial sense, risk could not be allocated in advance and therefore there is no reason to resort to tortured interpretations in order to find that one party did assume the risk of the event. There may be illnesses or treatments that are not foreseeable, in the sense that an insurer would not have included their costs in the actuarial calculations of underwriting. In that case, however, application of the doctrine of impracticability would argue against

¹⁴⁹ RESTATEMENT (SECOND) OF CONTRACTS § 281 (1981).

Performance may be impracticable because extreme and unreasonable difficulty, expense, injury, or loss to one of the parties will be involved A mere change in the degree of difficulty or expense due to such causes as increased wages, prices of raw materials, or costs of construction, unless well beyond the normal range, does not amount to impracticability since it is the sort of risk that a fixed-price contract is intended to cover.

Id.

Comment d to Section 281 states that the term “impracticability” is taken from Uniform Commercial Code § 2-615(a). *Id.* § 1355, cmt. d.

¹⁵⁰ *Aluminum Co. of America*, 499 F. Supp. at 79 (“To frame an equitable remedy where frustration, impracticability or mistake prevent strict enforcement of a long term executory contract requires a careful examination of the circumstances of the contract, the purposes of the parties, and the circumstances which upset the contract.”).

requiring the insurer to provide the treatment. This is because it focuses on the cost impact of performance, and not on the loss to the insured, regardless of whether that loss results in death or disability from lack of treatment.

The doctrine of frustration seems even less relevant. In a health insurance context it would seem to apply, if at all, to the patient rather than the insurer. The doctrine relieves a party from performance when performance would be of little or no value to him because of intervening circumstances. Here, typically, the party is disappointed because he would like to perform.¹⁵¹ It is difficult to imagine cases in which events would conspire to disappoint insurers, since their obligation is to pay for services. Similarly, patients are not likely to be disappointed by not needing medical care. Moreover, even if the doctrine applied, it would only excuse the patient's performance, which consists of paying insurance premiums and copayments; it would not require performance of a different sort from the insurer.

The sketch of these contract concepts illustrates how basic rules, albeit somewhat flexible, do not have obvious application to health insurance contracts. It is not clear that health insurance relationships can be structured entirely by contract unless principles in contract and insurance law can be adapted to better fit health insurance.

D. The Need for Research on Contracts and Doctrine

There has been little specific research on the legal tool for financing and delivering health care: the contract itself.¹⁵² Practicing attorneys rarely have an opportunity to contemplate how a contract should be structured to serve the health care system's goals, rather than the immediate needs of their clients. The National Association of Insurance Commissioners produces model state laws and regulations for all types of

¹⁵¹ The Restatement gives the example of B promising to pay A \$1,000 to watch a parade from A's window on a certain day, but the parade is cancelled because an official is ill. B would like to watch the parade and there is no impediment to his looking out the window, but B refuses to pay A the \$1,000 because there is no parade to be seen. B's duty to pay the \$1,000 is discharged and he is not liable for breach of contract. RESTATEMENT (SECOND) OF CONTRACTS §265 illus. 1 (1981).

¹⁵² A notable exception is George Washington University's collection and description of state Medicaid contracts, which do not address private health insurance. See George Washington University Center for Health Services Research and Policy, *Managed Care Contracting: Overview*, at http://www.gwhealthpolicy.org/managed_care.htm (last visited Jan. 31, 2004).

insurance, some of which recommend language for certain health insurance contract terms.¹⁵³ However, they do not address how the common law can or should be applied to unregulated contract terms. Thus, there are almost no independent sources of analysis of health insurance contracts.

Legal teaching and scholarship focuses heavily on judicial doctrine and abstract legal theory, with scant attention to its application to health insurance or health policy.¹⁵⁴ Few law professors are trained in empirical research and even fewer receive external funding, with most research money going to law and economics studies. As Professor Deborah Rhode notes, "For most legal scholars, data are a luxury good."¹⁵⁵ Yet, despite, or perhaps because of, the lack of data about a legal doctrine's effectiveness in achieving its own goals, it is doctrine that drives the drafting, interpretation, and enforcement of contracts.

Health law scholars, who are well positioned to use their familiarity with the health care system to examine relevant doctrine, have not emphasized analyses of theory. Perhaps because health law is an applied field covering so many areas of law, a focus on theory in one domain, like contract, may appear too narrow. Scholarship in health law often polarizes over the advantages and disadvantages of managed care.¹⁵⁶ Health law scholars have devoted more attention to ERISA preemption of liability for injury to patients than to contract or insurance law.¹⁵⁷ The primary focus of this

¹⁵³ MODEL LAWS, REGULATIONS AND GUIDELINES (Nat'l Assoc. of Ins. Comm'rs 2002). See generally Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625 (1999).

¹⁵⁴ See, e.g., Mark Pettit, Jr., *Freedom, Freedom of Contract, and the "Rise and Fall,"* 79 B. U. L. REV. 263 (1999).

¹⁵⁵ Deborah L. Rhode, *Legal Scholarship*, 115 HARV. L. REV. 1327, 1353 (2002).

¹⁵⁶ Compare, e.g., PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA (2002) (arguing that MCO decisions should not be judged on the basis of contract law and in favor of treating health care as a special category, rather than a consumer good), with Richard A. Epstein, *Managed Care Under Siege*, 24 J. MED. & PHIL. 434 (1999) (arguing that health care should be considered a consumer good properly distributed by voluntary contracts).

¹⁵⁷ Compare, e.g., Wendy K. Mariner, *What Recourse? - Liability for Managed-Care Decisions and the Employee Retirement Income Security Act*, 343 NEW ENG. J. MED. 592 (2000), Arnold J. Rosoff, *Breach of Fiduciary Duty Lawsuits Against MCOs: What's Left After Pegram v. Herdrich?*, 22 J. LEGAL MED. 55 (2001), and Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985 (1998) (favoring MCO liability), with David A. Hyman, *Accountable Managed Care: Should We Be*

debate is whether ERISA does or should preempt a variety of state law claims against MCOs; it rarely progresses to the next question, namely whether, if state law applies, it satisfactorily addresses those claims.¹⁵⁸ Yet, if state law is no better equipped to decide disputes over health benefits than ERISA decision rules, little is gained by avoiding preemption. Most important, liability applies only after a dispute arises – a dispute typically rooted in the contract.

Since prevention is better than compensation or punishment, everyone would be better served by contracts that did not give rise to disputes in the first place. This requires attention to what contracts should cover and how they can and should be written to serve the needs of patients, providers, and insurers in different circumstances in the future. It also requires determining which legal principles best fit different managed care and health insurance functions, either for consumers or patients. The goal should be to crystallize the most effective role for contracts in obtaining access to care, and help policy makers and the public take concrete steps toward developing a fair and sustainable health care system for the future. It should assist health insurers and employers to develop fairer, more effective contractual provisions, and consumers and patients to understand how they might participate in new forms of health insurance. It should also help legislators and other health policy makers determine which health insurance issues can be left to private contracting and which may require regulation. The selective and effective use of well-designed contracts may reduce the pressure on costs that has arisen from controversial provisions in the managed care contractual model. And while contracts cannot guarantee access to adequate health care, they can make it possible. If individuals are to have fair and equitable access to medical care in the future, it will be essential to develop contracts that serve the needs of patients, as well as employers and insurers.

Careful for What We Wish For?, 32 U. MICH. J.L. REFORM 785 (1999), and Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions*, 30 J. LEGAL STUD. 625 (2001) (arguing against MCO liability).

¹⁵⁸ Some scholars have proposed new theories of liability for MCOs. *See, e.g.*, Peter D. Jacobson & Michael T. Cahill, *Applying Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J.L. & MED. 155 (2000) (arguing that MCOs should have fiduciary duties to their members); Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7 (2000) (arguing that organizations should be accountable for the quality of care provided their patient/members).

VIII. CONCLUSIONS

It is time to rethink the conceptual framework for health insurance contracts and clearly define what insurers and patients can and cannot fairly agree upon in advance through contracts. A new framework could help to advance our knowledge about which types of promises should be included in health care contracts and which types should be jettisoned because they will not be kept.

Currently, the contracts that are intended to be the vehicle for distributing health care often become a roadblock instead. This may be because they are not capable of performing all the functions expected of them, at least as viewed through current doctrine. In the absence of more nuanced standards for interpreting and enforcing contracts that attempt to define legal rights to medical care and responsibility for providing it, health insurance contracts are likely to remain the source – rather than the resolution – of disagreement.

Current consumer-choice reform proposals do not address the legal principles governing health benefit plans or health insurance contracts. Rather, they perpetuate the problem by relying on contracts to reduce health care costs. Consumer-choice plans shift responsibility for saving the system money from employers and insurers onto consumers – not by denying care to consumers, but by having consumers deny care to their futures selves as patients.

It is possible that these plans effectively address some real consumer choices – those that are possible without insurance. They may eliminate many managed care features that annoyed consumers, like gatekeepers and preauthorization of care. They may work well for routine and preventive care that fit descriptions of consumer services. But they are likely to fail to address the most difficult problems facing patients: whether expensive care is medically necessary, and what law applies. For patients with expensive medical needs, consumer-choice plans may merely postpone the inevitable question of whether their care is covered by a defined package of benefits, without offering an answer that avoids disputes in the first place. If constrained by today's employment-based health insurance system, they are unlikely to solve the fundamental problems in that system: the rising cost of care and the inequitable distribution of care.

Much of the scholarly debate on health care policy focuses on whether health care – and health insurance – should be distributed by voluntary contract or subject to government standards. However, in the absence of any universal consensus on the nature of justice in health care distribution, health insurance remains to a large degree a matter of private contract. Moreover, whatever form any future health care system takes, contracts will play a key distributive role. Yet we do not fully understand where private contracting does and does not work to further the goals of equitable access to affordable care. In particular, no health reform that relies on contracts can succeed if it fails to remedy the resistance to contract limits experienced in the managed care context. As a first step, this Article has critiqued the ability of consumer-choice contracts to lessen that resistance, concluding that we still need to identify the ways in which contracts can be written and interpreted to meet the needs of both insurers and patients before all parties will accept them as fair, reasonable, and enforceable.