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Health Care's Market Bureaucracy

Allison K. Hoffman

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U.C.L.A. Law Review

Health Care's Market Bureaucracy

Allison K. Hoffman

ABSTRACT

The last several decades of health law and policy have been built on a foundation of economic theory. This theory supported the proliferation of market-based policies that promised maximum efficiency and minimal bureaucracy. Neither of these promises has been realized. A mounting body of empirical research discussed in this Article makes clear that leading market-based health care policies are not efficient—they fail to capture what people want. People struggle when making choices, and they often choose poorly. Even more, this Article describes how the failed struggle to bolster these policies—through constant regulatory, technocratic tinkering that aims to improve the market and the decisionmaking of consumers in it—has produced a massive market bureaucracy.

To illustrate the growth of the market bureaucracy, this Article traces the origin and development of several market-based theories that have been central to the modern era of health policy and law. The first, called managed competition, looks to consumerism in insurance markets and contends that people will choose wisely among health plan options, and their choices will drive higher value health care. The second, sometimes called consumer-driven health care, relies on consumerism when using medical care. The notion is that when people are subject to a share of the costs, they will more selectively choose when and where to use medical care and will avoid low-value products or services. The final example considers the application of antitrust to health care mergers, ostensibly to create a competitive field on which consumerism can flourish.

This Article shows that, in application, these ideas have not, nor will ever, deliver as imagined in a world that deviates irreconcilably from theory. Nonetheless, these ideas continue to spawn a vast web of health law and regulation in their support. The cost of this market bureaucracy includes the scaffolding to hold up an ineffective market-based structure and, more importantly, the opportunity cost of foregone alternatives to solve important health care system challenges.

Health care's market bureaucracy endures in light of repeated failure in part, as others have discussed, due to politics and political economy. Yet, this Article suggests that it persists equally because of its role in the sanctification of values of individualism and choice. Choice seems especially appealing when it comes to decisions about our health. We want to believe we are in control. Yet, choice as translated into market-based policies has proven empty. Understanding that markets do not actually enhance meaningful choice—and are as bureaucratic as any other approach—can clear the way to ask how to design better health law and policy.



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INTRODUCTION

Health policy and law is in flux. For most of its history, health law focused on the doctor and his patient, guided primarily by the goal of fostering the medical profession and protecting physician autonomy.¹ The law gradually took equal interest in protecting patients' autonomy. One way this interest has manifested most recently is in patients' role as consumers in a health care marketplace, as economic theory has emerged as the guiding light of health regulation.²

Patients as consumers are now charged with using their purchasing power to solve what are considered health care's most intractable problems: relatively high spending and poor outcomes in the United States.³ The United States spends nearly one-fifth of its gross domestic product on health care,⁴ more than all other peer nations and over 50 percent more than France, Germany, or Canada.⁵ Yet, we fall comparatively and embarrassingly short on key health outcomes, including life expectancy and infant mortality, as well as on subjective patient experience.⁶

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1. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* 27 (1982) ("Throughout the medical system, the profession was able by 1920—and for the next half century—to establish organizational structures that preserved a distinct sphere of professional dominance and autonomy.").
 2. See JACOB S. HACKER, *THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON'S PLAN FOR HEALTH SECURITY* 156 (1997) ("In the health policy community, the most influential ideas have been associated with economists.").
 3. TIMOTHY STOLTZFUS JOST, *HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT* (2007); Carl E. Schneider & Mark A. Hall, *The Patient Life: Can Consumers Direct Health Care?*, 35 *AM. J.L. & MED.* 7 (2009).
 4. *National Health Expenditure Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html> [https://perma.cc/SG66-P7MJ] (last updated Apr. 26, 2019).
 5. See ERIC C. SCHNEIDER ET AL., *THE COMMONWEALTH FUND, MIRROR, MIRROR 2017: INTERNATIONAL COMPARISON REFLECTS FLAWS AND OPPORTUNITIES FOR BETTER U.S. HEALTH CARE* 4 (2017), https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2017_jul_schneider_mirror_mirror_2017.pdf [https://perma.cc/FJ9F-KPJZ].
 6. *Id.* at 8–9, 11–12 (describing higher rates of mortality amenable to health care than peer nations, lower life expectancy, and higher infant mortality rates, even despite relative strong performance on things like in-hospital mortality after health attack or stroke); for more on high rates of infant mortality, see Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues*, 128 *OBSTETRICS & GYNECOLOGY* 447, 453 (2016). There is no neat explanation for this divergence. Poor outcomes remain after adjusting for demographics. And, higher spending is not easily

The United States is also unique in that it now relies on competition and consumer choice to attempt to fix the disparity between spending and outcomes. Market-based solutions enticingly promise patients control of their care, rather than relinquishing authority to doctors or insurers, as had been the practice in medicine in earlier eras.⁷ With the right incentives, theory predicts, consumers will select what they value most.⁸ In turn, health regulation has increasingly become a tool to define and lubricate markets, and a profession once exempt from competitive concerns is now consumed by them.

Market-based approaches have dominated all U.S. regulatory fields since the Reagan revolution. In this Article, I focus on the particular dysfunction that has resulted in health care regulation, where conditions are especially un conducive to consumerism and where getting regulation right is critically important for a massive industry that deals with life and death.

The turn to markets in health law and policy has been widespread and bipartisan,⁹ favored by the Reagan and Clinton Administrations alike. When President Obama assembled his health reform team, he turned to economists and economic theories.¹⁰ These advisors brought market-based ideas, which formed the bedrock of the Patient Protection and Affordable Care Act (ACA) and of

justified by investing in innovation. Evidence in many areas suggests that we have reached the flat of the curve, where “innovation” does not improve outcomes. See, e.g., Jonathan S. Skinner et al., *Is Technological Change in Medicine Always Worth It? The Case of Acute Myocardial Infarction*, 25 HEALTH AFF. 34 (2006); see also discussion and sources *infra* note 321.

7. STARR, *supra* note 1, at 27 (1982) (describing deference to the profession); see Schneider & Hall, *supra* note 3, at 10 (“Managed care has had successes in controlling costs, but it has been savaged by patients who felt they were losing control of their medical care and by doctors who felt they were losing control of their work.”); see also William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701 (1999) (describing a shift from regulatory solutions to disclosure-based solutions that try to improve purchasing through more information on pricing and quality).
8. As Deborah Stone, a skeptic, describes: “[M]arket reforms invite people to treat their health as a consumer good and to approach diagnostic, curative, preventive, and rehabilitative services as if they were part of the family market basket.” Deborah Stone, *The False Promise of Consumer Choice*, 51 ST. LOUIS L.J. 475, 477 (2007).
9. ROBERT I. FIELD, *MOTHER OF INVENTION: HOW THE GOVERNMENT CREATED FREE-MARKET HEALTH CARE* (2014); Stone, *supra* note 8, at 477 (“Indeed, the health sector has been more dramatically reconfigured according to market theory than any other sector of social policy.”).
10. Glenn Kessler, *Did Jonathan Gruber Earn ‘Almost \$400,000’ from the Obama Administration*, WASH. POST (Nov. 14, 2014), <https://www.washingtonpost.com/news/fact-checker/wp/2014/11/14/did-jonathan-gruber-earn-almost-400000-from-the-obama-administration/?arc404=true> (discussing role of Gruber’s work and Microsimulation Model in the design of the 2006 Massachusetts reform and the ACA); Kevin Sack, *Health Plan from Obama Spurs Debate*, N.Y. TIMES (July 23, 2008), <https://www.nytimes.com/2008/07/23/us/23health.html> (citing economist David Cutler as an early influential advisor).

thousands of pages of rules and regulations to direct market dynamics. Likewise, after the election of President Trump, the administration and Republican United States Congress sought to scale back comprehensive insurance coverage based on the economic theory that people will spend more judiciously with their own money at stake.¹¹ Scholars and think tanks, in turn, have focused on regulating markets through constant technocratic tinkering, rarely pausing to reevaluate or challenge their prominence.¹²

Market-based policies are hailed as offering two main advantages: being more efficient and less bureaucratic than alternatives.¹³ Efficiency is defined as

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11. See, e.g., Exec. Order No. 13,813, 82 Fed. Reg. 48,385 (Oct. 17, 2017) (encouraging increased uptake of Association Health Plans, short-term plans, and Health Reimbursement Accounts); American Health Care Act of 2017, H.R. 1628, 115th Cong. tit. II, subtit. A (2017) (promoting tax favored health savings accounts in House Bill that passed house on May 4, 2017).
 12. See K. SABEEL RAHMAN, *DEMOCRACY AGAINST DOMINATION* 5–7 (2017) (describing the managerialist approach from the New Deal to the present and its reliance on expertise that coexists with the centrality of markets). Even health law literature that recognizes the problems with consumerism often works within its paradigm. See, e.g., Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2008) (describing doctrinal approaches that give patients the benefit of the doubt because of their compromised bargaining position for medical care); Russell Korobkin, *Comparative Effectiveness Research as Choice Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis*, 112 MICH. L. REV. 523, 526–27 (2014) (acknowledging problems people have making insurance decisions but proposing an alternative that requires they do so). *But see*, e.g., Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL’Y. 47, 51–52 (2014) (noting increased attention to collective needs and social determinants of health, rather than just individual preferences); Stone, *supra* note 8 (critiquing the rise of consumer choice and free markets in health care).
 13. There are softer and harder versions of pro-market arguments, which vary in level of commitment to an unregulated market. Harder versions argue that government should be reduced to zero, or close to zero. See e.g., MURRAY N. ROTHBARD, *FOR A NEW LIBERTY* (1973); EDWARD PETER STRINGHAM, *PRIVATE GOVERNANCE: CREATING ORDER IN ECONOMIC AND SOCIAL LIFE* (2015). Softer versions concede government regulation for limited functions, such as to provide public goods that private providers might undersupply. See, e.g., F.A. HAYEK, *THE ROAD TO SERFDOM* 45 (1944) (rejecting the elimination of government); MILTON FRIEDMAN, *CAPITALISM AND FREEDOM* (1962) (arguing that the government role includes enforcing law and order, diminishing “neighborhood effects” and controlling money); ROBERT NOZICK, *ANARCHY, STATE, AND UTOPIA* (1974) (arguing for a minimalist state, arising from anarchy). In health care, pro-market arguments universally recognize some role for regulation, primarily to correct for market failures. See generally CHARLES SILVER & DAVID A. HYMAN, *OVERCHARGED: WHY AMERICANS PAY TOO MUCH FOR HEALTH CARE* (2018) (arguing that consumer control over spending is the only way to control health care spending); CLARK C. HAVIGHURST, *DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION* (1982) (arguing for deregulation to create a competitive market); MARK V. PAULY, *MERCATUS CENTER, GIVING COMPETITION IN MEDICAL CARE AND HEALTH INSURANCE A CHANCE* (2019), <https://www.mercatus.org/system/files/pauly-competition-medical-care-mercatus-research-v1.pdf> [<https://perma.cc/8V4D-WJWL>] (discussing empirical evidence on competition and where regulation is beneficial); James F. Blumstein & Michael Zubkoff, *Perspectives on*

producing what people want—maximizing their preferences, to put it in economic terms. Markets are held up as the *singular* vehicle to achieve this goal, and thus to honor autonomy and choice. Through such framing, individual choice has emerged as a sacred value in health care decisionmaking—where decisions are often scientifically imprecise, deeply personal, and potentially very expensive.¹⁴ Promises of market choice now pervade all corners of health care. You can choose your own insurance plan. You can choose your own doctor. You can choose your hospital, imaging center, pharmacy, urgent care facility, lab, and outpatient surgical center. You can choose your own procedures, drugs, and course of treatment. You can get your care at CVS, or in India. Market choice is sold as equivalent to freedom.

Regulation, in ironic contrast, is critiqued as ill-suited to provide what people want. In Richard Epstein and David Hyman's words: "No administrative agency or committee of experts, no matter how well intentioned and highly credentialed, will be able to do a better job of meeting consumer demands than the private market."¹⁵ In the private health care market, they posit that competition among businesses will in theory generate an array of options, allowing people to make individualized decisions.

The second promise of market-based policy is limited government and, in turn, less opportunity for government failure. Even though most experts concede markets need some regulatory structuring to exist,¹⁶ proponents claim government regulation can and should be more limited in a market-based

Government Policy in the Health Sector, 51 MILBANK Q. 395, 401 (1973) (describing the public finance criteria for government intervention—externalities, public goods, monopoly, and market imperfections—and how they apply in health); Richard A. Epstein & David A. Hyman, *Fixing Obamacare: The Virtues of Choice, Competition, and Deregulation*, 68 N.Y.U. ANN. SURV. AM. L. 493, 495, 517–536 (2013) (mapping out health care deregulation yet yielding the possible need for some price control). For a version of a health care system closer to complete deregulation, see RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* (1997).

14. Cf. Philip E. Tetlock, *Thinking the Unthinkable: Sacred Values and Taboo Cognitions*, 7 TRENDS COGNITIVE SCI. 320 (2003) (describing how commitment to some values becomes sacred, where tradeoffs with secular value of money or convenience is unthinkable, unless those tradeoffs are reframed rhetorically); Ryan Bubb & Richard H. Pildes, *How Behavioral Economics Trims Its Sails and Why*, 127 HARV. L. REV. 1593, 1601 (2014) (describing choice bias as broadly driven by the rise of behavioral law and economics and its "presumption or precommitment in favor of choice-preserving regulatory options over others").
15. Epstein & Hyman, *supra* note 13, at 537.
16. STEVEN K. VOGEL, *MARKETCRAFT: HOW GOVERNMENTS MAKE MARKETS WORK* (2018) (describing the many forms of public and private market governance); see also sources cited *supra* note 13.

system, which will lessen the influence of bureaucrats, who are criticized as both paternalistic and captured by powerful, vested interests.¹⁷

This Article draws from a mountain of empirical evidence to document the irrefutable failure of health care's most popular market-based policies to live up to both of these promises. To the contrary, despite decades of efforts and refinement, these policies produce exactly the opposite: a myth of choice and a market bureaucracy. Rather than helping people get what they want, market-based policies produce a maze of obligations and decisions that confuse people and burden them when they are sick. To illustrate, take just one example from the many described in more detail below. When selecting an insurance plan, people struggle to choose, dread the shopping experience, and often do not choose well. One study simulated plan choice in an ACA marketplace among a relatively informed group of participants, and they chose an objectively better plan only half of the time.¹⁸

Furthermore, efforts to fix flailing competition-based policies have required armies of health regulators, reams of regulation, and seemingly endless evaluation and adjustment by technocratic experts—to no avail. Behavioral economics-inspired attempts to educate and nudge participants to better results fall short,¹⁹ despite significant investments of time and money into these efforts. The result is a market-lubricating regulatory scaffold—a bureaucracy as vulnerable to capture and at least as large as what more direct regulatory approaches would likely produce.

Health care's market bureaucracy amasses equally within the walls of private industry.²⁰ The United States relies heavily on private industry to achieve social welfare goals. To the extent private industry forms the backbone of public programs, high private industry profits and salaries become part of the cost of

17. VOGEL, *supra* note 16, at 10.

18. See Eric J. Johnson et al., *Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture*, 8 PLOS ONE 1 (2013).

19. *Id.* at 3 (describing that traditional tools like cost calculators and just-in-time education did not significantly improve outcomes).

20. The United States has lower public social expenditures relative to other countries, but total social expenditures—public plus mandated private expenditures (those that serve redistributive purposes but are not directly government administered)—are higher in the United States than in all other countries except France. Ryan McMaken, “*Social Expenditures in the US are Higher Than all Other OECD Countries, Except France*,” MISES INST. (Oct. 30, 2015), <https://mises.org/wire/social-expenditures-us-are-higher-all-other-oecd-countries-except-france> [<https://perma.cc/LK83-5VP8>].

bureaucracy²¹ and drive the administrative costs of the U.S. health care system well above those of its peers.²²

The popular narrative about the benefits of markets over other forms of regulation is empirically, and clearly, wrong in key areas of health care regulation. Market-based policies do not enable effective consumer choice.

This Article argues that health policies that depend on consumerism, like those discussed below, have and will inevitably continue to fail. To be clear, it does not suggest no role for economics in health policy. Conversely, nor does it intend to imply, by elucidating that market-based policies have proven neither efficient nor nimble, that the aim of social policy should in fact be economic efficiency or minimalist government. Others have offered compelling critiques of these aims,²³ and have made explicit the hidden normative agenda of neoliberalism, obscured by the objective tone of the language of economics.²⁴

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21. As just one example, in 2018, the compensation of the CEO of Blue Cross Blue Shield of Michigan (just one insurer in one state) was \$19.2 million. Jay Greene, *Blues CEO's Compensation Rises 43 Percent to \$19.2 Million*, CRAIN'S DETROIT BUS. (Mar. 1, 2019, 2:25 PM), <https://www.crainsdetroit.com/health-care/blues-ceos-compensation-rises-43-percent-192-million> [https://perma.cc/58ZY-F84G].
 22. See Austin Frakt, *The Astonishingly High Administrative Costs of U.S. Health Care*, N.Y. TIMES: THE UPSHOT (July 16, 2018), <https://www.nytimes.com/2018/07/16/upshot/costs-health-care-us.html> [https://perma.cc/R5VE-WTE3].
 23. There are more examples than I could possibly cite here, but I list a few from different disciplines. Robert Evans and Tom Rice describe market-based policies as a form of American exceptionalism that replicates inequitable access and unusually high system administrative costs and prices. THOMAS RICE, *THE ECONOMICS OF HEALTH RECONSIDERED* (Ronald M. Andersen et al. eds., 1998); Robert G. Evans, *Going for the Gold: The Redistributive Agenda behind Market-Based Health Care Reform*, 22 J. HEALTH POL., POL'Y, & L. 427, 432 (1997) ("Distributional questions may be suppressed in economic analysis, but they remain at the forefront of public policy debates."). Tim Jost has aptly observed: "Even though the foundations and conclusions of neoclassical economics as a science are questionable and the ideological inclinations of the discipline render its normative prescriptions suspect, economics retains great influence on policy making in the United States, more so than any of the other social sciences." JOST, *supra* note 3, at 117. Much of Deborah Stone's work critiques the overinfluence of economics on policymaking. See, e.g., Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 14 (1999). Jacob Hacker critiques the rise of the idea of personal responsibility as part of the neoliberal project and how it has contributed to economic insecurity. See JACOB S. HACKER, *THE GREAT RISK SHIFT: THE ASSAULT ON AMERICAN JOBS, FAMILIES, HEALTH CARE, AND RETIREMENT AND HOW YOU CAN FIGHT BACK* (2006). For normative critiques of neoliberalism in other fields, see Anne L. Alstott, *Neoliberalism in U.S. Family Law: Negative Liberty and Laissez-Faire Markets in the Minimal State*, 77 L. & CONTEMP. PROBS. 25 (2014); Amy Kapczynski, *Intellectual Property's Leviathan*, 77 L. & CONTEMP. PROBS. 131 (2014).
 24. See, e.g., David M. Frankford, *Scientism and Economism in the Regulation of Health Care*, 19 J. HEALTH POL., POL'Y, & L. 773 (1994); see also, e.g., Suzanne Mettler, *Reconstituting the Submerged State: The Challenges of Social Policy Reform in the Obama Era*, 8 PERSP. ON POL. 803, 804 (2010) (summarizing the notion Mettler has advanced of the "submerged state,"

Rather, this Article shows that even when measured on their own terms, market-based policies have fallen short in health care and will continue to do so.

The Article proceeds in three Parts. The first Part describes why health care is fundamentally inhospitable to market-based policies. There is no one reason why health care consumerism does not work. Rather, the failures arise from multiple levels of structural problems. From the time Kenneth Arrow brought health care into mainstream modern economics, he warned that the most basic economic assumptions were belied in health care, including the most foundational principles that people have well-ordered preferences and the agency to make meaningful decisions.²⁵ Yet Arrow's caution did little to slow the eager adoption of microeconomic market-based approaches in health care.

Health care also defies the recipes of behavioral economics, ascribing to all of the cognitive ills and responding to few of the prescriptions for cure. Proponents have been overly optimistic about the ability to correct failures both in the markets and in patient decisionmaking, the totality of which is inscrutable. This first Part attempts to preview and summarize health care's exceptional characteristics as context for the pervasive failure of market-based approaches detailed in Part II.

Part II then traces the arc of microeconomic influence, through three market-based ideas that have deeply shaped the regulation of health care financing (how we pay for health care) and delivery (how we use and provide health care) and that have, in the end, fallen short of expectations. Market-based solutions to both financing and delivery problems fail for the same reasons: People lack the preferences, capacity, and desire to choose as these solutions demand.

The first example looks at consumerism in health insurance, focusing on the theory of managed competition, made famous by Alain Enthoven.²⁶ He argued that when people make good choices among health plans in a carefully regulated health insurance market, the choices will send signals to stimulate higher-value health care delivery. This idea undergirds the ACA and its health insurance exchanges and was influential for decades prior, as part of President Clinton's failed Health Security Act of 1993, Massachusetts's health reform in 2006, Medicare Advantage (Medicare's managed care marketplace), and the creation of Medicare's prescription drug program in 2003. The second example looks at patient decisions in health care delivery, about how and when to use medical care,

where policies are enacted in ways that are "formidable and elusive," such as through tax reform so that their inequitable results are opaque).

25. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 948 (1963).

26. See *supra* Part II.A.

and the trend toward what is often called “consumer-driven” or “consumer-directed” health care (CDHC), where higher out-of-pocket medical costs are supposed to incentivize patients to economize more wisely.²⁷ This pervasive trend is often described, somewhat crassly, as consumers having “skin in the game.” The final example focuses on antitrust law and oversight of mergers, which has seen a recent resurgence, and the hopes that healthy competition will benefit end consumers.

Each of these ideas spawned a regulatory structure built on a simple blueprint—the idea that if health law and regulation support a functioning market, people can make meaningful choices that will, in turn, improve the value of health care spending. These ideas transform the role of health regulation into fixing market failures and “flawed” decisionmakers. Yet, despite intensive regulatory tinkering, markets are still not delivering as promised.

The final Part of this Article examines why market-based approaches persist, even as evidence of their shortcomings amasses. The persistence of market-based policies is in part a story of conflict avoidance and political economy. Policymakers and regulators can avoid dealing with political pressure and hard normative tradeoffs over how much care we use, who uses it, and how much we pay for it. The market-based bureaucracy is, in part, the price we pay to avoid wrestling collectively with hard moral or political challenges.²⁸

Yet, market-based solutions also endure because they have elevated choice—a narrow version of it defined by how people spend their dollars in a market—as the barometer of good social policy. Market-based solutions are sold as the epitome of choice, even when the choice they produce proves empty.

Thus, this Article concludes by arguing that to develop more productive future foundations for health care regulation, we must revisit the privileging and narrow definition of choice that has undergirded the last era of health policy and law. In some cases, the value of choice has been overemphasized. We would be better off if simply handed the best available health plan, or, more controversially, if denied treatments and therapies that are low in value or do not work.

Yet, moving choice off its pedestal does not preordain paternalistic regulation; rather, it demands seeking proxies other than purchases in a market to understand what people most value. This final Part ends by describing several recent examples that illustrate how democratic processes and collective

27. See *supra* Part II.B.

28. Cf. Dan M. Kahan, *The Secret Ambition of Deterrence*, 113 HARV. L. REV. 413, 417 (1999) (“Citizens of diverse commitments converge on the deterrence idiom to satisfy social norms against contentious public moralizing; public officials likewise converge on it to minimize opposition to their preferred policy outcomes.”).

deliberation are surfacing shared values that can, in turn, inform regulation. In many ways, what people value most in a health care system is not so complicated or varied, as these examples show. People want to be able to see their doctor when they are sick. They do not want to have to go broke, nor do they want others in their community to go broke, to stay healthy. Most people expressly do *not* want to spend their time wading ineffectively through choices of health insurance plans, medical care prices, or treatment options. For all of these reasons, we must avoid the temptation to continue to build reflexively on the market bureaucracy in the next era of health policy and regulation.

I. PERFECT CONDITIONS FOR A MARKET BUREAUCRACY

The gap between economic theory and successful application in health care is vast. For this reason, economists did not see health care as an industry appropriate for economic analysis for many years.²⁹ In fact, the early health economists who worked on policy saw economics as one tool among many and not especially helpful in making normative decisions.³⁰ As an economist who served on the Council of Economic Advisers under President Kennedy wrote, “it is important that our political leaders listen to the wishes of society, not just the analyses of economists.”³¹

Many viewed the early increasing attention to health care microeconomics with a healthy dose of skepticism. At the nascence of modern health economics, Kenneth Arrow wrote that health care lacks many of the conditions necessary for a competitive market.³² In the late 1980s, even as market policies were gaining steam in the field, half of all economists agreed in one study that competition in health care does not work.³³ Now, however, many scholars, policymakers, and commentators have lost this skepticism;³⁴ others seem to know that getting health care markets to work is a Sisyphean task, but they keep at it, as examined below.

29. Daniel M. Fox, *From Reform to Relativism: A History of Economists and Health Care*, 57 MILBANK Q. 297 (1979).

30. *Id.* at 307–14 (describing the early work by economists, which deferred to medical views on questions of need and distribution of medical care).

31. Rashi Fein, Commentary, *From Reform to Relativism: A History of Economists and Health Care*, 57 MILBANK Q. 353, 357 (1979).

32. Arrow, *supra* note 25, at 948.

33. RICE, *supra* note 23, at 22.

34. See SILVER & HYMAN, *supra* note 13; David Brooks, *Do Markets Work in Health Care*, N.Y. TIMES (Jan. 13, 2017), https://www.nytimes.com/2017/01/13/opinion/do-markets-work-in-health-care.html?emc=edit_tnt_20170113&nlid=19338766&tntemail0=y&r=0 [https://perma.cc/8M56-ES7M].

This Part provides the groundwork for understanding why economic theory—both neoclassical and behavioral—repeatedly falls short in health care as context for understanding the many reasons that the policies discussed in Part II fail. Although market-based approaches can be, and have been, critiqued in many fields, this Part illustrates why health care is especially problematic. Thus, even though the studies in Part II below do not always explicate or fully examine why market-based policies have failed in each instance, this Part should make the evidence of such failure unsurprising.

The challenges are multilayered, and some are insurmountable. The basic assumptions of neoclassic economics—like well-ordered preferences and the possession of (or ability to acquire) necessary information and skills—evade consumers when it comes to health care. Even without such fundamental problems, health care consumers experience the full range of cognitive biases—from information overload to anchoring to deference—that have proven tough to correct using traditional behavioral economics interventions. In short, nearly every condition necessary for a well-functioning market is lacking.

At the most fundamental level, basic assumptions underlying economic theory are absent in health care.³⁵ First, neoclassical economics assumes that consumers have well-ordered preferences or “tastes” that are genuinely aligned with their interests. For this to be true, people must be able to judge what is in their best interest, but they routinely fail to do so with respect to medical care or health insurance choices.³⁶ As Arrow wrote: “The most obvious distinguishing characteristics of an individual’s demand for medical services is that it is not steady in origin as, for example, for food or clothing, but irregular and unpredictable.”³⁷

Instead of considering self-interest, people form preferences based on what they have experienced in the past, which economist Tom Rice describes as “wanting what they *got* rather than getting what they *want*.”³⁸ He offers the example of Americans accustomed to high use of medical technology and wanting more of it, whether beneficial or not.³⁹ Even if someone did have an

35. Thomas Rice, *Can Markets Give Us the Health System We Want?*, 22 J. HEALTH POL., POL'Y, & L. 383 (1997).

36. The Rand Health Insurance Experiment showed that when people have less insurance, they reduce equal amounts of what experts consider to be the most effective treatment and what experts consider to be the least effective types of treatment. Kathleen N. Lohr et al., *Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial*, 24 MED. CARE S1, S31 (Supp. 1986).

37. Arrow, *supra* note 25, at 948.

38. RICE, *supra* note 23, at 400.

39. *Id.*

accurate sense of self-interest, the most basic economic concept of “willingness to pay” is hard to understand in the context of decisions that can be life or death.

People must also understand the counterfactual, or what could have happened if they had made a different choice.⁴⁰ As one expert explains:

What a buyer wants to know is the difference between his state of well-being with and without the commodity being considered Thus, a consumer of such services who gets better after the purchase does not know whether the improvement was because of, or even in spite of, the ‘care’ that was received. Or if no health care services are purchased and the problem becomes worse, he is generally not in a strong position to determine whether the results would have been different, and better, if he had purchased certain health care.⁴¹

In short, people cannot judge their decisions against foregone alternatives.

Furthermore, interests must be exogenous and stable enough to inform meaningful decisions. Preferences are at times not exogenous but rather shaped by social pressure or addiction, which might cause someone to smoke, use illegal drugs, forgo a helmet, or gamble, any of which are not in a person’s long-term best interest.⁴² And preferences on critical matters can change across short time frames.⁴³ Women, for example, change their preferences about pain treatment throughout their pregnancy, during labor, and after labor.⁴⁴ People’s views about whether they would want lifesaving treatment if it comes with a high risk of physical or cognitive disability change over relatively short periods of time.⁴⁵ We

40. RICE, *supra* note 23, at 73–74.

41. Burton A. Weisbrod, *Comment, in* COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE, PROCEEDINGS OF A CONFERENCE SPONSORED BY THE BUREAU OF ECONOMICS, FEDERAL TRADE COMMISSION 49, 52 (Warren Greenberg ed., 1978).

42. RICE, *supra* note 23, at 22.

43. See, e.g., Jay J.J. Christensen-Szalanski, *Discount Functions and the Measurement of Patients’ Values: Women’s Decisions During Childbirth*, 4 MED. DECISION MAKING 47, 47 (1984) (showing that women’s preferences about using pain treatment during labor varied based on when measured during and after pregnancy); Terri R. Fried et al., *Inconsistency Over Time in the Preferences of Older Persons with Advanced Illness for Life-Sustaining Treatment*, 55 J. AM. GERIATRICS SOC’Y 1007, 1010 (2007) (reporting nearly half of study participants expressed inconsistent preferences over a short timeframe on willingness to risk disability in order to avoid death); Donald A. Redelmeier et al., *Understanding Patients’ Decisions: Cognitive and Emotional Perspectives*, 270 J. AM. MED. ASS’N 72, 74 (1993) (describing reasons for inconsistent preferences). For a more detailed discussion of the lack of stable preferences in health care decisionmaking, see Wendy Netter Epstein, *Nudging Patient Decision-Making*, 92 WASH. L. REV. 1255, 1275–77 (2017).

44. Christensen-Szalanski, *supra* note 43, at 47.

45. Fried et al., *supra* note 43, at 1008 (when asked about willingness to risk physical or cognitive disability for survival, half of all participants responses were inconsistent over time).

simply do not have preferences about health care in the way that economic theory envisions.

Another basic assumption of market-based policies is that consumers are in control of their choices. Health care decisions, however, are replete with what economists call principal-agent problems; decisions are often strongly influenced by doctors or by employers, who choose a menu of health plans and design benefits. There is ample evidence that people want their doctors to make decisions about their health care.⁴⁶ Studies suggest that half of the time patients simply do—and in fact a majority *prefer* to do—what a physician recommends.⁴⁷ Sometimes, physicians' recommendations align with a patient's preferences, but physicians can also be influenced by factors like time constraints and conflicting profit motives.⁴⁸ Finally, many people cannot afford good clinical decisions, even when the best option is clear—sometimes referred to as “financial toxicity.”⁴⁹

Health care markets also fail to meet another critical prerequisite for well-functioning markets—that people possess and understand information regarding options. The health care system is notoriously opaque. Patients rarely know the price of medical care.⁵⁰ Even if they did, patients do not understand

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46. See e.g., Peter Henry Huang, *Happiness Studies and Legal Policy*, 6 ANN. REV. L. SOC. SCI. 405, 422 (2010) (“[P]eople often prefer not to make decisions by procrastinating, leaving decisions to others, making second-order decisions, or avoiding decisions . . .”).
 47. Wendy Levinson et al., *Not All Patients Want to Participate in Decision Making: A National Study of Public Preferences*, 20 J. GEN. INTERNAL MED. 531, 532 (2005) (“Fifty-two percent [of respondents] preferred to leave final decisions to their physicians and 44% preferred to rely on physicians for medical knowledge rather than seeking their own information.”); see also Neeraj K. Arora & Colleen A. McHorney, *Patient Preferences for Medical Decision Making: Who Really Wants to Participate?*, 38 MED. CARE 335, 338 (2000) (finding that 69 percent of patients prefer to leave medical decisions to their physicians, with rates increasing among older, less-educated, and sicker patients). But see Betty Chewning et al., *Patient Preferences for Shared Decisions: A Systematic Review*, 86 PATIENT EDUC. & COUNSELING 9 (2012) (reviewing studies on shared decisionmaking from 1980–2007 and finding mixed results on patients' preferences for an active role). See generally CARL E. SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* (1998).
 48. See John McKinlay et al., *Non-Medical Influences on Medical Decision-Making*, 42 SOC. SCI. & MED. 769 (1996) (describing a range of nonmedical factors that influence physician decisionmaking); Amitabh Chandra et al., *Who Ordered That? The Economics of Treatment Choices in Medical Care*, 2 HANDBOOK HEALTH ECON. 397, 412–18 (2012) (describing financial influences over physician decisionmaking).
 49. S. Yousuf Zafar & Amy P. Abernathy, *Financial Toxicity, Part I: A New Name for a Growing Problem*, 27 ONCOLOGY 149 (2013). See also COMM. ON CONSEQUENCES OF UNINSURANCE, INST. OF MED., *CARE WITHOUT COVERAGE: TOO LITTLE TOO LATE* 27–28 (2002) (describing studies showing that the uninsured lack access to necessary care); Stone, *supra* note 8, at 478–81 (describing the many ways that people make poor decisions for their own health when operating within budgetary constraints). See also studies cited *infra* Part II.
 50. Hall & Schneider, *supra* note 3, at 47–62 (describing the opacity of pricing in health care and the reticence of doctors to discuss or patients to ask about prices).

basic aspects of the system, including that a doctor might recommend unnecessary surgery, that a doctor can only admit a patient to a hospital where she has privileges, or that doctors are *not* reexamined routinely prior to licensure renewal.⁵¹ Understanding these realities would make a rational person approach medical advice and decisions with some skepticism.

More information is not the answer. Many Americans, regardless of education level, lack the numeracy and literacy to make the kinds of complex decisions necessary to choose among health plans or medical care options.⁵² Studies have shown that over half of American adults have only basic or below basic quantitative skills.⁵³ This means, for example, that they are unable to determine whether their car has enough gas to get to the next gas station, knowing all of the relevant inputs (the distance to the next station, the reading on their gas gauge, and how many miles per gallon their car gets).⁵⁴ Or even more pertinent, they cannot determine what time to take a prescription medicine,

51. JOSEPH P. NEWHOUSE ET AL., HOW SOPHISTICATED ARE CONSUMERS ABOUT THE MEDICAL CARE DELIVERY SYSTEM? 6–10 (1981).

52. On numeracy, see, e.g., Wendy Nelson et al., *Clinical Implications of Numeracy: Theory and Practice*, 35 ANNALS BEHAV. MED. 261 (2008) (providing an overview of research on health numeracy and the clinical implications for patients); Ellen Peters & Irwin P. Levin, *Dissecting the Risky-Choice Framing Effect: Numeracy as an Individual-Difference Factor in Weighting Risky and Riskless Options*, 3 JUDGMENT & DECISION MAKING 435 (2008) (showing that lower levels of numeracy led to higher loss aversion); Valerie F. Reyna et al., *How Numeracy Influences Risk Comprehension and Medical Decision Making*, 135 PSYCH. BULL. 943, 945–46 (2009) (reviewing studies showing links between innumeracy and poor health decisions); Stacey Wood et al., *Numeracy and Medicare Part D: The Importance of Choice and Literacy for Numbers in Optimizing Decision Making for Medicare’s Prescription Drug Program*, 26 PSYCH. & AGING 295, 296 (2011) (summarizing studies showing that low numeracy impedes health-related decisionmaking). On health literacy, see, e.g., ZSOFIA A. PARRAGH & DEANNA OKRENT, HEALTH LITERACY AND HEALTH INSURANCE LITERACY: DO CONSUMERS KNOW WHAT THEY ARE BUYING? (2015), http://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit_163.pdf [<https://perma.cc/X732-GG4N>] (describing health literacy and summarizing studies on health and health insurance literacy); Helen Levy & Alex Janke, *Health Literacy and Access to Care*, 21 J. HEALTH COMM. 43, 45–46 (2016) (reporting that individuals with low literacy are more likely to forgo needed care or to self-report difficulty in finding a health care provider); Tetine Sentell, *Implications for Reform: Survey of California Adults Suggests Low Health Literacy Predicts Likelihood of Being Insured*, 31 HEALTH AFF. 1039, 1044–45 (2012) (finding that low health literacy is higher among the uninsured and that people with low health literacy are likely to be sicker). On financial literacy, see generally Annamaria Lusardi, *Financial Literacy: An Essential Tool for Informed Consumer Choice?* 2 (Nat’l Bureau of Econ. Research, Working Paper No. 14084, 2008), <https://www.nber.org/papers/w14084.pdf> [<https://perma.cc/VF4N-5YT7>] (explaining that financial “[i]lliteracy is widespread among the general population and particularly acute among specific demographic groups, such as women, African Americans, Hispanics, and those with low educational attainment”).

53. MARK KUTNER ET AL., AM. INSTS. FOR RESEARCH, LITERACY IN EVERYDAY LIFE: RESULTS FROM THE 2003 NATIONAL ASSESSMENT OF ADULT LITERACY 13 fig.2-2 (2007).

54. *See id.* at 7.

based on the drug label instructions for timing of doses to eating.⁵⁵ Even college educated patients, doctors, and medical students show surprisingly high levels of error on numeracy assessments and simple arithmetic tests.⁵⁶ Many patients do not understand straightforward and important information, such as when their next appointment is scheduled.⁵⁷

People especially lack health *insurance* literacy. Repeatedly, studies affirm that people do not understand the technical terms that describe their health insurance policy, how much it costs, and what benefits are covered.⁵⁸ Most people do not understand even the basic structure of their health insurance, including whether they are in a plan where they can see any doctor or in a managed care plan that restricts provider options.⁵⁹ In a survey of insured adults, only 14 percent correctly answered four simple multiple-choice questions about cost-sharing features like a deductible.⁶⁰ Yet, people overestimated the extent to which they understand insurance concepts, which suggests many would not seek more information even when needed and if offered.⁶¹

55. *Id.*

56. See Nelson et al., *supra* note 52, at 263.

57. *Id.* at 262–63.

58. See, e.g., eHealthInsurance, *New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology*, EHEALTH (Jan. 3, 2008), <https://news.ehealthinsurance.com/news/rel344367> [<https://perma.cc/68LD-AZ58>] (reporting that in a phone survey, “[l]ess than a quarter of respondents (23 percent) reported that they were very sure of what the terminology used in their health insurance policy actually means” and only half knew how much they paid for monthly premiums or annual deductible); M. SUSAN MARQUIS, RAND CORP., CONSUMERS’ KNOWLEDGE ABOUT THEIR HEALTH INSURANCE COVERAGE 12, 15–16 (1981) (showing in survey that many people do not understand what their insurance covers, many patients underreport coverage especially when their insurance covers outpatient care, and that with higher cost-sharing and more complicated insurance structures, more people incorrectly report that physician services and prescription drugs are not covered); Deborah W. Garnick et al., *How Well Do Americans Understand Their Health Coverage?*, 12 HEALTH AFF. 204, 206 (1993) (finding that even though consumers largely understood whether their plans covered hospitalization or doctors’ visits, they underreported that their plans covered services including mental health, alcohol and drug abuse treatment, or prescription drugs and overreported that their plans covered longterm care).

59. Peter J. Cunningham et al., *Do Consumers Know How Their Health Plan Works?*, 20 HEALTH AFF. 159, 161–62 (2001) (finding overestimation of the need to sign up with a primary care provider and to get approval for specialty care); David E. Nelson et al., *What People Really Know About Their Health Insurance: A Comparison of Information Obtained From Individuals and Their Insurers*, 90 AM. J. PUB. HEALTH 924, 926 (2000) (reporting that 84.2 percent of people in fee-for-service plans incorrectly believed they were in managed care plans).

60. George Loewenstein et al., *Consumers’ Misunderstanding of Health Insurance*, 32 J. HEALTH ECON. 850, 855 (2013).

61. *Id.*; KATHRYN A. PAEZ & CORETTA J. MALLERY, AMERICAN INSTS. FOR RESEARCH, A LITTLE KNOWLEDGE IS A RISKY THING: WIDE GAP IN WHAT PEOPLE THINK THEY KNOW ABOUT

The vast gap between this reality of what health care consumers know and understand and an idealized informed consumer cannot be bridged, even if it could be somewhat narrowed. Often, solutions to these problems focus on providing more information or real time education or coaching on options, which is like chipping away at the tip of an iceberg.⁶² One might imagine more literate and numerate decisionmaking if everyone in the United States received a better basic education, but that reality is unlikely to manifest in the name of producing better health care consumers. Even with the best structured just-in-time education, most consumers will never be able to navigate many choices in health care in the way models assume. These gaps in capacity and understanding should be disqualifying, in and of themselves, of approaches that look to patients as consumers.

Finally, even in the extraordinary situation where these basic neoclassical conditions were all met—well-ordered, exogenous preferences, good information and understanding of both choices and counterfactuals, agency to decide, and the financial resources to make the best decision—a patient must then act consistently and rationally in line with her preferences and understanding. The abundant work in cognitive psychology and behavioral economics has made clear that decisionmakers are far from the rational archetype.⁶³

The reasons people fail to make rational decisions are heightened in the medical care and health insurance contexts.⁶⁴ Medical decisions are often scientifically and technically complex.⁶⁵ People are overly optimistic about their own health, especially since the consequences of decisions are often delayed (for

HEALTH INSURANCE AND WHAT THEY ACTUALLY KNOW (2014), https://www.air.org/sites/default/files/Health%20Insurance%20Literacy%20brief_Oct%202014_amended.pdf [<https://perma.cc/4Y8Y-RRZZ>].

62. See, e.g., Johnson et al., *supra* note 18, at 3 (showing that most interventions, including educational interventions, only made a small change in the number of people choosing a dominated health plan).

63. See Herbert A. Simon, *A Behavioral Model of Rational Choice*, 69 Q.J. ECON. 99 (1955). For a sampling of this work in law, see RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008); Christine Jolls et al., *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471, 1476–79 (1998) (describing the research on bounded rationality—the reasons why actual behavior differs from rational behavior); Russell B. Korobkin & Thomas S. Ulen, *Law and Behavioral Science: Removing the Rationality Assumption From Law and Economics*, 88 CALIF. L. REV. 1051 (2000) (outlining empirical evidence inconsistent with the rationality assumption).

64. See Redelmeier et al., *supra* note 43 (describing reasons, based on studies in cognitive psychology, why patients are flawed decisionmakers); Korobkin, *supra* note 12, at 532–38 (summarizing some of the key factors that contribute to bounded rationality in health care decisionmaking, such as complexity, novelty of the decision, evaluability problems, and emotion).

65. See Schneider & Hall, *supra* note 3, at 54.

example, skin cancer develops years after the pleasure of warm sun on your face).⁶⁶ People tend to focus too much on possibilities that are unlikely but frightening (for example, a spot that a doctor says has a very small probability of being cancerous) when making a decision.⁶⁷ Emotional responses, such as disgust, are overly influential.⁶⁸ People struggle deeply to comprehend and factor risk into decisions⁶⁹—an element central, of course, to choices of health insurance and medical care (for example, what does it mean for something to increase or decrease your risk of heart attack by 10 percent?). When people are making decisions about major medical care, they are often dealing with questions of first impression. Even when not, people do not accurately remember past medical experiences. Duration of past pain, for example, is less memorable than intensity of pain.⁷⁰ Framing can significantly affect decisions, as when people make different decisions when told survival rates versus mortality rates.⁷¹

Medical care decisions often must be made when ill and vulnerable or, in the case of emergency care, unconscious.⁷² For most big-ticket items, health care spending does not feel discretionary. Consider the case of a patient with advanced cancer, who must decide between expensive, intense treatments with no chance of cure yet some probability of prolonging life for months or years, on one hand, and less expensive, less invasive treatment (or no treatment) that will mean a better quality of life in the remaining time but less likelihood of prolonged

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66. See Neil D. Weinstein, *Unrealistic Optimism About Future Life Events*, 39 J. PERSONALITY & SOC. PSYCH. 806 (1980).
67. See Korobkin & Ulen, *supra* note 63, at 1100–02 (describing “anchoring” errors); Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, 185 SCI. 1124 (1974); Redelmeier et al., *supra* note 43, at 75 (“[S]udden problems with short deadlines tend to be most compelling, whereas intermittent problems of insidious onset are often overlooked.”).
68. Redelmeier et al., *supra* note 43, at 75 (describing a study showing that people are averse to wearing clothing of people with disease, disfigurement, or moral faults after that clothing has been sterilized).
69. *Id.* at 71–72 (describing how people tend to categorize something as safe or dangerous, without regard for the level of risk, and overvalue reducing risk to zero). For an overview of cognitive biases with respect to risk and uncertainty, see Daniel Ellsberg, *Risk, Ambiguity, and the Savage Axioms*, 75 Q. J. ECON. 643 (1961); Christine Jolls & Cass R. Sunstein, *Debiasing Through Law*, 35 J. LEGAL STUD. 199, 203–24 (2006); Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 ECONOMETRICA 263, 264 (1979) (showing that people tend to make choices inconsistent with their own expected utility when dealing with risky options).
70. See Redelmeier et al., *supra* note 43, at 75.
71. See *id.* at 73.
72. See Farzon A. Nahvi, *Don't Leave Health Care to a Free Market*, N.Y. TIMES (July 10, 2017), <https://www.nytimes.com/2017/07/10/opinion/health-insurance-free-market.html> [<https://perma.cc/86JG-2S8B>] (“describing the circumstances under which patients make decisions in an emergency room.”).

survival, on the other. The patient is sick and scared, perhaps under pressure from family to make certain choices, and she knows that no choice will save her life. These are impossible conditions for decisionmaking, and yet are routinely present in medical care decisions.⁷³

It should be unsurprising that with so many major barriers separating theory from reality, a mounting body of empirical evidence, discussed in detail in Part II below, has shown that consumerism does not work in health care. As an illustration, among expectant mothers who felt they had a choice in prenatal care providers, only 24 percent seriously considered another provider and only 14 percent had contact with one.⁷⁴ These low rates belied the authors' expectations because of the importance of the decision and the relative ease of searching for a prenatal care provider.⁷⁵

The widespread academic response to evidence of consumerist failure, motivated by the rise and deep influence of behavioral law and economics, has been to try to nudge imperfect consumers to better answers through choice architecture.⁷⁶ Yet, the studies below illustrate that nudges are falling short.⁷⁷ Addressing all of these aforementioned barriers would demand Herculean effort, and some barriers cannot be dismantled, even with such efforts.

Economic theory and competition can be productive in some circumstances in health care. For example, there is evidence that in more competitive provider markets, hospitals compete on price, and when price is fixed, on quality.⁷⁸ The threat of disruption by retail clinics or medical tourism can prompt doctors and hospitals to lower their prices, even if patients have not yet begun to flee.⁷⁹ These supplier-level dynamics seem to have the potential to

73. See Hall & Schneider, *supra* note 3, at 650–51 (describing how illness affects patient, pulling quote from literature describing people's experience as ill patients and consumers).

74. See Thomas J. Hoerger & Leslie Z. Howard, *Search Behavior and Choice of Physician in the Market for Prenatal Care*, 33 MED. CARE 332, 341 (1995).

75. See *id.* at 348.

76. See generally NUDGING HEALTH: HEALTH LAW AND BEHAVIORAL ECONOMICS (I. Glenn Cohen et al. eds., 2016).

77. *Infra* Part II.

78. See Martin Gaynor et al., *Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service*, 5 AM. ECON. J. 134, 150–51 (2013) (finding market concentration has a positive effect on mortality); Daniel P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q.J. ECON. 577, 601 (2000) (finding that Medicare patients receiving care for heart attacks in less competitive areas experienced higher rates of mortality); Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, 2019 MED. CARE RES. & REV. (finding that increased market concentration is strongly associated with reduced quality, based on patient satisfaction).

79. See SILVER & HYMAN, *supra* note 13, at 331–32, 352–53.

produce some benefit, even without effective patient consumerism.⁸⁰ In some very limited and unique situations, consumer-focused competition may move the needle. An oft-cited example, which may be due to consumerism or other factors, is laser eye surgery, or Lasik, which costs one-tenth today what it did twenty years ago, in nominal terms.⁸¹ Similar results have been shown with plastic surgery, fertility services, and, most recently, hearing aids.⁸² But it is fallacious to extrapolate from these examples of mostly simple, elective care to the more common, complicated decisions that today's policies are asking patients to make.⁸³ The patient earning just over minimum wage with a \$500 deductible and a chronic disease is in a wholly different decisionmaking situation than a cash-pay patient seeking out elective breast augmentation.

The following Part illustrates what should be an unsurprising result of policymaking on this shaky foundation: Decades of market-reliant policies are not producing as promised.

II. THE PRODUCTION OF HEALTH CARE'S MARKET BUREAUCRACY

Economic concepts may not translate well into law and policy for various reasons. Some theories are wrong conceptually, even if applied perfectly. Alternately, the assumptions underlying the theory may not prove true in application, or in application in a particular field, for reasons such as those outlined above in Part I. Policymakers, lawyers, and judges might extend a theory beyond its usefulness⁸⁴ or undermine benefits that can be derived from the theory. This Part illustrates how all of these types of shortcomings have occurred

80. Some people, like Silver & Hyman, draw a logical fallacy about the success of cash-pay health care from trends like CVS minute clinics and medical tourism. In these very situations, services in new settings are often reimbursed by insurers (not cash pay), who encourage insureds to use care in new settings. Cheryl-Ann N. Williams et al., *Marketing Retail Health Clinics: Challenges and Controversies Arising from a Health Care Innovation*, 28 HEALTH MARKETING Q. 270, 276 (2011) ("By 2007, only 15.9% of retail clinic visits were paid cash out of pocket. . . . Some insurers, for example Aetna and Blue Cross Blue Shield, give their members incentives which could include low or zero co-pays for using a retail health clinic for nonurgent health issues instead of an emergency room or urgent care facility.").

81. Brooks, *supra* note 34; see also SILVER & HYMAN, *supra* note 13, at 318–19.

82. See SILVER & HYMAN, *supra* note 13, at 318–22, 324–25.

83. Evans, *supra* note 23, at 450. Even though these examples are cited as successes because prices have decreased over time in real terms, it does not mean that patients navigate these markets especially well. Anyone who has been to Los Angeles knows there is a glut of bad cosmetic surgery, even if competitively priced.

84. Cf. Eric A. Posner, *Economic Analysis of Contract Law After Three Decades: Success or Failure?*, 112 YALE L.J. 829 (2003) (describing the disconnect between doctrines of contract law and predictions of economic theory).

as economic theory has permeated health law and policy in the form of microeconomic market-based solutions.

As these market-based ideas have been increasingly adopted as the favored policy approach, health law has shaped to accommodate them, using regulation as scaffolding. Examining several of the most vital areas of modern health care regulation reveals that market ideology has become increasingly institutionalized—and bureaucratized—as the intellectual core of the field.

Each of the following Subparts look to a different economic theory and market tool employed to reduce health care spending or improve quality. Part II.A examines the theory that consumers will choose well among insurance plans, eventually reshaping health care delivery. Part II.B examines the idea that higher cost-sharing can incentivize patients to ration medical care and price compare and, in turn, reduce low-value health care spending. The final Part II.C describes using antitrust regulation to improve dynamics in larger market competition to drive value for end consumers. By considering these ideas in parallel, this Part highlights that they share two main themes. First, each relies on the theory that markets and consumerism will achieve the best solution if we can just get the regulation (or deregulation) right. Second, they have all failed, despite tremendous investment of regulatory effort and intellectual capital. Although the studies cited below do not prove definitively that the ideas never work, concerted efforts over decades have repeatedly fallen short. At the very least, these failed efforts are proof that these ideas rarely work.

A. Managed Competition and the Market for Health Insurance

Managed competition has been one of the most influential ideas of the past half century in the development of health insurance design and regulation, yet its predictions of what consumer choices among health plans will produce have not materialized. This Part documents this irrefutable failure, as well as the Herculean efforts and massive regulatory infrastructure built in unsuccessful attempts to produce better results. Subpart II.A.1 describes the theory, Subpart II.A.2 describes why it has failed in implementation and why efforts at refinement have likewise fallen short, and Subpart II.A.3 describes the bureaucracy built up to support this faltering idea.

1. The Theory of Managed Competition and Its Promise

The ACA's health insurance exchanges were built loosely on a concept that has come to be called managed competition, most often associated with Stanford economist Alain Enthoven.⁸⁵ Republicans, even as they called for a dismantling of the ACA, proposed policies that build on this same idea,⁸⁶ and private exchanges have begun to develop in parallel to serve the employer-based health insurance market.⁸⁷

The oversimplified idea is that when consumers choose among health plans in a regulated marketplace that is carefully controlled by "sponsors," they will make choices based on their preferences.⁸⁸ Since they will presumably choose plans where they get better care at lower costs, their choices will ultimately drive health plans to compete for their business by offering higher-value options.⁸⁹ Enthoven initially called the idea "Consumer-Choice Health Plan" (CCHP), emphasizing the element of choice involved.⁹⁰

Enthoven proposed implementing this idea with a system of vouchers for buying health insurance, where each person would receive a credit to buy a health plan in a regulated, competitive market.⁹¹ The value of these vouchers would vary based on an individual's age, and low-income people would receive additional subsidies.⁹² The ground rules he proposed included mandating that insurers accept any applicant during an open enrollment period (guaranteed issue), requiring "community-rated" premiums that do not vary based on health status, and placing limits on out-of-pocket spending⁹³—all rules that the ACA enacted

85. Alain C. Enthoven, *Consumer-Choice Health Plan (First of Two Parts): Inflation and Inequity in Health Care Today: Alternatives for Cost Control and an Analysis of Proposals for National Health Insurance*, 298 NEW ENG. J. MED. 650 (1978) [hereinafter Enthoven, *First Part*]; Alain C. Enthoven, *Consumer Choice Health Plan (Second of Two Parts): A National-Health Insurance Proposal Based on Regulated Competition in the Private Sector*, 298 NEW ENG. J. MED. 709 (1978) [hereinafter Enthoven, *Second Part*]; Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 24 (Supp. 1993).

86. American Health Care Act of 2017, H.R. 1626, 115th Cong. (2017); Pete Sessions et al., *How We Can Repeal the ACA and Still Insure the Uninsured*, HEALTH AFF. BLOG (Jan. 18, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170118.058364/full/#one> [<https://perma.cc/CL4G-HMK2>].

87. Alain C. Enthoven, *Managed Competition 2014: Rescued by the Private Sector?*, HEALTH AFF. BLOG (May 12, 2014), <https://www.healthaffairs.org/doi/10.1377/hblog20140512.038969/full> [<https://perma.cc/4ACT-JP2D>].

88. Enthoven, *Second Part*, *supra* note 85, at 709.

89. *Id.* at 716–17.

90. Enthoven, *First Part*, *supra* note 85, at 650, 652.

91. Enthoven, *Second Part*, *supra* note 85, at 710.

92. *Id.*

93. *Id.* at 713–14.

for exchange plans to make those plans both accessible and more affordable to people regardless of their health status.

In his vision, an individual consumer would assess the different offerings and structure among plans and buy the one most consistent with her preferences. As Enthoven put it: “What distinguishes [this plan] from the others is that it seeks to give the consumer a choice from among alternative systems for organizing and financing care, and to allow him to benefit from his economizing choices.”⁹⁴ For example, Enthoven posited that if someone wanted a plan that prioritized better access to home health care or ambulatory care over, for example, hospitalization, she should choose it.⁹⁵

Enthoven’s assumption when he introduced this idea at the nascence of managed care was that tightly-managed health maintenance organizations (HMOs) would prevail.⁹⁶ In particular, he was motivated by HMOs that adopted a payment model that pays doctors based on the number of patients they care for and not based on individual patient visits.⁹⁷ These plans relied on primary care providers as gatekeepers to ration more expensive specialty and inpatient care, enabling them to benefit financially if they kept down use of this expensive care among their patients.⁹⁸

This gatekeeping function, in turn, unlocks the rest of Enthoven’s masterplan. The reduction of wasteful care would prompt a rationalization of the health care workforce and reduce the number of specialists. Enthoven writes: “Primary care physicians would assume more of the responsibility for the total costs of care of their patients, and specialists whose costs were judged by such primary care physicians to be excessive would find themselves obliged to negotiate lower fees to retain their referrals.”⁹⁹ Enthoven thought mobilizing consumer choice could correct the overreliance on expensive, specialty doctors in the United States—a politically thorny problem resistant to direct regulation.

This theory, now referred to as managed competition, has so deeply permeated the health policy zeitgeist that it has influenced nearly every major health financing reform effort of the past decades. It graduated to the main stage of the policy scene in the early 1990s, when it was incorporated into the blueprint for President Clinton’s attempt at health reform in 1993, the Health Security Act.¹⁰⁰ Although that reform failed, the idea persisted. It undergirds the design of

94. *Id.* at 718 (emphasis omitted).

95. Enthoven, *First Part*, *supra* note 85, at 652.

96. Enthoven, *Second Part*, *supra* note 85, at 718.

97. *Id.* at 717.

98. *Id.*

99. Enthoven, *Second Part*, *supra* note 85, at 715.

100. Health Security Act, H.R. 3600, 103d Cong. (1993–1994).

the Medicare Part D prescription drug coverage and Medicare Advantage, where Medicare beneficiaries can choose among plans administered by private health insurance companies. Most recently, the idea is reflected in the creation of the ACA's health insurance exchanges, or marketplaces, based on the 2006 Massachusetts reform. Managed competition ideals have informed proposals floated by Republicans to replace the ACA and to privatize Medicare.¹⁰¹ And managed competition emerged again in the 2020 Democratic primaries, usually in the form of the idea of a public option to compete with private plans. Even though none of these efforts followed Enthoven's blueprint exactly, they all internalized the concept he preached: Consumers with buying power will drive value in a managed, competitive insurance marketplace.

2. The Shortcomings of Managed Competition

Enthoven aimed to solve politically sticky problems in the health care system: overuse of overpriced specialty care and fee-for-service payment, where providers are paid per unit of care. The theory, as applied, however, has neither enabled people to choose better what they want, nor has it generated the hoped-for system transformation. The first Subpart describes why the idea is conceptually flawed. The second Subpart offers empirical evidence of the failure of managed competition in various health care programs. The final Subpart describes how these shortcomings persist in the ACA's exchanges, despite various attempts to use decision aids and nudges to improve consumer decisionmaking.

a. Conceptual Shortcomings

Enthoven's vision is built on false assumptions about people's ability to select well among health plans. Choosing a health insurance plan implicates all of the challenges described in Part I. To Enthoven's credit, the best empirical evidence on this point emerged later, but the outcomes were largely predictable.

Enthoven expected people to consider tradeoffs between, for example, possible future use of home health care versus hospital care,¹⁰² possibly having no experience with or exposure to either. Thus, it would be hard to imagine how to order preferences between the two or know how much to be willing to pay for each one.

Furthermore, insurance choices require at least moderate mathematic skills to determine total possible spending, taking into consideration benefits,

101. See *supra* note 11.

102. Enthoven, *First Part*, *supra* note 85, at 652.

networks, premiums, and cost-sharing.¹⁰³ Most importantly, the choice of health plan is all about risk and uncertainty, conditions that thwart decisionmaking for even a perfectly informed and well-educated buyer.

Finally, even if Enthoven's idealized customer did exist, managed competition would be unlikely to transform health care delivery as it exists in the United States. He imagined insurers would internalize consumers' preferences and negotiate with providers accordingly to improve health care delivery structures.¹⁰⁴ Yet, insurers lack the requisite market power vis-à-vis providers. Although less true when Enthoven first wrote, providers have accreted substantial market power through consolidation, undermining insurers' relative bargaining position.¹⁰⁵ When providers flex their muscles in negotiations, they usually win.¹⁰⁶

Even more, the very structure of Enthoven's model undermines insurers' ability to gain leverage over providers. Managed competition relies on having multiple insurers competing for customers, but the more insurers there are, the harder it is for any single insurer to enroll enough people to gain bargaining power over providers. The ACA's piecemeal design exacerbates this problem by rolling out the policy to a small slice of the population. In initial best-case scenario estimates, about twenty-three million people (a mere 7 percent of the population) would buy an ACA exchange policy by 2016;¹⁰⁷ the actual enrollment numbers have been less than half this number.¹⁰⁸ This number of enrollees spread across fifty states does not give insurers much added leverage against behemoth hospital systems. The theory of managed competition becomes untenable in real markets and, especially, with real consumers.

103. See *supra* note 53.

104. Enthoven, *Second Part*, *supra* note 85, at 717.

105. See *infra* note 339 and accompanying text.

106. *Id.*

107. CONGRESSIONAL BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 13 (2012), <https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/43472-07-24-2012-coverageestimates.pdf> [<https://perma.cc/69YC-FLEB>] ("According to the current estimates, from 2016 on, between 23 million and 25 million people will receive coverage through the exchanges . . .").

108. EMILY P. ZAMMITTI ET AL., NAT'L CTR. FOR HEALTH STAT., HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NHIS, JANUARY-JUNE 2016 1 (2016), <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201611.pdf> [<https://perma.cc/8RLB-WNDW>].

b. Empirical Evidence on Managed Competition's Shortcomings as Applied

Mountains of empirical evidence confirm that people do not choose as Enthoven predicted. Studies have tried to pinpoint what exactly impedes good decisionmaking—from complexity of choices to insufficient information. Increasingly, experts have recognized a fundamental inability among consumers to evaluate and rank options even in the best-case scenario, with simple choices and transparent information.¹⁰⁹

Much of the empirical research on health plan choices examines situations with a dominant—or clearly superior—choice among options.¹¹⁰ This means that there is no scenario in which Plan A is better than Plan B, for any buyer. For example, imagine two health plans with the same benefits and price but the second has a smaller network; no one should choose the latter. Or imagine Plan A has high monthly premiums and low cost-sharing and Plan B has low monthly premiums and high cost-sharing, such as a high deductible. They cover identical benefits and offer the same provider network, but someone who chooses Plan A will face higher total annual spending at any level of medical care use. No one should choose Plan A. Studies of private insurance, the Medicare market, and ACA plans all reveal the pervasiveness of people choosing such dominated plans. Since there is no one who would rationally choose a dominated plan, doing so is objectively a poor choice and ripe for study.

Based on a simulated insurance purchase, one study by Eric Johnson and colleagues reported that people have less than even odds of making the right insurance choice when given a small number of options and information about a family's medical needs.¹¹¹ This study excluded respondents who failed to

109. Saurabh Bhargava & George Loewenstein, *Choosing a Health Insurance Plan: Complexity and Consequences*, 314 J. AM. MED. ASS'N 2505, 2506 (2015) (“[T]he main barrier to financially efficient choice was not the number of options confronting employees, nor the transparency of their presentation, but rather the . . . lack of basic understanding on health insurance . . .”); Saurabh Bhargava, George Loewenstein, & Justin Snyder, *Choose to Lose: Health Plan Choices from a Menu With Dominated Options*, 132 Q. J. ECON. 1319, 1325 (2017) (“Taken collectively, results from the experiments suggest that the demand for dominated plans does not predominantly reflect the informed preferences of consumers or the consequences of menu complexity, but instead involves a failure of consumers to accurately evaluate and compare plans.”).

110. Compare Ian Ayres & Quinn Curtis, *Beyond Diversification: The Pervasive Problem of Excessive Fees and “Dominated Funds” in 401(k) Plans*, 124 Yale L.J. 1476 (2015) for a discussion of the problem of choice of dominated options occurring in other financial realms.

111. Johnson et al., *supra* note 18, at 3. The study concludes: “Consumers left to their own devices seem to make large errors when choosing health insurance . . . and they seem to be unaware of that failure.” *Id.* at 5.

demonstrate that they understood basic insurance terms (premiums, deductibles, or copayments) after a brief lesson.¹¹² This means that the under 50 percent rate of success was among a pool of people with relatively more knowledge or capacity. Even the Wharton business school participants in this study got it wrong over one-quarter of the time.¹¹³

Studies reveal similar results when employees choose among options for their employer-sponsored health insurance. Among enrollees in the University of Michigan employee plan, over one-third of all workers enrolled in a dominated plan, which was identical to another option in every way, except that it had a more restricted provider network.¹¹⁴ Again, there is no scenario in which a worker would be better off enrolled in this plan than a large number of the University's employees selected.¹¹⁵ Another study of a large U.S. firm similarly found that a majority of employees chose a dominated option, which was more expensive than a higher-deductible option at every level of possible health care use but otherwise identical (in terms of benefits, provider network, administrator, etc.), and which resulted in 24 percent excess spending on premiums.¹¹⁶ Lower-income employees were more likely to select dominated plans.¹¹⁷ These studies also refute the idea that employers serve as skilled intermediaries, acting as more informed agents to select good plan option for their employees.

In the Medicare market, a well-known study of Part D, where beneficiaries choose among private prescription drug plans, showed that over 73 percent of enrollees could have chosen a less expensive plan without increasing future spending variance, and the average enrollee could have spent nearly one-quarter

112. *Id.* at 4.

113. *Id.*

114. Anna D. Sinaiko & Richard A. Hirth, *Consumers, Health Insurance, and Dominated Choices*, 30 J. HEALTH ECON. 450, 453 (2011).

115. One may rightfully ask why the University of Michigan is even offering such a plan—a point discussed further below.

116. Bhargava, Loewenstein, & Sydnor, *supra* note 109, at 1321–22 (studying an employer where employees can “build” their own plans by choosing four cost-sharing elements—deductible, copayment, coinsurance, and out-of-pocket maximum—for plans that otherwise are identical in terms of, for example, covered benefits, provider network, and plan administrator). To illustrate a dominated plan, for employees to lower their deductible from \$1000 to \$750, they had to pay \$528 more in premiums per year, spending \$278 more than they would in any scenario under the \$1000 deductible plan. *But cf.* Benjamin R. Handel, *Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts*, 103 AM. ECON. REV. 2643 (2013) (showing that in one employer setting, correcting inertia that leaves people in dominated plans exacerbates adverse selection and leads to an overall welfare reduction).

117. Bhargava, Loewenstein, & Sydnor, *supra* note 109, at 1322.

less.¹¹⁸ Another revealed that fewer than 10 percent of Part D enrollees choose plans that end up being optimal for them in terms of total cost.¹¹⁹ Even though people might chose a more expensive plan for rational reasons other than price, including formulary or favorite provider, this study tested and ruled out such possibilities.¹²⁰ One-quarter of individuals could have done better by picking at random, and nearly three-quarters would have done better simply by picking the plan with the lowest premium.¹²¹

Despite some early evidence suggesting that people might get better at making decisions in the Medicare Part D program over time,¹²² these poor choices have persisted in the decade since the program began and have in fact grown worse, suggesting that people are not becoming better consumers.¹²³

The same results emerge in the Medicare supplemental insurance market, where people buy private policies to pay for costs not covered by traditional Medicare, which only pays for 60 percent of costs for the average retiree.¹²⁴ There

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118. Jason Abaluck & Jonathan Gruber, *Heterogeneity in Choice Inconsistencies Among the Elderly: Evidence from Prescription Drug Plan Choice*, 101 AM. ECON. REV. 377, 379 (2011). They find that individuals consider premiums, instead of total out-of-pocket costs, in making decisions. *Id.* See also Florian Heiss et al., *Mind the Gap! Consumer Perceptions and Choices of Medicare Part D Prescription Drug Plans* 3 (Nat'l Bureau of Econ. Research, Working Paper No. 13627, 2007) (finding that Medicare Part D consumers selected inexpensive plans when more expensive plans with more comprehensive coverage were actuarially better); Chao Zhou & Yuting Zhang, *The Vast Majority of Medicare Part D Beneficiaries Still Don't Choose the Cheapest Plans that Meet Their Medication Needs*, 31 HEALTH AFF. 2259, 2261 (2012) (finding that only 5.2 percent of beneficiaries choose the cheapest plan and that, by doing so, they spent on average \$368 more annually).
119. Florian Heiss et al., *Plan Selection in Medicare Part D: Evidence From Administrative Data 20–22* (Nat'l Bureau of Econ. Research, Working Paper No. 18166, 2012) (reporting that only 5.8 percent of individuals chose an ex post optimal plan in 2007 and 7.4 percent in 2008, with average losses of \$399 in 2007 and \$435 in 2008).
120. *Id.* at 24.
121. *Id.* at 21.
122. Jonathan D. Ketcham, *Sinking, Swimming, or Learning to Swim in Medicare Part D*, 102 AM. ECON. REV. 2639, 2653 (2012) (studying enrollment in Caremark Part D plans in the initial and second year (2006–2007) and finding that people switched to plans that notably decreased their overspending). Later studies, such as Abaluck and Gruber, *supra* note 118, were not able to replicate such results while looking at a longer time period and a broader range of plan options.
123. See Jason Abaluck & Jonathan Gruber, *Evolving Choice Inconsistencies in Choice of Prescription Drug Insurance* 3 (Nat'l Bureau of Econ. Research, Working Paper No. 19163, 2013). People err both by over- and under-insuring. *Id.* at 29.
124. PAUL FRONSTIN & JACK VANDERHEI, EMP. BENEFIT RES. INST., SAVINGS MEDICARE BENEFICIARIES NEED FOR HEALTH EXPENSES: SOME COUPLES COULD NEED AS MUCH AS \$400,000, UP FROM \$370,000 IN 2017 4 (2018), https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_460_medicare-8oct18.pdf?sfvrsn=5c1b3e2f_2 [https://perma.cc/L97A-PN9R].

are two main types of supplemental private plans that fill in the rest.¹²⁵ Medicare Advantage is a managed care plan that replaces original Medicare with a private plan that has a narrower network of providers.¹²⁶ These plans cover all Medicare benefits, fill in gaps in cost-sharing, and sometimes cover additional services such as dental, vision, and hearing.¹²⁷ The second option, called Medigap plans, layer on top of original Medicare, filling in cost-sharing gaps but not narrowing the network or covering additional services.¹²⁸ Once someone chooses between Medicare Advantage or Medigap, few make an active choice again between them in subsequent years, which leaves some people in a dominated plan.¹²⁹ One study documented that when a policy change made Medicare Advantage clearly superior, 75 percent of enrollees remained in the dominated Medigap plans.¹³⁰ The authors hypothesized any number of reasons might have influenced them, from inertia to limited cognitive capacity to the complexity of these decisions and the difficulty of comparing the many options.¹³¹ Not surprisingly, insurers in this market take advantage of this stickiness by increasing premiums after the first year.¹³²

125. Patricia Neumann and Gretchen A. Jacobson, *Medicare Advantage Checkup*, 379 *NEW ENG. J. MED.* 2163, 2163–4 (2018).

126. *Id.* at 2164.

127. *Id.*; see also *Medicare Advantage Plans Cover All Medicare Services*, MEDICARE, <https://www.medicare.gov/what-medicare-covers/what-medicare-health-plans-cover/medicare-advantage-plans-cover-all-medicare-services> [https://perma.cc/V437-3TB6] (last visited Oct. 19, 2019) (“Most Medicare Advantage Plans offer coverage for things that aren’t covered by Original Medicare, like vision, hearing, dental, and wellness programs (like gym memberships).”).

128. Neumann & Jacobson, *supra* note 125, at 2164.

129. Anna D. Sinaiko et al., *Enrollment in Medicare Advantage Plans in Miami-Dade County: Evidence of Status Quo Bias?*, 50 *INQUIRY* 202, 211 (2013). This stickiness may be from a genuine aversion to revisiting options or over-loyalty to a past choice, what psychologists call “status quo bias.” For the study that first revealed status quo bias in the selection of health plans, observing health plan choices among Harvard University employees, see William Samuelson & Richard Zeckhauser, *Status Quo Bias in Decision Making*, 1 *J. RISK & UNCERTAINTY* 7, 26–31 (1988).

130. Christopher C. Afendulis et al., *Dominated Choices and Medicare Advantage Enrollment*, 119 *J. ECON. BEHAV. & ORG.* 72, 73 (2015) (finding that a majority of beneficiaries did not switch out of traditional Medicare plans dominated by private fee-for-service plans, which became available in the mid-2000s).

131. *Id.* at 75; see also J. Michael McWilliams et al., *Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decision Making*, 30 *HEALTH AFF.* 1786, 1791–92 (2011) (describing the cognitive limitations of Medicare beneficiaries, especially as they age, and how it affects plan choice).

132. Joseph P. Newhouse & Thomas G. McGuire, *How Successful is Medicare Advantage?*, 92 *MILBANK Q.* 351, 359 (2014) (“For example, in 2006, the first year of Part D, the insurer Humana priced its Part D policies much lower than its competitors and, as a result, obtained a relatively large market share. It subsequently raised its premiums to near the level of its competitors but largely maintained its market share, very likely because of status quo bias.”).

Other studies document how the overwhelming number of options in the Medicare supplemental market can also impede consumers. If there are too many Medicare Advantage options, for example, people opt instead for original Medicare and Medigap.¹³³ Likewise, for Medigap, consumers can choose among ten different benefits designs, but a majority choose the most comprehensive plan design with the highest premiums.¹³⁴ It is possible, but unlikely, that most retirees have the same preference for this plan design.¹³⁵ More likely, people are opting for what seems simplest and least risky, as a result of what is called “choice overload,” where too many choices cause people to attempt to simplify,¹³⁶ disproving the basic economic assumption that more choices are better.¹³⁷

Even when there is not a plan that is objectively a better option, people may still not choose the plan most aligned with their own stated preferences because of a variety of misunderstandings. A study of a large firm by economists Benjamin Handel and Jonathan Kolstad showed that basic misunderstanding of plan options could influence decisions significantly.¹³⁸ The employees had a choice between two health plans: a high deductible health plan (HDHP) or a preferred provider option (PPO), the latter with higher premiums and lower cost-sharing.¹³⁹ Both offered access to the same benefits and medical network, which is a critically important feature for choosing a plan but which over half of the employees did not understand, despite this fact being emphasized in

133. McWilliams et al., *supra* note 131, at 1791. See also Yaniv Hanoch et al., *How Much Choice Is Too Much? The Case of the Medicare Prescription Drug Benefit*, 44 HEALTH SERVS. RES. 1157, 1163–64 (2009) (finding that increasing the number of drug plan options decreased accuracy of identifying plans with specific attributes, including lowest cost).

134. CTR. FOR POL'Y AND RESEARCH, AMERICA'S HEALTH INS. PLANS, TRENDS IN MEDIGAP ENROLLMENT AND COVERAGE OPTIONS, 2014 10 (2015), https://ahip.org/wp-content/uploads/2016/04/MedigapEnrollmentReport_Linked.pdf [<https://perma.cc/5AN5-ELX5>].

135. Mark J. Brown & Helen Doeringhaus, *Asymmetric Information and the Demand for Medigap Insurance*, 31 INQUIRY 445, 448 (1994) (“There is no statistically significant difference in the policy provisions chosen or the premiums paid by self-reported high- and low-risk insured individuals.”).

136. Sheena S. Iyengar & Emir Kamenica, *Choice Proliferation, Simplicity Seeking, and Asset Allocation*, 94 J. PUB. ECON. 530, 538 (2010) (“Our results establish that the size of the choice sets also impacts what types of options are selected by the market participants. We find that a larger choice set increases the appeal of simple, easy-to-understand, options.”).

137. For a comprehensive, easily digestible version of this idea, see BARRY SCHWARTZ, *THE PARADOX OF CHOICE: WHY MORE IS LESS* (2016).

138. Benjamin R. Handel & Jonathan T. Kolstad, *Health Insurance for “Humans”: Information Frictions, Plan Choice, and Consumer Welfare*, 105 AM. ECON. REV. 2449, 2485 (2015) (“Consumers who believe that the PPO plan has a larger network of medical providers value the HDHP by \$2,326 less than someone who correctly knows that these plans grants the same access.”).

139. *Id.*

information given to them.¹⁴⁰ A large majority of people also incorrectly estimated their spending from the prior year, yet a majority were confident in their estimates—more evidence that people do not understand their shortcomings enough to seek to remedy them.¹⁴¹

This study estimated that someone who believed incorrectly that one option with a lower deductible had a larger network than the second option with the higher deductible valued the latter at \$2,326 less than someone who understood they both had the same network structure.¹⁴² Misunderstanding the options, rather than a genuine preference for more comprehensive coverage, likely shapes some decisions.

The bottom line of this body of studies is that regardless of age, plan type and options, and capacity, people fail to choose well among health plans for a variety of reasons. Early evidence on the ACA exchanges, discussed in the next subpart, only affirms this fact. A common response has been to attempt to nudge people toward better decisions. That strategy has not worked either, as the following discussion illustrates.

c. The ACA, More Flawed Decisionmaking, and Failed Nudges

Emerging studies of the ACA exchanges show that, even with “nudges” toward better decisions, people are not choosing well. Consistent with the evidence above, many people are selecting almost exclusively based on lowest premium sticker price, often resulting in the choice of a dominated plan once subsidies are factored in.¹⁴³

Others choose health plans that are not aligned with their own stated medical needs and preferences.¹⁴⁴ In a study simulating the purchase experience

140. *Id.* at 2465.

141. *Id.* at 2466.

142. Handel & Kolstad, *supra* note 138, at 2485.

143. Reed Abelson, *Cost, Not Choice, is Top Concern of Health Insurance Customers*, N.Y. TIMES (Aug. 12, 2016), https://www.nytimes.com/2016/08/13/business/cost-not-choice-is-top-concern-of-health-insurance-customers.html?_r=0 [<https://perma.cc/7HFV-3WKX>]; DEP'T. OF HEALTH & HUMAN SERVS., HEALTH PLAN CHOICE AND PREMIUMS IN THE 2016 HEALTH INSURANCE MARKETPLACE 7 (2015), <https://aspe.hhs.gov/system/files/pdf/135461/2016%20Marketplace%20Premium%20Landscape%20Issue%20Brief%2010-30-15%20FINAL.pdf> [<https://perma.cc/HPQ6-U3F2>] (noting that in 2014, the majority (64 percent) of enrollees selected the lowest (43 percent) or second lowest (21 percent) priced plan in their metal tier. In 2015, 47 percent selected the lowest or second lowest price plans (31 percent and 17 percent, respectively)).

144. Andrew J. Barnes et al., *Determinants of Coverage Decisions in Health Insurance Marketplaces: Consumers' Decision-Making Abilities and the Amount of Information in Their Choice Environment*, 50 HEALTH SERVS. RES. 58, 67 (2015) (finding in a simulation based on

on ACA exchanges, only one-third of respondents chose the cost-minimizing plan, based on their own anticipated medical care need.¹⁴⁵ In contrast, 43 percent of respondents chose a plan that would leave them over insured (resulting in, on average, overspending by 24 percent, or \$1,324 on premiums), and nearly a quarter selected a plan that would leave them underinsured.¹⁴⁶ The authors estimated that if all people buying plans on the ACA exchanges had similar error rates as the study population, “the result would be roughly \$7.1 billion of excess spending each year, borne by a population with low to moderate incomes.”¹⁴⁷

The study hypothesized that the labeling of plans in the ACA exchanges, which was an attempt to steer people to better choices, may instead have created confusion.¹⁴⁸ The ACA plans are organized and sold by “metal” level, such as Gold, Silver, and Bronze.¹⁴⁹ Higher metal levels indicate that a plan will on average pay for a higher share of spending on essential health benefits—known as higher actuarial value—generally in return for higher premiums.¹⁵⁰ The authors found more generic labels improved choices, but only a little.¹⁵¹

Other studies show how low-income consumers are leaving money on the table. For people with especially low incomes (defined as 100–250 percent of the federal poverty level, or \$25,750–\$64,375 for a family of four in 2019¹⁵²), the law requires insurers to provide a second subsidy called cost-sharing reductions (CSRs), which decrease out-of-pocket spending when someone uses medical

purchasing actual ACA exchange plans that 40 percent of respondents choose a plan that would cost them at least \$500 more than another option, based on their self-reported health needs).

145. Saurabh Bhargava et al., *The Costs of Poor Health (Plan Choices) & Prescriptions for Reform*, 3 BEHAV. SCI. & POL'Y 1, 7 (2017). This study varied plans only by cost. It told respondents that benefits were equal among plans and did not mention network differences. *Id.*

146. *Id.* at 7–8.

147. *Id.* at 10.

148. *See id.* at 1.

149. *The ‘Metal’ Categories: Bronze, Silver, Gold & Platinum*, HEALTHCARE.GOV, <https://www.healthcare.gov/choose-a-plan/plans-categories> [https://perma.cc/B4PZ-8BDB] (last visited Oct. 19, 2019).

150. This is not universally true after the 2018 open enrollment, where plans in many states priced up Silver Plans to increase federal premium subsidies to make up for the cost-sharing reductions the Trump Administration will not pay. *See* Margot Sanger-Katz & Kevin Quealy, *When Silver Costs More Than Gold: How Trump’s Actions Have Scrambled Insurance Prices*, N.Y. TIMES (Oct. 27, 2017), <https://www.nytimes.com/2017/10/27/upshot/when-silver-costs-more-than-gold-how-trumps-actions-have-scrambled-insurance-prices.html> [https://perma.cc/FBC7-JWEN].

151. *See* Bhargava et al., *supra* note 145, at 10–11.

152. *Poverty Guidelines*, OFF. OF THE ASSISTANT SECRETARY FOR PLAN. & EVALUATION (Jan. 11, 2019), <https://aspe.hhs.gov/poverty-guidelines> [https://perma.cc/7BRW-JD9V].

care.¹⁵³ To get CSR assistance, someone must buy at least a Silver-level plan.¹⁵⁴ If she buys the plan with the cheapest premiums she can find, likely a Bronze plan, she disqualifies herself from these subsidies, and her total spending on premiums and cost-sharing will almost certainly be higher than if she bought the Silver-level plan. Millions of low-income enrollees have fallen into this trap.¹⁵⁵

The overwhelming response by scholars and policymakers to all of this evidence has been to try to correct pervasive decisionmaking errors, using the insights of behavioral law and economics.¹⁵⁶ Several exchanges, for example, try to nudge consumers eligible for cost-sharing reductions to Silver plans by displaying them first on websites, instead of showing the cheapest Bronze plans first as they do for other buyers who are not eligible for CSRs.¹⁵⁷ More assertively, the federal exchange healthcare.gov issues a warning if someone eligible for CSRs tries to buy a Bronze plan.¹⁵⁸ Even with such efforts, only about 80 percent of people eligible for CSRs were buying Silver plans.¹⁵⁹ It is possible that some people could not stomach higher spending on premiums at the point of purchase, but many will ultimately spend more in a year due to defaulting on the CSRs.

Marketplaces have acknowledged the challenges of designing useful decision-support tools to help people choose their best option, balancing the need for enrollment simplicity against predictive accuracy. One state reported,

153. Louise Norris, *The ACA's Cost-Sharing Subsidies*, HEALTHINSURANCE.ORG (Sept. 23, 2019), <https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies> [<https://perma.cc/P3LL-E53P>].

154. *Id.*

155. See Vicki Fung et al., *Nearly One-Third of Enrollees in California's Individual Market Missed Opportunities to Receive Financial Assistance*, 36 HEALTH AFF. 21 (2017); *More Than 2 Million Exchange Enrollees Forgo Cost-Sharing Assistance*, AVALERE HEALTH (Aug. 19, 2015), <http://avalere.com/expertise/managed-care/insights/more-than-2-million-exchange-enrollees-forgo-cost-sharing-assistance> [<https://perma.cc/22M2-6C23>].

156. See, e.g., TOM BAKER ET. AL, PENN LEONARD DAVIS INST. HEALTH ECON., WINDOW SHOPPING ON HEALTHCARE.GOV AND THE STATE-BASED MARKETPLACES: MORE CONSUMER SUPPORT IS NEEDED (2014), <https://ldi.upenn.edu/sites/default/files/pdf/window%20shopping%20on%20healthcare%20gov.pdf> [<https://perma.cc/ZNP9-P6EB>]; JUSTIN GIOVANNELLI & EMILY CURRAN, COMMONWEALTH FUND, EFFORTS TO SUPPORT CONSUMER ENROLLMENT DECISIONS USING TOTAL COST ESTIMATORS: LESSONS FROM THE AFFORDABLE CARE ACT'S MARKETPLACES (2017), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_feb_1929_giovannelli_total_cost_estimators_rb.pdf [<https://perma.cc/2E3B-UNPD>].

157. BAKER ET AL., *supra* note 156, at 4. See also *In Washington State, Too Many Low-Income Bronze Plan Buyers*, XPOSTFACTOID (Mar. 29, 2015, 10:41 AM), <http://xpostfactoid.blogspot.com/2015/03/in-washington-state-too-many-low-income.html> [<https://perma.cc/RF9W-W5LP>].

158. *Id.* (“While the site does provide a pop-up warning to CSR-eligible buyers who make a preliminary selection of a metal level other than silver, it’s not a very clear warning . . .”).

159. *Id.*

tellingly, that it avoided asking too many input questions because it “might give consumers a false sense of accuracy.”¹⁶⁰ The outputs from any website supports are inevitably complicated, breaking down total annual estimated costs into monthly premiums, deductible spending, and basic plan information.¹⁶¹ One study aptly noted: “Delivering on this vision [of a consumer-friendly shopping experience] is difficult because health insurance is complicated.”¹⁶² More, or different, information does not necessarily help.

The Johnson simulation, discussed above, tested various decision-support tools and concluded that most had little positive effect. A cost calculator, for example, which displayed total annual cost among options, resulted in only small decisionmaking improvements.¹⁶³ The only approach that substantially reduced errors was a combination of just-in-time education, cost calculator, and, most importantly, a smart default with an opt out.¹⁶⁴ Yet, consumers with these tools did not demonstrate a large increase in their confidence in their decisions, even though their final decisions were considerably better.¹⁶⁵ The study authors conclude: “Consumers left to their own devices seem to make large errors when choosing health insurance, suggesting that they will select options that are not cost-efficient and they seem to be unaware of their failure.”¹⁶⁶

Another favorite approach among researchers is to simplify the choices or to package them differently. One set of health economics researchers homed in on and tested the hypothesis that people would do better if they had fewer, simpler options, only to find out that it made little difference when tested empirically.¹⁶⁷

Others propose repackaging medical care into different bundles to fix decisionmaking errors caused by bounded rationality. For example, law professor Russell Korobkin has proposed a redesign of health insurance policies, which he calls “relative value health insurance.”¹⁶⁸ Insurance policies would bundle services based on evidence of their comparative cost effectiveness, or technically-calculated value.¹⁶⁹ Putting aside the lack of data to calculate in this way (which is a large concession), the idea is that a Level 1 policy would cover only the most cost-effective treatments and a Level 10 would cover the universe,

160. GIOVANNELLI & CURRAN, *supra* note 156, at 5.

161. *See id.* at 6.

162. *Id.* at 7.

163. Johnson et al., *supra* note 18, at 4.

164. *Id.* at 5 (defaulting consumers into the best options and allowing them the ability to opt out into a different option).

165. *Id.*

166. *Id.*

167. *See* Bhargava & Loewenstein, *supra* note 109.

168. Korobkin, *supra* note 12.

169. *Id.* at 528.

from high to low value.¹⁷⁰ He explains that: “[t]he simple numerical rating scale would provide boundedly rational consumers with a useful tool for allocating resources between their medical care and other goods and services.”¹⁷¹ He imagines that “[a]t the time of insurance enrollment, consumers could consult the current list of relative value ratings for all treatments, organized by condition, which would provide concrete examples of what interventions would need to be covered by policies set at different rating levels.”¹⁷²

The proposal may offer a reasonable way to root out some low-value care if most people do not buy the top-level plans. It may also eliminate some bias toward overuse that happens when rationing occurs at the point of care, but other biases will be stronger with *ex ante* decisionmaking, including over-optimism, anchoring on certain treatments on (or not on) a particular level list, or risk aversion.

More detrimentally, even if options are designed more rationally, people still will not understand the implications of particular bundle levels. People will no more understand what they get with a Level 8 policy than with the Gold-level Blue Shield PPO option. More fundamental problems, such as the lack of well-ordered preferences, the failure to understand risk and probability, and literacy and numeracy deficits remain. What will undoubtedly occur is that people with more disposable income will pick more comprehensive coverage, while people without as much disposable income will buy as much as they can afford. Few people will make the kinds of rational tradeoffs Korobkin envisions; his proposal merely becomes an even more forceful rationing of medical care by economic means and does little to enhance meaningful choice.

Worse even, it perpetuates the false notion that people are getting what they want. Most people will have a hard time deciphering what the effects of different bundles would be on their lives and livelihoods, and how to trade off a level upgrade against spending on other goods and services. Furthermore, to the extent people have preferences about deeper or shallower coverage, they might not align any better to bundles of services organized by some measured value than to today’s insurance plan bundles. Yet, an insurer, hospital, or policymaker can claim that someone chose her own fate if she selected a Level 5 plan when later denied Level 6 medical care.

This type of technocratic tinkering is celebrated as innovation within a market structure. It might reduce the use of low-value care overall, if fewer plans

170. *Id.*

171. *Id.*

172. *Id.* at 557.

cover it than do now (although that same end could be achieved without an overhaul of health plan design). Yet, it unquestionably grows market bureaucracy, requiring huge investment in comparative effectiveness research, sorting treatments into levels, and redesigning health insurance policies accordingly.

At the end of the day, and in light of the reality of how people choose among health plans, creating choices, even among simplified or differently-organized options, neither produces the ability for people to choose what they want, nor does it drive health care value based on those choices. The ACA exchanges have successfully increased the number of people with insurance. Yet, it is a stretch to say that they have enabled people to choose health plans most aligned with their preferences or that competition among plans has resulted in better health care.

Enthoven's vision of managed competition—with its many iterations over the years—is hard to square with reality. The research shows that people do not navigate options with the sophistication Enthoven imagined. More so, it is difficult to improve their decisions with anything short of a strong default, a decision-support shove, so to speak.¹⁷³ If people are defaulted into their best option, choice becomes an empty concept.

3. The Bureaucracy and Costs of Managed Competition

Managed competition has not produced efficient results, nor has it avoided extreme government oversight. Just the ACA version of managed competition has generated a massive regulatory infrastructure that was established and continues to grow in a futile attempt to support better consumer choice among barely distinguishable health plans.

Federal and state governments have spent billions of dollars to establish and run these ACA exchanges, though the structure sets people up for failure and creates anxiety. The federal government spent nearly \$5 billion on state grants to establish exchanges and continues to spend \$1–2 billion a year on an ongoing basis for the operation of *healthcare.gov*, the federally-funded exchange.¹⁷⁴ It spent \$2.5 billion to support temporary health insurance cooperatives, many of which failed.¹⁷⁵ When the initial rollout of the *healthcare.gov* website, which over

173. Cf. Bubb & Pildes, *supra* note 14, at 1621, 1625 (describing default contributions rates as operating more like a mandate than a nudge in reality).

174. ANNIE L. MACH & C. STEPHEN REDHEAD, CONG. RES. SERV., FEDERAL FUNDING FOR HEALTH INSURANCE EXCHANGES (2014), <https://www.fas.org/sgp/crs/misc/R43066.pdf> [<https://perma.cc/GPD6-RNDX>].

175. C. STEPHEN REDHEAD, CONG. RES. SERV., APPROPRIATIONS AND FUND TRANSFERS IN THE AFFORDABLE CARE ACT (ACA) 9 (2017), <https://fas.org/sgp/crs/misc/R41301.pdf> [<https://perma.cc/T8ES-YBUA>].

half of the states rely on, failed, enrolling only six people on its first day, the effort to overhaul it cost \$1.7 billion, compared to an initial budget of \$93.7 million.¹⁷⁶ It also wrought reputational harm on the ACA and the Obama Administration.

States with their own exchanges must fund a large part of their ongoing operations. California estimates annual costs of over \$350 million, funded out of plan assessments.¹⁷⁷ Even a smaller state like Vermont will spend about \$50 million a year to run its state exchange on an ongoing basis.¹⁷⁸

Innumerable hours of labor have been spent launching and refining this market. The Department of Health and Human Services proposed, revised, and issued hundreds of pages of federal regulations to implement the exchanges—all of which face the same risk of regulatory capture as nonmarket based regulation and perhaps more because of the critical role that private industry plays.¹⁷⁹ From the passage of the ACA through the end of the Obama Administration, CMS promulgated twenty-four new rules and generated sixty-four guidance documents with respect to the exchanges alone.¹⁸⁰ An entirely new office, the Center for Consumer Information and Insurance Oversight, was established within CMS in part to implement them.¹⁸¹

In parallel, the state regulators have been doing the same, first to set up the exchanges and then later to adapt to the many regulatory changes that have rolled out over the past ten years of ever-shifting implementation. Implementing an ACA model based on the ideas of managed competition has required a tremendous investment of money and regulatory effort. All of this expensive,

176. *The Failed Launch of www.HealthCare.gov*, HBS DIGITAL INITIATIVE, <https://rctom.hbs.org/submission/the-failed-launch-of-www-healthcare-gov> [<https://perma.cc/VJ3Q-8PTK>] (last modified Nov. 18, 2016).

177. COVERED CALIFORNIA, FISCAL YEAR 2018–2019 BUDGET: PROPOSED 23 (2018), https://board.coveredca.com/meetings/2018/05-17/CoveredCA_2018-19_Proposed_Budget-5-17-18.pdf [<https://perma.cc/9S3L-4823>].

178. VT. AGENCY OF HUM. SERVS., BUDGET DOCUMENT: STATE FISCAL YEAR 2016 88, 92 (2016), <https://dvha.vermont.gov/budget-legislative/sfy201602042015.pdf> [<https://perma.cc/MNH5-ZSXL>].

179. As one example, the 2019 annual ACA exchange market rule received over 400 comments, about one-third of which came from industry participants, including Anthem, PhRMA, and DaVita. HHS Notice of Benefit and Payment Parameters for 2019, 82 Fed. Reg. 51052 (Nov. 2, 2017); cf. Bubb & Pildes, *supra* note 14, at 1605 (“Soft paternalist measures run the risk of being less visible than more traditional regulations and mandates, which could make the political dynamics more prone to capture rather than less . . .”).

180. See *The Center for Consumer Information & Insurance Oversight: Regulations and Guidance*, CMS.GOV, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#HealthInsuranceMarketplaces> [<https://perma.cc/537U-AKRN>] (counting listings under “Health Insurance Marketplaces” through calendar year 2016).

181. *The Center for Consumer Information & Insurance Oversight*, CMS.GOV, <https://www.cms.gov/cciio> [<https://perma.cc/WBC6-J782>].

time-intensive tinkering and scrutiny serves to bolster a market structure that provides insurance for a mere 3 percent of the population.¹⁸²

This type of effort is replicated in various degrees for the Medicare supplemental market, including both Medicare Advantage and Medigap, as well as the Medicare Part D market. Add to these costs the private bureaucracy, including the operating costs and profits of the insurers who sell policies in these various managed marketplaces.

There are also opportunity costs. The cost of this bureaucracy arguably includes price inflation that might have been avoided with a more effective policy strategy. The efforts needed to bolster the exchanges have consumed health insurance regulators at both the state and the federal level. They have commanded oversized technocratic analysis of exchanges and their successes and shortcomings, with some of the most talented researchers and think tanks consumed by this task.¹⁸³

From 2010 until mid-2017, a constant stream of research studies and news articles obsessed over the functioning of the exchanges. The *New England Journal of Medicine* published thirty-five articles focused on the exchanges, *Health Affairs* published 280 articles that mention and 140 that focus on the exchanges, and over 800 law review articles discussed the exchanges, 250 of which focused on them in depth.¹⁸⁴ The *New York Times* alone published over 300 articles discussing the exchanges from 2010–2016,¹⁸⁵ many of which focus almost obsessively on the state of competition, as measured by the number of competitors or premiums.¹⁸⁶ Scores of researchers track premium prices, declaring them higher or lower than anticipated and setting off celebration or dismay.¹⁸⁷ Stories of increasing prices or a major insurer, such as United

182. *Marketplace Effectuated Enrollment and Financial Assistance*, HENRY J. KAISER FAM. FOUND. (February 2017), <https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D> [<https://perma.cc/J4KA-83S4>]; *U.S. and World Population Clock*, U.S. CENSUS BUREAU, <https://www.census.gov/popclock> [<https://perma.cc/9GUN-PQRV>].

183. See Allison K. Hoffman, *Cost-Sharing Reductions, Technocrat Tinkering, and Market-Based Health Policy*, 46 J.L. MED. & ETHICS 873 (2018) (offering one example of such analysis with respect to cost-sharing reductions).

184. Original research (on file with author).

185. *Id.*

186. *Id.*

187. See, e.g., Jon R. Gabel et al., *In Second Year of Marketplaces, New Entrants, ACA 'Co-Ops,' and Medicaid Plans Restrain Average Premium Growth Rates*, 34 HEALTH AFF. 2020 (2015) (measuring premium growth in federally facilitated and state-based marketplaces 2014–2015 and finding only modest growth); SABRINA CORLETTE & JOANN VOLK, GEO. U. HEALTH POL'Y INST., ACTIVE PURCHASING FOR HEALTH INSURANCE EXCHANGES: AN

Healthcare, dropping out of the exchanges incite panic.¹⁸⁸ Microscopic attention to increases in premium prices grabs attention, while revealing little about whether this model is working or will eventually work.¹⁸⁹

Finally, the exchanges have fueled several high-profile, high-stakes legal challenges, including *King v. Burwell*,¹⁹⁰ over the availability of premium subsidies in the federal exchange, and *House v. Hargan*,¹⁹¹ (née *House v. Burwell* and briefly *House v. Price*) over the legitimacy of the Obama Administration's payment of cost-sharing reductions without Congressional appropriation. Dozens of lawsuits have been filed against the federal government for the nonpayment of money owed to exchange insurers under the ACA.¹⁹² Such litigation arises largely due to the of the complexity of the market-based infrastructure,¹⁹³ and likely consumes a lion's share of the resources in the Solicitor General's office.

In sum, managed competition, embodied in the ACA health insurance exchanges has created a massive regulatory scaffolding—bureaucracy—without the payoff that the theory predicts. Billions of dollars per year go to the mere administration of various marketplaces. Countless hours of time are spent scrutinizing them and making technocratic adjustments to try to get them to work a little better at the margins, and they have fueled an endless stream of

ANALYSIS OF OPTIONS (2011), https://www.nasi.org/sites/default/files/research/Active_Purchasing_for_Health_Insurance_Exchanges.pdf [<https://perma.cc/FJ3E-PFTG>] (analyzing requirements for and models of active purchasing in health insurance exchanges); DAVID CUSANO & KEVIN LUCIA, COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: PROMOTING COMPETITION IN THE INDIVIDUAL MARKETPLACES (2016), <https://www.commonwealthfund.org/publications/issue-briefs/2016/feb/implementing-affordable-care-act-promoting-competition> [<https://perma.cc/SG48-YKCB>] (studying the ACA's effects on competition in the individual market in Kansas, Nevada, Rhode Island, and Washington).

188. See Christopher F. Koller, *United's Withdrawal from Exchanges—Much Ado About the Wrong Things?*, 375 NEW ENG. J. MED 303 (2016).
189. See David Blumenthal & Sara R. Collins, *Turmoil in Individual Private Health Insurance Markets: Welcome to Real Competition*, COMMONWEALTH FUND (July 26, 2016), <https://www.commonwealthfund.org/blog/2016/turmoil-individual-private-health-insurance-markets-welcome-real-competition> [<https://perma.cc/CFF2-7LMZ>] (“As reports of turmoil among private insurers in ACA marketplaces arise, we should keep in mind these characteristics of private health insurance markets, and competitive markets generally.”).
190. *King v. Burwell*, 135 S. Ct. 2480 (2015) (holding that premium subsidies are available on the federally run exchange, as well as on state exchanges, in favor of the Obama Administration).
191. *U.S. House of Representatives v. Price*, No. 16-5202, 2017 WL 3271445 (D.C. Cir. Aug. 1, 2017).
192. See *How the ACA ‘Risk Corridor’ Fallout Is Hurting Health Care*, KNOWLEDGE@WHARTON (Mar. 29, 2018), <http://knowledge.wharton.upenn.edu/article/significance-risk-corridors-lawsuits> [<https://perma.cc/H226-PCGP>].
193. See Allison K. Hoffman, *What Health Reform Reveals About Health Law*, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW (I. Glenn Cohen, Allison K. Hoffman, & William M. Sage eds., 2017).

litigation and related costs. This is all in addition to the operational costs of private insurers who are the machinery behind the exchanges. In all likelihood, this market-based policy creates as much, perhaps more, bureaucracy than a more direct approach to expanding access would have, and consumers are arguably worse off than they would have been under a simpler approach.

B. Moral Hazard, Consumer-Driven Health Care, and the Market for Medical Care

Perhaps the most influential of economic theories on the development of health law and policy over the past decades has been moral hazard.¹⁹⁴ Moral hazard has come to mean, most simply, that insurance increases losses. The greater protection against losses someone has, the less incentive she has to avoid them.¹⁹⁵ Perhaps more than any other idea, it has impeded productive health care regulation by perpetuating the flawed idea that health care consumers can, and should, themselves rationalize health care spending. Reflecting on the American obsession with moral hazard, Malcolm Gladwell wrote in 2005: “Health economists in other Western nations do not share this obsession But [in the U.S.] moral hazard has profoundly shaped the way think tanks formulate policy and the way experts argue and the way health insurers structure their plans and the way legislation and regulations have been written.”¹⁹⁶ He goes on to credit the U.S. health care “mess” to the particular way moral hazard has shaped how American policymakers think about insurance.¹⁹⁷

Among other influences, moral hazard prompted a phenomenon of consumer-driven health care (CDHC). Like managed competition does for health plans, CDHC relies on individual decisions regarding medical care—at the point of service—to spark price competition among providers and to reduce spending on low-value items or services. As economists Jamie Robinson and Paul Ginsburg put it: “In the consumer-driven world view, patients should manage their own care, with the advice of their physicians and with information on prices and performance derived from Internet sites, patient groups, and

194. See Arrow, *supra* note 25, at 961–62 (introducing the idea of “the moral hazard” for patients and physicians); Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531 (1968) (arguing that moral hazard is more serious of a problem than Arrow hypothesized and that it may make some expenses uninsurable).

195. See Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 238 (1996).

196. Malcolm Gladwell, *The Moral-Hazard Myth*, NEW YORKER (Aug. 21, 2005), <https://www.newyorker.com/magazine/2005/08/29/the-moral-hazard-myth> [<https://perma.cc/3VT9-W26D>].

197. *Id.*

personal advisers.”¹⁹⁸ In theory, if patients must pay for more out-of-pocket, rather than with insurance, they would price compare and spend less on low-value health care, which would enable them to spend more on things they value more, such as housing, food, or leisure.¹⁹⁹ In turn, a regulatory morass has developed to try to realize this vision—with a web of laws promoting the transparency of price information and policing the amount of skin in the game—even as mounting evidence show this concept does not work in application as theory predicts.²⁰⁰ As in Part II.A above, this Part proceeds in three Subparts that outline first the theory, second how and why CDHC has failed to produce wise rationing as predicted, and finally the bureaucratic scaffolding that has risen up to support this faltering idea.

1. The Theory of Moral Hazard and Consumer-Driven Health Care

The concept of moral hazard originated in early fire insurance underwriting, where it operated in a different way, to describe individuals as “moral hazards,” or not trustworthy enough to deserve the benefits that insurance confers.²⁰¹

Economists, including Kenneth Arrow in 1963²⁰² and Mark Pauly, writing in response to Arrow in 1968,²⁰³ brought the idea of moral hazard into broader economic theory, where Pauly made it a phenomenon about rationality, more than morality.²⁰⁴ Instead of a character flaw, moral hazard came to represent the idea that any rational person who does not have to internalize the full extent of a

198. James C. Robinson & Paul B. Ginsburg, *Consumer-Driven Health Care: Promise and Performance*, 28 HEALTH AFF. 272, 274 (Supp. 2009), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.2.w272> [<https://perma.cc/2CBD-RACD>].

199. John C. Goodman, *What is Consumer-Directed Health Care?*, 25 HEALTH AFF. w540, w540 (2006), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.w540> [<https://perma.cc/6LPS-YP6L>] (describing the tradeoff between health care and other goods and services and why patient power is the right approach to such tradeoffs).

200. Several reviews synthesize research prior to the ACA. See, e.g., KATHERINE SWARTZ, ROBERT WOOD JOHNSON FOUND., *COST-SHARING: EFFECTS ON SPENDING AND OUTCOMES* (2010), <https://pdfs.semanticscholar.org/786b/cb85cdd5bba0f4b5939d0f428707b6e9bbe2.pdf> [<https://perma.cc/7355-S7CL>]; Katherine Baicker & Dana Goldman, *Patient Cost-Sharing and Healthcare Spending Growth*, 25 J. ECON. PERSP. 47 (2011); JONATHAN GRUBER, KAISER FAM. FOUND., *THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND* (2006).

201. Baker, *supra* note 195, at 263–64.

202. Arrow, *supra* note 25, at 961–62.

203. See Pauly, *supra* note 194.

204. See Baker, *supra* note 195, at 271 (describing that economists described what insurers thought as temptation instead as rational responses to “incentives” based on cost-benefit calculations).

cost has less incentive to avoid or limit it.²⁰⁵ Pauly argued that “need” for health care does not exist independently, and that demand for health care is elastic and follows the same rules as any other consumer product.²⁰⁶ In turn, insurance should be limited so people do not overconsume health care because the price feels artificially low.²⁰⁷

Moral hazard can arise in two ways when people have insurance against losses.²⁰⁸ First, insurance reduces incentives to avoid harms, which is sometimes called “ex ante” moral hazard.²⁰⁹ Second, insurance creates a risk of malingering after a loss, or “ex post” moral hazard.²¹⁰ For example, once sick, people will overuse care if it is fully paid for by insurance, in turn driving up health insurance premiums.²¹¹

From its initial adoption, leading economists challenged the accuracy of Pauly's conception of moral hazard on technical and normative grounds. Arrow, both in his original writing and in response to Pauly, suggested that other countervailing factors limit overuse, including the physician acting as a “controlling agent” by attesting to necessity of a treatment,²¹² as well as the insurance company's review and prevailing social norms.²¹³ John Nyman challenged the notion that moral hazard was a problem, by showing that much of what Pauly's initial models deemed inefficient was in fact efficient spending because insurance caused a positive income effect once people were ill.²¹⁴

205. Pauly, *supra* note 194, at 535. Arrow and others extended the idea beyond insurance, to any situation where one party's actions create a loss borne by another. See Kenneth J. Arrow, *The Economics of Moral Hazard: Further Comment*, 58 AM. ECON. REV. 537 (1968). Joseph Stiglitz later modeled this insight. See Joseph E. Stiglitz, *Risk, Incentives and Insurance: The Pure Theory of Moral Hazard*, 8 GENEVA PAPERS ON RISK & INS. 4 (1983).

206. Pauly, *supra* note 194, at 532.

207. *Id.* at 536.

208. See Baker, *supra* note 195, at 270 (explaining the distinction between the two); George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1547 (1987) (describing the former as the “reduction in precautions taken by the insured to prevent the loss” and the latter as an “increase in claims against the insurance policy beyond the services the claimant would purchase if not insured”).

209. See Priest, *supra* note 208, at 1547.

210. *Id.*

211. Pauly, *supra* note 194, at 533–34.

212. Arrow, *supra* note 25, at 961.

213. Arrow, *supra* note 205, at 538 (“Nonmarket controls, whether internalized as moral principles or externally imposed, are to some extent essential for efficiency.”).

214. JOHN A. NYMAN, *THE THEORY OF DEMAND FOR HEALTH INSURANCE* (2003). Nyman also challenged the accuracy of the findings in the RAND study that suggested that cost-sharing did not produce negative health effects, illuminating that a significant number of people in the high cost-sharing experimental population dropped out of the study. John A. Nyman, *Moral and Other Hazards of Economic Analysis of Health Insurance*, in *RESEARCH HANDBOOK ON THE ECONOMICS OF INSURANCE LAW* (Daniel Schwarcz & Peter Siegelman eds., 2015).

Yet, at the end of the day, Pauly's arguments and overly-simplified conception prevailed in the marketplace of ideas, and moral hazard became a central tenet of law and economics scholarship that is applied widely across fields—from torts to contracts to bankruptcy—usually to justify limiting liability and compensation regimes.²¹⁵ In health care, it motivated a cottage industry of policy design and scholarship attempting to solve the problem that “over-insurance” causes people to use medical services inefficiently. The solution is to scale back insurance coverage so that people experience a greater share of costs,²¹⁶ sometimes referred to as having more “skin in the game.” In turn, people with more money at stake, in theory, will stop choosing low-value medical care. Once patients reduce their demand for certain lower-value goods and services, basic economic theory predicts their prices will drop.

Mark Pauly and Regina Herzlinger, who have written volumes on the topic, were early academic proponents of CDHC.²¹⁷ Timothy Jost and others were wary of the idea from its nascence, cautioning that it likely would not work and would disproportionately harm lower-income and sicker patients.²¹⁸ Jost's cautions were prescient, as the studies discussed below increasingly illuminate.

These ideas drove an increase in high deductible health plans, beginning in the late 1990s and early 2000s, where the insured have to pay the first share of

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215. See, e.g., STEVEN SHAVELL, *ECONOMIC ANALYSIS OF ACCIDENT LAW* 21, 26 (1987) (discussing the need to make sure that liability rules induce people to take the right amount of care to reach an equilibrium between risk and utility created by their actions); Richard A. Epstein, *Products Liability as an Insurance Market*, 14 J. LEGAL STUD. 645, 666 (1985) (arguing against the foreseeable misuse doctrine that holds manufacturers liable in products cases because shifting liability to manufactures creates moral hazard of misuse); George L. Priest, *A Theory of the Consumer Product Warranty*, 90 YALE L.J. 1297, 1313–14 (1981) (discussing how to limit moral hazard through ex-ante definition of warranties in products contracts).
216. See WILLARD G. MANNING & M. SUSAN MARQUIS, *HEALTH INSURANCE: THE TRADE-OFF BETWEEN RISK POOLING AND MORAL HAZARD* 31 (1989) (contending that 55 percent coinsurance is optimal); JOHN C. GOODMAN & GERALD L. MUSGRAVE, *PATIENT POWER: SOLVING AMERICA'S HEALTH CARE CRISIS* (1992); Martin Feldstein & Jonathan Gruber, *A Major Risk Approach to Health Insurance Reform* 25 (Nat'l Bureau Econ. Res., Working Paper No. 4852, 1994) (arguing for 50 percent coinsurance and 10 percent of income limits on out-of-pocket spending).
217. See CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS (Regina E. Herzlinger ed., 2004); REGINA HERZLINGER, *MARKET-DRIVEN HEALTH CARE: WHO WINS, WHO LOSES IN THE TRANSFORMATION OF AMERICA'S LARGEST SERVICE INDUSTRY* (1996); REGINA HERZLINGER, *WHO KILLED HEALTH CARE? AMERICA'S \$2 TRILLION MEDICAL PROBLEM—AND THE CONSUMER-DRIVEN CURE* 157 (2007); MARK V. PAULY, *AN ANALYSIS OF MEDICAL SAVINGS ACCOUNTS: DO TWO WRONGS MAKE A RIGHT?* (1994).
218. See JOST, *supra* note 3, at x; M. Gregg Bloche, *Consumer-Directed Health Care and the Disadvantaged*, 26 HEALTH AFF. 1315 (2007); Colleen L. Barry et al., *Who Chooses a Consumer-Directed Health Plan?*, 27 HEALTH AFF. 1671 (2008).

medical care costs before insurance reimburses spending.²¹⁹ Proposals usually pair these plans with private savings accounts that patients can use to save and pay for their increased out-of-pocket share.²²⁰

CDHC is in strong resurgence. Policymakers have recently advocated for an expansion of tax credits for health savings accounts and regulations that allow higher cost-sharing in ACA health plans.²²¹ Moral hazard is used to justify the current trend toward increased cost-sharing and other “personal responsibility” policies in state Medicaid programs.²²² A new wave of Medicaid waiver proposals includes, for example, higher cost-sharing and penalties for using the emergency room for nonemergency care.²²³

Employers increasingly offer high deductible plans and make plan design changes that reduce their responsibility for their employees' medical care spending; 58 percent of workers with an employer plan had a deductible of \$1,000 or higher for individual coverage in 2018, compared to 22 percent in 2009²²⁴ and 10 percent in 2006.²²⁵

Moral hazard also motivated the rise of tax-advantage savings accounts that individuals can use to pay for their medical care, when their insurance no longer does. These accounts were first created as a demonstration project as part of HIPAA in 1996.²²⁶ Even though the demonstration results were disappointing with very low uptake, a next generation product of health savings accounts (HSAs) emerged in response to lobbying efforts as part of the 2003 Medicare Modernization Act and the Bush Administration's “ownership society

219. JOST, *supra* note 3, at x.

220. For a comprehensive history of and critique of consumer-driven health care, see JOST, *supra* note 3; HEALTH CARE AT RISK: AMERICA'S AILING HEALTH SYSTEM—AND HOW TO HEAL IT (Jacob S. Hacker ed., 2008).

221. Stephanie Armour, *Trump Targets Medicare for All in Re-Election Campaign*, WALL ST. J. (Oct. 3, 2019), <https://www.wsj.com/articles/trump-to-target-medicare-for-all-proposals-in-re-election-campaign-11570104191> [<https://perma.cc/KPU4-JRYS>].

222. KAISER COMM'N ON MEDICAID AND THE UNINSURED, PREMIUMS AND COST-SHARING IN MEDICAID: A REVIEW OF RESEARCH FINDINGS (2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf> [<https://perma.cc/5RDX-QA7D>].

223. Robin Rudowitz & MaryBeth Musmeci, *The ACA and Medicaid Expansion Waivers*, KAISER FAM. FOUND. (Nov. 20, 2015), <https://www.kff.org/report-section/the-aca-and-medicaid-expansion-waivers-issue-brief> [<https://perma.cc/7L8G-R7NV>].

224. KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS SURVEY 2018 112 (2018), <https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey> [<https://perma.cc/6JYE-M8L3>].

225. KAISER FAM. FOUND., 2016 EMPLOYER HEALTH BENEFITS SURVEY 4 (2016), <https://www.kff.org/health-costs/report/2016-employer-health-benefits-survey> [<https://perma.cc/BLS8-S4XX>].

226. JOST, *supra* note 3, at 81–83.

agenda.”²²⁷ In parallel, the IRS created rules that require a person to have a plan with a high deductible to qualify for a tax-advantaged HSA.²²⁸ This combination of high deductible plans with tax-favored savings accounts made them disproportionately beneficial to people with high incomes who could gain more from tax-sheltered savings. In 2017, in the wake of the 2016 elections, countless policies supporting high deductible plans and HSAs came in quick sequence from Congress and the Trump Administration.²²⁹

All of these types of proposals rely on the same theory, that with the right financial incentives, people will use less low-value health care.

2. The Shortcomings of Law and Policy to Combat Moral Hazard

Moral hazard relies on assumptions about how people react to incentives that, even if compelling in theory, have not proven true in practice. The conceptual shortcomings and the mounting body of evidence described in the following Subpart make clear that patients will no sooner choose high-value medical care than they will select wisely among health insurance plans, regardless of how the incentives are structured. The three Subparts describe first the theory’s conceptual shortcomings, second empirical evidence of its shortcomings as applied in policies, and third why efforts to correct failings through choice architecture and other technocratic tinkering are unlikely to lead to improvements.

a. Conceptual Shortcomings

Like with managed competition, even before applied in the real world, the assumptions that the theory of moral hazard relies on struggle under scrutiny, as Arrow’s and Nyman’s work argued and as Tom Baker has artfully detailed.²³⁰ In theory, moral hazard assumes money can compensate for losses, so that someone who is fully insured can be made whole and lacks incentive to avoid losses.²³¹ For instance, if a fully-insured house burns down and the fire insurance company pays the owner the full value of the house, the owner is made whole.

227. M. Gregg Bloche, *Consumer-Directed Health Care*, 355 NEW ENG. J. MED. 1756, 1756 (2006).

228. INTERNAL REVENUE SERV., PUB. NO. 969, HEALTH SAVINGS ACCOUNTS AND OTHER TAX-FAVORED HEALTH PLANS 3–4 (2016), <https://www.irs.gov/pub/irs-pdf/p969.pdf> [<https://perma.cc/N3MV-BMD4>] (requiring at least \$1,350 for individual coverage and \$2,700 for family coverage).

229. See *supra* note 10.

230. See Baker, *supra* note 195, at 276–83.

231. *Id.* at 276.

Theoretically, if insured for more than the full value of the house, the owner would not prevent a fire or, even worse, might encourage one. This example illustrates clear practical limits to moral hazard. Although money can replace some losses, there are many that it cannot, such as the emotional value of home and possessions.

In the context of health insurance, where losses usually follow from bodily harm, money is an even worse substitute, which tempers moral hazard's effects. An individual has independent reasons to avoid bodily harm, even if the costs of medical care are fully reimbursed. Many people exercise and eat vegetables to stay healthy, regardless of whether they have comprehensive health insurance. And much of illness is random.

It is more plausible that well-insured people will use more medical care after they are sick or injured. The first empirical support for this idea came when the RAND Health Insurance Experiment (RAND HIE) showed that, indeed, people scale back on care when they have to pay for more of it themselves.²³²

Yet, even this ex-post moral hazard has its conceptual limits. People have reasons independent from cost to use, or not use, care. Many people would rather spend their time in places other than a waiting room, and some avoid medical care altogether.²³³ Using more care, especially diagnostic care, increases the risk of false positives that will require more testing, time, and possibly invasive procedures.²³⁴ On the other end of the spectrum, some types of expensive care, including emergency care, are insensitive to price, meaning that people will use roughly the same amount regardless of whether they are well insured.²³⁵ And as

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232. JOSEPH P. NEWHOUSE ET AL., FREE FOR ALL?: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 40, 162 (1993) (showing that people with less insurance coverage used less care). This study examined nearly 3000 nonelderly families in plans with several levels of cost-sharing, ranging from none to 95 percent, and several levels of maximum dollar expenditures, and found that people with higher coinsurance used less care, reporting spending 45 percent lower in the 95 percent coinsurance plan than in the free plan. *Id.* at 8, 40.
233. Jennifer M. Taber et al., *Why do People Avoid Medical Care? A Qualitative Study Using National Data*, 30 J. GEN. INTERNAL MED. 290 (2014) ("People often avoid seeking medical care even when they suspect it may be necessary; nearly one-third of respondents in a recent national United States (U.S.) survey reported avoiding the doctor.") (footnotes omitted).
234. See, e.g., Joann G. Elmore et al., *Ten-Year Risk of False Positive Screening Mammograms and Clinical Breast Examinations*, 338 NEW ENG. J. MED. 1089, 1089 (1998) (finding a 49 percent risk of false positive result in a retrospective cohort study of 2400 women, resulting in 870 outpatient appointments, 539 diagnostic mammograms, 186 ultrasound examinations, 188 biopsies, and 1 hospitalization).
235. See Newhouse et al., *supra* note 232, at 47 (showing that demand for some categories of care, including inpatient medical care for children, was inelastic).

Arrow noted, doctors as “controlling agents” will resist overuse of care, at least to some extent.²³⁶

A second assumption of moral hazard is that people control their spending so that they could, in theory, avoid spending on low-value care if sick or injured. This assumption maps especially poorly in the health care context: The RAND HIE showed that most of the difference in care utilization by less-insured subjects occurred when they decided to forgo care altogether.²³⁷ Once someone went to a doctor or hospital, the amount of care used or what they spent on it did not differ by level of insurance coverage.²³⁸ This is because people routinely follow their doctors’ advice.²³⁹ Doctors are especially influential when care is most expensive, or for serious illness or injury.²⁴⁰ While moral hazard has some blunt, predictive value on spending, countervailing forces mute its impact.

A final, critical assumption is that with more skin in the game people will cut out low-value care. Yet, as discussed above in Part I and proven by the empirical evidence below, layers of impediments thwart sound medical care choices. So, health care consumers will indeed ration, but not in ways that are especially efficient.

b. Problems in Practice

A deep body of empirical evidence has grown to show that the moral hazard theory has strong practical limits in health care.²⁴¹ CDHC-based policies are for the most part not encouraging better tradeoffs between medical care and other goods, nor is this market-based approach quelling bureaucracy or regulatory intervention. In fact, it demands the opposite.

236. Arrow, *supra* note 25, at 961.

237. NEWHOUSE ET AL., *supra* note 232, at 98–100.

238. *Id.* at 95.

239. *Cf.* Levinson et al., *supra* note 47 (finding that many people prefer to rely on a physicians’ advice).

240. See Arora & McHorney, *supra* note 47, at 338; Lesley F. Degner & Jeffery A. Sloan, *Decision Making During Serious Illness: What Role do Patients Really Want to Play?*, 45 J. CLINICAL EPIDEMIOLOGY 941, 945–46, 948 (1992) (finding that 59 percent of newly diagnosed cancer patients preferred physicians to make treatment decisions on their behalf; only 12 percent wanted an active role).

241. Studies of social insurance programs fail to show the increased utilization that moral hazard predicts would occur with the introduction of indemnity programs. Baker, *supra* note 195, at 284–89 (citing empirical studies that provide no strong evidence that insurance reduces the level of care and little evidence of significant “ex-post” moral hazard). As one example, switching from third-party to no-fault insurance, which under classic theory would increase accidents considerably, shows only small increases. See J. David Cummings & Mary. A Weiss, *The Stochastic Dominance of No-Fault Automobile Insurance*, 60 J. RISK & INS. 230, 233 (1993).

i. Evidence on Reductions of Care and Outcomes

To review, proponents claim that CDHC increases efficiency because people will spend less on lower-value medical care and shift resources to things they value more. One way they might do so is by reducing the use of low-value types of care. Another way is to compare prices and choose less-expensive providers. Yet, the evidence suggests that in practice people are not following this theoretical playbook.

Studies beginning with the classic RAND HIE confirmed the basic claim that increased cost-sharing will lower health care spending.²⁴² Yet, what RAND HIE also showed, and has been affirmed now by a quarter-century of empirical research, is that reductions do not result from better consumerism, such as shopping for lower-priced services, or from elimination of wasteful care. With higher cost-sharing, people reduce beneficial care as much as wasteful care.²⁴³ Consumers reduce spending across most health services, including cutting out beneficial pharmaceuticals and preventive care,²⁴⁴ as well as lower-value care,

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242. NEWHOUSE ET AL., *supra* note 232 at 40; Amelia M. Haviland et al., *Do "Consumer Directed" Health Plans Bend the Cost Curve Over Time?*, 46 J. HEALTH ECON. 33, 42 (2016) ("We find that health care cost growth among firms offering a CDHP is significantly lower in each of the first three years after offer."); *see also* M. KATE BUNDORF, ROBERT WOOD JOHNSON FOUND., CONSUMER-DIRECTED HEALTH PLANS: DO THEY DELIVER? 12 (2012) (reporting, based on survey of studies, between 5 percent and 14 percent reductions on health care spending on average from CDHPs).
243. NEWHOUSE ET AL., *supra* note 232 at 162, 166. *See, e.g.*, Zarek C. Brot-Goldberg et al., *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 Q.J. ECON. 1261, 1266 (2017); ("[C]onsumers meaningfully reduce both types of care, calling into question whether quantity reductions overall are net welfare increasing or decreasing."); Judith H. Hibbard et al., *Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?*, 65 MED. CARE RES. & REV. 437, 443 (2008) (showing reduction in both low-priority, or less cost-effective, and high-priority acute and chronic visits among people who switched into a CDHP); Mitchell D. Wong et al., *Effects of Cost Sharing on Care Seeking and Health Status: Results from the Medical Outcomes Study*, 91 AM. J. PUB. HEALTH 1889 (2001) (finding that cost-sharing reduced the use of care for both minor and serious symptoms in a chronically ill population who faced high copayments).
244. *See, e.g.*, Brot-Goldberg et al., *supra* note 243, at 1293 ("Despite the fact that preventive services are free both before and after the switch to high-deductible care, we find that consumers meaningfully reduce consumption of these services."). Consumers also reduce services like mental health care and prescription drugs for diabetes management, cholesterol management, depression, and hypertension. *Id.* at 1295–96; Michael T. Eaddy et al., *How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review*, 37 PHARMACY & THERAPEUTICS 45, 47, 49 (2012) (reporting that 85 percent of relevant studies reviewed showed that increasing patient share of medication costs led to lower adherence and, among studies on adherence and outcomes, 86 percent showed statistically significantly improved outcomes with increased adherence); Leonard Fromer, *Prevention of Anaphylaxis: The Role of the Epinephrine Auto-Injector*, 129 AM. J. MED. 1244, 1247 fig.1 (2016) (showing

such as nonemergent use of emergency departments.²⁴⁵ Economist Katherine Baicker and colleagues characterize the underuse of high value care as a type of “behavioral hazard,” which can result even from small cost-sharing.²⁴⁶

There has been a more extensive debate over whether such reductions ultimately lead to negative health outcomes, although increasingly studies suggest they can. There have been only two controlled experiments—RAND HIE and the Oregon Experiment—to examine the ultimate link between insurance coverage and health outcomes, and neither found a strong connection in the overall study population.²⁴⁷ If these studies were definitive and people with higher cost-sharing were randomly to reduce both high- and low-value care and end up no worse off, that might be an acceptable result, even if different than anticipated.

Other recent studies, however, have shown evidence of harm when people face high cost-sharing and reduce care. Even RAND HIE found negative health outcomes for low-income populations.²⁴⁸ Numerous observational and quasi-experimental studies since found negative outcomes both among low-income populations and more broadly, among older adults, a population that was excluded from RAND HIE design.²⁴⁹

increased abandonment of prescriptions for lifesaving EpiPens as cost increases, with more than 50 percent of prescriptions abandoned when patient cost exceeds \$300).

245. J. Frank Wharam et al., *Emergency Department Use and Subsequent Hospitalizations Among Members of a High-Deductible Health Plan*, 297 J. AM. MED. ASS'N 1093 (2007).
246. Katherine Baicker et al., *Behavioral Hazard in Health Insurance*, 130 Q. J. ECON. 1623, 1623 (2015).
247. NEWHOUSE ET AL., *supra* note 232; Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, 127 Q. J. ECON. 1057 (2012).
248. NEWHOUSE ET AL., *supra* note 232, at 208–11.
249. See, e.g., Amitabh Chandra et al., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AM. ECON. REV. 193, 194 (2010); John Hsu et al., *Unintended Consequences of Caps on Medicare Drug Benefits*, 354 NEW ENG. J. MED. 2349, 2354–55 (2006); Robyn Tamblyn et al., *Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Persons*, 285 J. AM. MED. ASS'N 421, 426–27 (2001). Other studies show that higher cost-sharing reduces behaviors that are known to improve health outcomes, such as medication adherence. Michael Chernew et al., *Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care*, 23 J. GEN. INTERNAL MED. 1131, 1134–35 (2008) (studying data from 6 million employees in large firms and finding that increased cost-sharing resulted in relatively lower medication adherence among individuals in low-income areas); Amelia M. Haviland et al., *How do Consumer-Directed Health Plans Affect Vulnerable Populations?*, 14 F. HEALTH ECON. & POL'Y 1 (2011) (showing that higher cost-sharing reduces beneficial preventive and chronic care). For reviews of these and other studies, see Thomas Rice & Karen Y. Matsuoaka, *The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors*, 61 MED. CARE RES. & REV. 415 (2004) (reviewing Medicare studies up until 2004); Katherine Baicker & Dana Goldman, *Patient Cost-Sharing and Healthcare Spending Growth*, 25 J. ECON. PERSP. 47, 56–60 (2011)

For example, Medicare recipients whose drug benefits were capped showed lower rates of drug adherence than did those without caps, even for chronic diseases like high blood pressure and diabetes.²⁵⁰ Those with capped benefits were, in turn, more likely to have higher blood pressure and LDL cholesterol and higher rates of visits to the emergency department, nonelective hospitalizations, and death.²⁵¹ Likewise, when a new Canadian law imposed a 25 percent coinsurance rate and a deductible on prescription drugs, a study showed that rates of serious adverse events, including hospitalization, nursing home admission or death roughly doubled among elderly persons and welfare recipients.²⁵² Another study of significant increases in cost-sharing in the California Public Employees Retirement System (CalPERS) supplemental coverage for retirees showed decreased use of prescription drugs and physician office visits.²⁵³ Savings from this decrease were offset by increased hospitalization, which contradicts the findings of the RAND HIE that reductions in spending were not offset.²⁵⁴

Studies also show that people with less insurance act in ways that might cause more significant future medical problems, and short-term spending reductions may not mean less spending in the long run—a finding that neither the RAND nor Oregon studies were able to measure.²⁵⁵ Inversely, studies show a link between increased insurance and participation in activities that are proven to make people healthier, such as better medication adherence and using certain preventive services.²⁵⁶

(describing studies on insurance and health outcomes, especially on pharmaceuticals); JOST, *supra* note 3, at 130–31 (summarizing various studies pre-2007); SWARTZ, *supra* note 200.

250. See Hsu et al., *supra* note 249, at 2354–55.

251. *Id.* at 2355–56.

252. Tamblyn et al., *supra* note 249, at 426–27 (reporting incidence of adverse events associated with reductions increasing from 5.8 to 12.6 per 10,000 person-months in the elderly population and from 14.7 to 27.6 among welfare recipients in the study). People reduced use of both nonessential and essential drugs—the latter including, for example, antibiotics and gastroprotective medications. *Id.*

253. Chandra et al., *supra* note 249, at 194.

254. *Id.* at 211 (conflicting with the RAND HIE bottom line and suggesting that it may have missed implications by focusing on a nonelderly population).

255. Research shows that uninsured people who forgo beneficial care in their pre-Medicare years catch up and spend relatively more when they age into Medicare. See, e.g., J. Michael McWilliams et al., *Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults*, 290 J. AM. MED. ASS'N 757 (2003); J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Beneficiaries*, 357 NEW ENG. J. MED. 143 (2007).

256. Benjamin D. Sommers et al., *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586 (2017) (surveying research on the impact of health insurance on financial security and health); Finkelstein et al., *supra* note 247 (reporting higher use of preventive care, access to care, and perceived quality of care, as well as self-reported health improvements, following Medicaid expansion to previously uninsured).

ii. Exploring Consumerist Shortcomings in CDHC

Empirical studies reveal a range of explanations for why skin-in-the-game incentives are not working as predicted; these studies suggest that even with endless regulatory tinkering, they are unlikely to improve. One problem is that people do not seem to understand the incentives created by these health plans and, if they do, fail to respond as a rational person would to them. For example, when high-value care is excluded from a plan's deductible, the goal is to create incentives for people to maintain use of this care by making it free. Yet, patients do not understand this dynamic.²⁵⁷ Similarly, people reduce care throughout a plan year, even if it is fairly certain they will exceed the deductible and other cost-sharing obligations over the course of the year.²⁵⁸ In doing so, they eliminate care that is in effect free to them.

More detrimentally, people do not seem willing to price compare to get a better deal, even under ideal conditions for price shopping, with their own dollars on the line, for relatively fungible services, and when price data is right at their fingertips.²⁵⁹ A recent study, based on a natural experiment that occurred when a large employer changed its employee plan from coverage that paid for all medical care to a high deductible health plan with high cost-sharing, showed decreased overall utilization, as in earlier studies.²⁶⁰ Yet, there was no evidence that

257. Mary E. Reed et al., *In Consumer-Directed Health Plans, A Majority of Patients were Unaware of Free or Low-Cost Preventive Care*, 31 HEALTH AFF. 2641 (2012) (finding that a majority of enrollees were unaware that the deductible did not apply to certain high-value care, such as preventive office visits, medical tests, and screenings).

258. See e.g., Brot-Goldberg et al., *supra* note 243, at 1306–07 (describing that 25 percent of total spending reductions over the year in population studied occur from the consumer (i) while under the deductible and (ii) who is predictably sick and will almost certainly outspend the deductible). This pattern holds in future years, suggesting people do not learn to estimate their true shadow prices in future years. *Id.* at 1308.

259. Brot-Goldberg et al., *supra* note 243, at 1286–88 (finding that among employees with access to leading technology for price comparison, there appeared to be no price shopping at all and that only a minority of employees reported that they knew of (33 percent), used (22 percent) or benefitted from (4 percent) the tool); Judith H. Hibbard & Edward C. Weeks, *Does the Dissemination of Comparative Data on Physician Fees Affect Consumer Use of Services?*, 27 MED. CARE 1167, 1172–73 (1989) (finding that providing hundreds of government employees and Medicare Part B enrollees a directory listing and the fees charged by local physicians for common procedures had little effect on their behavior and use of services); Sunita Desai et al., *Association Between Availability of a Price Transparency Tool and Outpatient Spending*, 315 J. AM. MED. ASS'N 1874, 1879–80 (2016) (testing a price transparency tool among employees at two large companies and finding it was not associated with lower spending or choosing lower-priced ambulatory settings and, in fact, resulted in modestly higher spending). This study found that only 10 percent of employees even logged into the tool in the first year of use. *Id.* at 1879.

260. Brot-Goldberg et al., *supra* note 243, at 1263.

employees price compared among services, even though the price comparisons were made easy and employees paid a significant share of the costs out-of-pocket.²⁶¹ A coauthor of this study, leading economist Amitabh Chandra, told the *New York Times*: “I was all for high-deductible plans before I wrote my paper,” which he said disabused him of the belief that deductibles and data would prompt good consumerism.²⁶²

Other studies testing price transparency laws or decision aids show similar results.²⁶³ Despite a tool offered in the California Public Employees' Retirement System (CalPERS) that displayed prices for lab tests, office visits, and imaging services, only 12 percent of people used the tool in the first fifteen months after it was introduced and, for the most part, they did not choose a lower-priced service after using the tool.²⁶⁴ The study authors concluded that “simply increasing deductibles and introducing price transparency tools will not induce consumers to price-shop.”²⁶⁵ Even the study with the strongest positive results showed very limited consumerism.²⁶⁶

261. *Id.* at 1265.

262. Margot Sanger-Katz, *The Big Problem With High Health Care Deductibles*, *N.Y. TIMES* (Feb. 5, 2016), <https://www.nytimes.com/2016/02/07/upshot/the-big-problem-with-high-health-care-deductibles.html> [<https://perma.cc/ZL25-C2E6>].

263. See Sunita Desai et al., *Offering a Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees*, 36 *HEALTH AFF.* 1401, 1405–06 (2017) (finding that only a small percent of purchases followed a price search and access to a price transparency tool did not lower spending). This study did find that people used lower-priced imaging services but only 1 percent of people using imaging services conducted a price search. *Id.* See also Ateev Mehrotra et al., *Americans Support Price Shopping for Health Care, But Few Actually Seek Out Price Information*, 36 *HEALTH AFF.* 1392, 1398–99 (2017) (finding that an unwillingness to switch providers or insurance networks constraints contribute to extremely low levels of price shopping). Two studies do show modest reduction in prices for imaging services among people who used a price-transparency tool, but also show that only a small number of people used it. Christopher Whaley et al., *Association Between Availability of Health Service Prices and Payments for These Services*, 312 *J. AM. MED. ASS'N* 1670 (2014) (5.9 percent of laboratory claims, 6.9 percent of advanced imaging claims, and 26.8 percent of clinician office visits matched a search with respective savings of 13.93 percent, 13.15 percent, and 1.02 percent); Anna D. Sinaiko et al., *Association Between Viewing Health Care Price Information and Choice of Health Care Facility*, 176 *JAMA INTERNAL MED.* 1868, 1869 (2016) (reporting that 3.5 percent of users used Aetna's web-based price transparency tool and, of those, users chose lower-price services for sleep studies, but the difference was not significant for the other six services studied).

264. Desai et al., *supra* note 263, at 1401.

265. *Id.* at 1406.

266. Whaley et al., *supra* note 263, at 1672–73 (finding that about 6–7 percent of employees searched prior within fourteen days of using a service and among those who did, spending was 13.93 percent lower for laboratory tests, 13.15 percent lower for advanced imaging, 1.02 percent lower for office visits, and 2.4 percent lower for new patient office visits). There is some limited evidence that people may respond more to a well-designed system of reference pricing—where price is set at the level of a designated provider and patients must pay extra if

A sweeping study among people with high deductible plans and easy access to price data on lower-leg MRIs, which are shoppable, expensive, and “among the least differentiated health care services” found that “on average, patients travel past six lower-priced providers in route to where they received care.”²⁶⁷ This study found that only 14 percent of people went to the lowest-cost MRI provider within thirty minutes of her home and that patients could have reduced out-of-pocket costs by over \$80 and insurer spending by over \$220 (over 27 percent and 40 percent excess spending).²⁶⁸ The referring physician was the strongest determinant of where people went for an MRI and the median referring orthopedic doctor sent no patients to the lowest-cost provider.²⁶⁹ While many of the above studies document the failures of consumerism without pinpointing the exact situs of the failure, this one suggests that at least one factor is agency, namely that patients rely on their doctors to make decisions.

In sharp contrast to these scenarios where prices were made transparent, the price of health care is usually indecipherable.²⁷⁰ Often, neither insurers nor providers can or will disclose the price of a service beforehand. This is in part due to a belief that prices are proprietary—a problem regulation could address. Yet, it is also due to the unpredictable way medicine is reimbursed, by units of care, so that prices may genuinely be unknowable in advance. If a surgery proves more complicated than anticipated, surgical or hospital bills will be higher. Prices may differ by insured, by insurer, and by provider, so that even the doctor providing the services is unlikely to know how much her services will cost for the patient.²⁷¹

It is also noteworthy that typically even if users have good information on price, they lack that on quality, which is just as important for making wise

they choose nondesignated providers with higher prices. The California Personnel Retirement System (CalPERS), for example, has had success in reducing spending with reference pricing combined with preauthorization to explain pricing to patients. David Frankford & Sara Rosenbaum, *Go Slow on Reference Pricing: Not Ready for Prime Time*, HEALTH AFF. (Mar. 9, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20150309.045147/full> [<https://perma.cc/G9Y9-YSQT>]. Although this experiment showed the ability to steer people toward lower-cost services, it saved 0.26 percent of total expenditure and increased plan administrative costs. *Id.*

267. Chernew et al., *supra* note 249, at 10.

268. *Id.*

269. *Id.* at 3.

270. See generally STEVEN BRILL, *AMERICA'S BITTER PILL: MONEY, POLITICS, BACKROOM DEALS, AND THE FIGHT TO FIX OUR BROKEN HEALTHCARE SYSTEM* (2015); Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Feb. 20, 2013 (exposing the high and indecipherable prices of medical care and the reasons why).

271. See e.g., G. Michael Allan et al., *Physician Awareness of Drug Cost: A Systemic Review*, 4 PLOS MED. 1486, 1486 (2007) (reviewing studies showing doctors' ignorance of prescription drug prices).

decisions. Although ratings systems have attempted to judge high and low hospital performance, they are underdeveloped and inconclusive, and studies show that the four existing national rating systems have produced inconsistent assessments.²⁷² Even if consumers had good data on both price and quality and wanted to use it, they would be faced with impossibly complex decisions about cost/quality tradeoffs and might lack the proficiency to navigate this complexity.

CDHC advocates argue consumers can overcome such shortcomings because they successfully navigate markets for other complex goods. Yet, the complexity of health care has proven greater than choosing between a Mac and PC. More importantly, it is becoming evident that patients do not view their medical care as just another consumer good, and resist invitation to price compare. They will follow a doctor's specific advice, even if the doctor recommends, knowingly or not, avoidably higher-priced options.

Some scholars herald international examples as consumerism success stories, such as Switzerland, Singapore, Germany, and even China. Even though these countries have systems that build in some degree of choice of services or health plan, none relies on consumerism to save money; rather, they (and other peer nations) all use supply-side incentives and regulatory price controls or rationing to get results.²⁷³ What choice-based features in these systems do is to allow people to opt for higher level service or amenities, such as a private room, for the most part. The theory that consumer choice will drive better health care quality and prices is becoming increasingly hard to defend, as CDHC is tested in practice.

272. J. Matthew Austin et al., *National Hospital Ratings Systems Share Few Common Scores and May Generate Confusion Instead of Clarity*, 34 HEALTH AFF. 423 (2015).

273. In the Swiss system, for example, the government mandates benefits, sets national fee schedules for physicians and maximum pricing for hospitals and pharmaceuticals, and approves community-rated premiums. Nikola Biller-Andorno & Thomas Zeltner, *Individual Responsibility and Community Solidarity—The Swiss Health Care System*, 373 NEW ENG. J. MED. 2193, 2195 (2015). In Singapore, government control of prices and rationing of health services, not the presence of medical savings accounts, drive cost control efforts. Michael D. Barr, *Medical Savings Accounts in Singapore: A Critical Inquiry*, 26 J. HEALTH POL., POL'Y, & L. 709, 716–18 (2001). See also Winnie C. Yip & William C. Hsiao, *Medical Savings Accounts: Lessons From China*, 16 HEALTH AFF. 244, 250 (1997) (describing that neither China nor Singapore are demand-side success stories and that the Singaporean system, which is often cited by CDHC advocates as an example of success, led to redundant proliferation of technology and overprescribing); Olga Khazan, *What American Healthcare Can Learn From Germany*, ATLANTIC (Apr. 8, 2014), <https://www.theatlantic.com/health/archive/2014/04/what-american-healthcare-can-learn-from-germany/360133> [<https://perma.cc/PDW7-JPG7>] (describing the uniform fee schedule and other German cost-cutting regulatory measures).

c. More Technocratic Tinkering to Improve CDHC's

Like in insurance plan choice, rather than see these deep failures as a sign that consumers may not be the right agents to drive down prices or root out low-value services, these shortcomings have impelled attempts to design more nuanced systems to nudge consumers toward better decisions. Scholars propose rebates and incentives to steer choices by making low-value goods relatively more expensive.²⁷⁴ The classic model in this mold is value-based insurance design (VBID), proposed by A. Mark Fendrick and Michael Chernew and others, which proposes charging a patient higher copayments for lower-value therapies and less for therapies that are more likely to be effective.²⁷⁵ Unlike later iterations, Fendrick and Chernew wisely suggest not paying for wasteful care at all, which would reduce or eliminate zero-value care without consumerism. A related idea is reference pricing, usually applied to pharmaceuticals, where insurance covers the price for a low-cost benchmark drug, and if the patient chooses another higher-priced drug that is deemed a close substitute, she must pay the difference.²⁷⁶ These efforts show some, albeit limited, success in carefully designed pilots and populations.²⁷⁷

Other proposals, like Korobkin's discussed above, also attempt to vary coverage by value to shape how people use care.²⁷⁸ People precommit to plans that cover only higher value care, and have to pay out of pocket altogether for uncovered services, creating a blunt and strong deterrent against using such services and, as a side effect, a maze of coverage and decisions for consumers to navigate.

Another similar proposal uses cash payments in a complex system to discourage people from lower-value care.²⁷⁹ Christopher Robertson proposes that when a doctor recommends expensive treatments that are arguably not cost effective, the insurer could offer the choice between a portion of the cost of the

274. This idea began with value-based insurance design (VBID) research by A. Mark Fendrick, Michael Chernew, and others and was initially called benefit-based copay. Michael E. Chernew et al., *Value-Based Insurance Design*, 26 HEALTH AFF. w195 (2007), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.26.2.w195> [<https://perma.cc/KPF4-LYVH>]. Iterations on the idea by legal scholars include Korobkin, *supra* note 12; Christopher Robertson, *The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game*, 98 CORNELL L. REV. 921 (2013).

275. Chernew et al., *supra* note 274.

276. See Panos Kanavos & Uwe Reinhardt, *Reference Pricing for Drugs: Is It Compatible With U.S. Health Care?*, 22 HEALTH AFF. 16 (2003) (describing international models of reference pricing and early results).

277. See Frankford & Rosenbaum, *supra* note 266.

278. See Korobkin, *supra* note 12.

279. Robertson, *supra* note 274.

treatment in cash or the full treatment in kind. He gives the example of a drug that costs \$70,000, where the insurer will either provide the drug or pay the patient \$10,000 in cash.²⁸⁰

He sells this approach as the “painless” way to have skin in the game. It seems potentially quite painful, however, especially for lower-income people. The proposal enhances incentives to forgo care, but much more strongly for poor people, who are more sensitive to the potential for a cash payoff. Such choices are morally problematic and unproductive in the long run. A policy that suggests people have a “choice” to use care or get cash reduces social obligations to ensure care for one another, while prompting poor people disproportionately to tradeoff among what they may perceive as basic needs.

More importantly, this proposal only adds complexity to decisions that people already struggle to make. Imagine that a patient is deciding between an expensive drug with a low probability of saving her life, versus paying the rent, or helping her child afford higher education. Dangling the potential for this treatment that her doctor has recommended or offered and that she will struggle to evaluate independently, and then making her choose between it and desperately needed cash is far from painless.

These proposals all offer clever, technocratic solutions that reinforce scaffolding around market based CDHC approaches. Yet, to the extent certain drugs or treatment have no value or are “not worth their cost,”²⁸¹ the goal should be for insurers simply not to pay for them and for doctors not to prescribe them. Scholars and policymakers should redouble efforts on resisting FDA approval for such drugs,²⁸² rather than contorting the shape of insurance policies in hopes that patients will refuse them, to preserve some imagined and unattractive version of choice.

Nudge solutions result in an unsatisfactory middle ground. The stronger the push, the less the approach honors individual decisionmaking. Choice and autonomy become illusory. The weaker the incentive, the less an individual will decide based on it, as the evidence above shows. When it comes to health insurance or health care decisions, the level of default needed to prompt successful consumerism may be a determinative default, not a suggestive nudge like framing effects.²⁸³

280. *Id.* at 945.

281. *Id.* at 927.

282. See, e.g., Arti K. Rai & Barak D. Richman, *A Preferable Path for Thwarting Pharmaceutical Product Hopping*, HEALTH AFF. BLOG (May 22, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180522.408497/full> [<https://perma.cc/L876-3MY8>].

283. See Johnson et al., *supra* note 18.

Finally, to the extent higher cost-sharing plus informed nudges did prompt better consumerism, system effects would be marginal. A relatively small number of very sick people are responsible for the majority of health care spending annually,²⁸⁴ and most high spenders are not using discretionary services (or those that a consumer would perceive as discretionary). One study estimates that, at most, only 7 percent of consumer out-of-pocket spending is on “shoppable” services, defined as scheduled in advance and with a choice of providers and price data.²⁸⁵ Conversely, many clearly discretionary services, including elective procedures such as cosmetic surgery, laser eye surgery, or bariatric surgery, are generally not covered by insurance.²⁸⁶ So even if these skin-in-the-game policies incentivized consumers to decline low-value, discretionary spending or to shop for lower-priced services, the potential dollars saved would be small in comparison to the investment needed to get these policies to work.

An extreme response to the failures described is that the incentives are not blunt enough and the right answer is to maximize one’s skin in the game to drive down prices to what people are willing to pay.²⁸⁷ A no-insurance approach would undoubtedly have a downward effect on overall spending, but that would be the only good result. The early twentieth century taught that medical markets without insurance produce unsatisfying results.²⁸⁸ People failed to get critical care.²⁸⁹ Others faced insolvency due to medical spending.²⁹⁰ And eventually, this cash pay system receded and insurance grew up because medical professionals who had a hard time getting bills paid had to select patients they believed could pay the bills.²⁹¹ It is no surprise that no developed country takes a no-insurance approach.

The body of evidence discussed above undermines the very foundation of CDHC and skin-in-the-game thinking. People with financial incentives and good data do not reduce low-value care or make decisions based on price

284. STEVEN B. COHEN, AGENCY FOR HEALTHCARE RES. & QUALITY, THE CONCENTRATION OF HEALTH CARE EXPENDITURES AND RELATED EXPENSES FOR COSTLY MEDICAL CONDITIONS, 2012 1 (2014) (reporting that the top 5 percent of the population accounted for 50 percent of total health care spending).

285. Amanda Frost et al., *Health Care Consumerism: Can the Tail Wag the Dog?*, HEALTH AFF. BLOG (Mar. 2, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160302.053566/full> [<https://perma.cc/3VZM-YBPC>]. An estimated 40 percent of total health care expenditures are on shoppable services. *Id.*

286. See DIANA FARRELL ET AL., MCKINSEY GLOBAL INST., ACCOUNTING FOR THE COST OF US HEALTH CARE: A NEW LOOK AT WHY AMERICANS SPEND MORE 28 (2008).

287. SILVER & HYMAN, *supra* note 13.

288. See JOST, *supra* note 3, at 43–46.

289. *Id.*

290. *Id.*

291. *Id.* at 46.

comparisons. It seems the best possible result of these policies is a reduction in use of care overall—good and bad—which will be harmful in at least some cases.

What these policies have accomplished is to shift responsibility for paying for health care from insurance pools and employers to individuals. This may be the result that CDHC advocates ultimately and honestly seek—less on-budget health care spending, rather than a genuine rationalization of medical care use or prices. But it is fallacious to claim that such a result improves welfare by enabling people to better use their resources to get what they want.

3. The Bureaucracy and Costs of Consumer-Driven Health Care

As with managed competition, the efforts to limit moral hazard through market-based policy have produced tremendous regulatory and intellectual scaffolding. This infrastructure has high direct and opportunity costs, which are hard to justify in light of the ethical concerns with and technical failings of such policies in practice.

The CDHC bureaucracy is perhaps best illustrated by the proliferation of transparency laws and private investment into transparency tools that support this particular market-based bureaucracy. Transparency might have benefits if the mere public sharing of data shames providers to lower prices, but the evidence above suggests that policies that aim to increase transparency to support consumer decisionmaking will offer little benefit.

Transparency has generated business for private companies like Castlight or Truven Health Analytics, who build cost-estimator and other tools that major health plans are now offering. Venture capital firms, according to one source, “have poured money into healthcare transparency tool companies,” including \$184 million into Castlight before its 2014 initial public offering, \$86.3 million into a provider-search website competitor, Vitals, \$26.5 million for MDsave, which lists prices for competitors, and \$45 million for Amino, part of a “new wave of transparency companies with its consumer-friendly interface and real-time data.”²⁹²

Proposals—academic and legislative—to increase price transparency have become nothing short of a health policy obsession.²⁹³ Half of the states have

292. Maria Castellucci & Shelby Livingston, *Achieving Transparency in Healthcare*, MODERN HEALTHCARE, <https://www.modernhealthcare.com/reports/achieving-transparency-in-healthcare/#> [https://perma.cc/3MPT-A95R].

293. See, e.g., *TRANSPARENCY IN HEALTH AND HEALTH CARE IN THE UNITED STATES* (Holly Fernandez Lynch et al. eds., 2019); David Cutler & Leemore Dafny, *Designing Transparency Systems for Medical Care Prices*, 364 *NEW ENG. J. MED.* 894 (2011) (challenging total transparency but offering more nuanced versions); Morgan A. Muir et al., *Clarifying Costs:*

passed laws to make prices more transparent to consumers.²⁹⁴ Many states are working to create, either through regulation or through voluntary efforts, databases that aggregate commercial claims data in part to publish price comparisons for consumers.²⁹⁵ Organizations encourage proliferation of these laws by rating each state based on them, scoring the scope of information, type of information, and quality of website for consumers.²⁹⁶

The federal government has also joined in. As CMS Administrator, Seema Verma, touted in a press release on the various transparency rules the current Administration has issued: “You Have the Right to Know the Price.”²⁹⁷ To help vindicate this right, CMS finalized a 2019 rule requiring that all hospitals publish a list of their standard charges online in a machine-readable format.²⁹⁸ CMS also requested input on what it would take for hospitals to better inform patients of out-of-pocket obligations, including those for out-of-network physicians working at an in-network hospital, resulting in high surprise bills.²⁹⁹ CMS required drug manufactures to include list prices in television ads and launched new dashboards for Medicare and Medicaid drug spending—presumably to shame the companies, as much as to inform consumers.³⁰⁰ And CMS is releasing

Can Increased Price Transparency Reduce Healthcare Spending?, 4 WM. & MARY POL’Y REV. 319 (2013) (explaining price transparency and examining existing initiatives and their shortcomings); Uwe E. Reinhardt, *Health Care Price Transparency and Economic Theory*, 312 J. AM. MED. ASS’N 1642 (2014) (arguing for greater price transparency based on the Whaley study, *supra* note 266).

294. DENISE LOVE ET AL., THE COMMONWEALTH FUND, ALL-PAYER CLAIMS DATABASES: STATE INITIATIVES TO IMPROVE HEALTH CARE TRANSPARENCY (2010) (describing the use of state all-payer claims databases to improve price transparency).
295. *Id.* at 3. These states must navigate carefully, after Vermont’s law requiring all employers and insurers to disclose claims and utilization data was found preempted by the federal Employee Retirement Income Security Act of 1974 (ERISA). See *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016).
296. See, e.g., FRANÇOIS DE BRANTES & SUZANNE DELBANCO, REPORT CARD ON STATE PRICE TRANSPARENCY LAWS—JULY 2016 (2016), https://dev-catalyst-for-payment-reform.pantheonsite.io/wp-content/uploads/woocommerce_uploads/2017/04/2016-Report-Card-on-State-Price-Transparency-Laws.pdf [<https://perma.cc/6TME-Q36U>] (reporting on the states’ relative development of transparency rules on a “report card” suggesting that more development is beneficial).
297. Seema Verma, *You Have the Right to Know the Price*, CMS.GOV (Nov. 17, 2018), <https://www.cms.gov/blog/you-have-right-know-price> [<https://perma.cc/Z4P6-T54G>].
298. Medicare Program, 83 Fed. Reg. 41,144, at 41,686 (August 17, 2018) (to be codified at 42 C.F.R. pts. 412, 413, 424, and 495), <https://www.federalregister.gov/documents/2018/08/17/2018-16766/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the> [<https://perma.cc/3ZX8-TMAT>].
299. Jeff Byers & David Lim, *CMS Pushes Hospitals to Post Prices Online*, HEALTHCARE DIVE (Apr. 25, 2018), <https://www.healthcaredive.com/news/cms-IPPS-2019-proposed-rule/522089> [<https://perma.cc/C56W-WXRR>].
300. Verma, *supra* note 297.

a web-based Medicare price lookup to compare prices and copayments for procedures that are offered in both hospital and outpatient settings.³⁰¹

This regulatory fixation imagines that if prices were transparent and comprehensible, it would pave the way for better consumerism, despite the rich body of evidence to the contrary, discussed above. CMS's intended regulated disclosure of surprise bills from out-of-network anesthesiologists or radiologists is especially ironic because most patients have little or no ability to navigate around these bills, and there is little evidence that disclosure alone will shame these out-of-network providers into lower prices.

The governmental infrastructure in support of CDHC takes other forms as well, including consumer protection regulations and constant revision of tax laws. Before the passage of the ACA, states had enacted consumer protection laws to limit the amount of financial exposure that people, especially those in vulnerable populations, could have to health care spending.³⁰² The rise of high deductible plans and HSAs demanded that states reconsider these laws.³⁰³ Many states, for example, prohibited cost-sharing for certain services or populations, such as for home health visits or for victims of violent crimes.³⁰⁴ Yet, because health plans had to be considered "high deductible" (defined in 2019 as having deductibles of \$1350 per individual and \$2700 per family) to be eligible to be paired with HSAs under federal law, states revisited and often repealed these protections.³⁰⁵ In addition, states had to decide whether to reconcile state tax law exemption of HSAs with the federal exemption. In 2005–2006, fifteen states amended their laws to enable favorable treatment for HSAs under state tax law.³⁰⁶ In total—from 2004 to early 2011—states passed over eighty laws to accommodate and promote HSAs,³⁰⁷ losing tax revenue in the process.

Federal law regarding HSAs and high deductible plans is also in constant flux. The ACA mandated coverage for preventative health care without copayments, even in high deductible plans.³⁰⁸ It also reduced the breadth of

301. *Id.*

302. JOST, *supra* note 3, at 160–65.

303. *Id.*

304. *Id.*

305. *Id.*

306. NATIONAL CONFERENCE OF STATES LEGISLATORS, HEALTH SAVINGS ACCOUNTS AND THE STATES (2017), <https://www.ncsl.org/research/health/hsas-health-savings-accounts.aspx> [<https://perma.cc/A44Y-42WK>].

307. *Id.* at tbls.1, 1A, 2 & 3 (summarizing HSA bills signed into law from 2004 through March 2011).

308. ACA § 1001 (2010), amending Public Health Service Act § 2713 (exempting routine examination and well-childcare, immunizations, tobacco cessation programs, and certain preventive health screenings from cost-sharing, so that they are paid fully by insurance plans).

services that could be funded from HSAs, eliminating, for example, the use of HSA funds on over-the-counter drugs.³⁰⁹ This type of regulatory tinkering requires a constant revisiting of how much skin in the game is appropriate and for what services, with much greater precision than consumers could possibly understand.

Even before actively encouraged to do so in early 2018 by the Trump Administration,³¹⁰ state Medicaid programs experimented with policy designs that incorporated cost-sharing, despite the unambiguous evidence that even small amounts of cost-sharing can cause poor health outcomes in low-income populations.³¹¹ These demonstration experiments consume regulatory resources and deflect attention away from testing other ways to achieve more efficient Medicaid spending without risking negative health outcomes.³¹² To try to create some boundary for experimentation with such strategies in Medicaid, DHHS developed detailed federal rules outlining how much cost-sharing is allowable and in what forms. These rules are rehashed and rewritten by each administration, playing in the weeds of health policy.³¹³

More detrimentally, building this kind of regulatory scaffolding around CDHC perpetuates the idea that we should turn to individuals to solve what are complex and systemic problems, like high prices and low-value care. CDHC feeds a culture of individual responsibility.³¹⁴ It also perpetuates a false idea that consumer overconsumption of health care drives high health care spending in the United States, even though research regularly affirms that price and mix of services, not quantity, make the United States an outlier.³¹⁵ Americans rely more on specialists and high-end technology that do not necessarily improve outcomes.³¹⁶ This American story of overuse will not be solved by the blunt instruments of deductibles, copayments, or transparency laws, especially if the

309. *See id.* § 9003.

310. Letter from Brian Neale, Dir., Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs. (SMD: 18-002, Jan. 11, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf> [<https://perma.cc/5JR7-R2LK>].

311. Newhouse et al., *supra* note 232, at 208–11.

312. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 222, at 1.

313. *Id.*

314. Allison K. Hoffman, *The Unhealthy Return to Individual Responsibility in Health Policy*, REG. REV. (Jan. 16, 2017), <https://www.theregreview.org/2017/01/16/hoffman-unhealthy-return-individual-responsibility-health-policy> [<https://perma.cc/3N5L-H8FU>].

315. Gerald F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89 (2003); FARRELL ET AL., *supra* note 286; Gerald F. Anderson et al., *It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt*, 38 HEALTH AFF. 87 (2019).

316. FARRELL ET AL., *supra* note 286, at 16, 25, 48–49.

providers who guide patient decisionmaking recommend such care. Consumers lack the power, knowledge, and will to rewrite this story.

C. Health Care Marketplace Competition and Antitrust Law

The two above Subparts focus on how economic theory influenced the rise of policies that rely on individual-level consumerism. This Subpart examines antitrust law, focusing on merger analysis, which is one step removed from consumer decisionmaking. Nevertheless, what is interesting is that modern antitrust analysis is still deeply reliant on assumptions of effective consumerism. This Subpart offers a brief sketch of how reflexive and pervasive reference to consumer preferences pervades health law, even when less explicit.

What antitrust law shares with the two ideas above is the desire to use market dynamics to produce higher-value health care. As one set of experts wrote, “[e]nsuring that markets function efficiently is central to an effective health system that provides high quality, accessible, and affordable care.”³¹⁷ Also like the above ideas, antitrust regulation and enforcement has fallen short in practice, despite tremendous efforts spent on scrutinizing and refining it. Ironically, in light of the failings of regulated market dynamics to contain prices, some experts now suggest consumerist techniques to disrupt the current, consolidated state of the market and, in theory, reinvigorate competition.

Looking at antitrust law is important both as a discreet example of a struggling market-based regulatory approach, and because the application of antitrust law to health care has lubricated the accelerated roll out of market-based policies, like managed competition and CDHC, by offering principled boundaries for government intervention and regulation. Instead of arguing for total deregulation, proponents of market-based solutions make the more moderate case that if the government enforces antitrust law well, competitive markets can create efficient results and, in turn, government regulation of prices or production will be unnecessary.³¹⁸ As antitrust expert Tim Greaney described: “Properly applied, antitrust law should promote decentralized decision-making

317. MARTIN GAYNOR ET AL., MAKING HEALTH CARE MARKETS WORK: COMPETITION POLICY FOR HEALTH CARE 2 (2017), https://healthpolicy.usc.edu/wp-content/uploads/2018/01/04.2017_Making20healthcare20markets20work-1.pdf [<https://perma.cc/7SQH-3JDU>].

318. See, e.g., Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 871 (2011) (arguing for the benefits of greater antitrust enforcement with respect to ACOs); Clark C. Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROBS. 716, 777–84 (1970) (arguing for increased reliance on antitrust law and federal preemption of state regulation of health maintenance organizations).

by market participants while encouraging efficient combinations that serve consumer welfare.³¹⁹ In other words, markets can find sweet spots in pricing and production in a way that government regulators cannot. These promises turn attention to antitrust regulation so that the market can produce better quality and lower cost care without having to rely on direct substantive regulation.

Finally, proponents argue that even if antitrust law produces imperfect results, it is better than direct regulation of market participants or prices, which would risk harm to innovation.³²⁰ These claims are a stretch. Even though there has been important health care innovation in the United States, it is not clear that it was the result of, or maximized by, market-based regulation. Further, evidence shows that, in recent years, so-called health care innovation is largely on the flat of the curve, doing more work to drive up prices than to improve health.³²¹

This Part describes, first, very briefly antitrust theory with respect to health care mergers, second, how this theory falls short, and third, the costs of this approach, in terms of market bureaucracy and, more importantly, forgone opportunities to deal with the high prices in U.S. health care. Finally, it considers how experts respond to these problems, including, for some, by proposing an ironic return to consumerism.

1. The Theory of Antitrust Law and Competitive Markets

The U.S. Department of Justice's website states that the goal of antitrust law is to promote competition to protect the people from harms that could result from an anticompetitive environment.³²² Since the Progressive Era, antitrust law has shifted its analytical center from trust busting and preventing concentrations

319. Thomas L. Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT. L. REV. 217, 225 (2009).

320. Havighurst, *supra* note 318, at 743.

321. See, e.g., Vinay Prasad et al., *Precision Oncology: Origins, Optimism, and Potential*, 17 LANCET ONCOLOGY e84 (2016) (noting high prices of proton beam accelerators and scarcity of evidence regarding their superiority to other therapies); Skinner et al., *supra* note 6 at 44–45 (questioning innovation in cardiac research); Ian F. Tannock & John A. Hickman, *Limits to Personalized Cancer Medicine*, 375 NEW ENG. J. MED. 1289 (2016) (questioning whether spending on precision medicine will justify outcomes). For critiques that focus on suggestions for driving higher-value health care, by focusing spending and innovation in more cost-effective directions, see STEVEN GARBER ET AL., REDIRECTING INNOVATION IN U.S. HEALTH CARE: OPTIONS TO DECREASE SPENDING AND INCREASE VALUE (2014); NICHOLAS BAGLEY ET AL., HAMILTON PROJECT, CORRECTING SIGNALS FOR INNOVATION IN HEALTH CARE 5 (2015).

322. *Mission*, U.S. DEP'T OF JUST., <https://www.justice.gov/atr/mission> [<https://perma.cc/7P39-MX6V>] (last visited Oct. 2, 2017).

of private power to consumer welfare.³²³ As the DOJ website promises: “Competition in a free market benefits American consumers through lower prices, better quality and greater choice.”³²⁴ This shift has brought with it an analytical lens focused on the end consumer.

Antitrust law became relevant in health care starting only in the mid-1970s. Before then, the health care marketplace was largely sheltered from antitrust liability by the “learned profession exemption,” which placed professionals outside the scope of normal commerce.³²⁵ The basic idea was that since doctors, and other professionals, acted to serve patients, they should be exempt from antitrust scrutiny, which could have the adverse effect of introducing considerations of profitmaking into their consciousness.³²⁶

In the mid-1970s, as medicine looked and acted more and more like a business, the U.S. Supreme Court rejected the learned profession exemption,³²⁷ and, in parallel, the Federal Trade Commission (FTC) and Department of Justice (DOJ) bolstered their health care antitrust enforcement programs and efforts.³²⁸ Under modern law, the FTC and DOJ may review³²⁹ and block a transaction when the “effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.”³³⁰ Legal inquiry weighs harm to consumers against potential benefits of a merger to competition, and usually focuses on price effects.

Especially as regulatory attempts to stem growing health care costs failed or were rejected, such as health planning in the 1970s and managed care in the 1980s, attention turned to fostering competition in the industry to use the market to mediate price inflation and value. In recent years, the potential anticompetitive effect of health care mergers has gained particular attention once

323. RAHMAN, *supra* note 12, at 72, 81.

324. *See supra* note 322.

325. *See* Joseph P. Bauer, *Professional Activities and the Antitrust Laws*, 50 NOTRE DAME L. REV. 570, 571–72 (1975). Other rationales were that professional activity was local (not interstate commerce) and that physicians were already supervised and regulated by state laws. *Id.* at 571.

326. *Id.* at 572, 587.

327. *Goldfarb v. Va. State Bar*, 421 U.S. 773, 787–88 (1975). *Goldfarb* included a placeholder in footnote 17 that suggested the exception might not be totally extinguished. *Id.* at 788 n.17. In a second case, the U.S. Supreme Court held that local hospital activity affects interstate commerce sufficient for it to exercise subject matter jurisdiction under the Sherman Act. *Hosp. Bldg. Co. v. Trs. of Rex Hosp.*, 425 U.S. 738 (1976).

328. 1975 F.T.C. Ann. Rep. at 3–4.

329. Hart-Scott-Rodino Antitrust Improvements Act of 1976, 15 U.S.C. § 18a (2016).

330. Clayton Act § 7, 15 U.S.C. § 18 (2016).

again.³³¹ Regulators scrutinize mergers to try to preserve a competitive market to keep prices in check and quality high, but, in practice, efforts fall short of this ideal.

2. Shortcomings of Antitrust Theory as Applied to Health Care Mergers

a. Conceptual Problems

Conceptually, the unusual structure of health care purchasing through insurance complicates health care antitrust analysis from the start. Even defining the consumer is challenging. Insurers or employers usually act as an intermediary between the patient and health care providers (doctors, hospitals, and other suppliers), by designing plans and networks and negotiating for prices for services.³³²

Antitrust analysis sometimes considers an employer or an insurer as a proxy for the hypothetical end consumer, which is problematic.³³³ The analysis assumes these intermediary buyers will negotiate on this end consumer's behalf for the best plans, networks, and prices possible.³³⁴ Yet, neither employer nor insurer interests are necessarily aligned with the end users.³³⁵ Insurers, for example, can and do pass higher prices off to employers. Employers who face higher health care spending, in turn, pass costs off to their employees in the form of stagnant wages.³³⁶ These dynamics reduce the motivation for insurers to find

331. Edith Ramirez, *Antitrust Enforcement in Health Care—Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245, 2245 (2014).

332. Most people have insurance through employers, and most of those plans are “self-funded,” which means the employers have nearly total control over defining health plan options for employees, including what services are covered and what providers are included. See KAISER FAM. FOUND., *supra* note 224.

333. See William M. Sage & Peter J. Hammer, *A Copernican View of Health Care Antitrust*, 65 LAW & CONTEMP. PROBS. 241, 255 (2002).

334. See Sage & Hammer, *supra* note 333, at 270; *FTC. v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 342 (3d Cir. 2016) (looking to how insurers would respond to a SSNIP when considering result of a merger); *FTC. v. Advocate Health Care Network*, 841 F.3d 460, 475 (7th Cir. 2016) (“But as we have explained, insurers are the most relevant buyers. Insurers must consider both whether employers would offer their plans and whether employees would sign up for them.”); *Kartell v. Blue Shield*, 749 F.2d 922, 925–26 (1st Cir. 1984).

335. See DAVID M. FRANKFORD & SARA ROSENBAUM, RUTGERS L. SCH. & GEO. WASH. U., *TAMING HEALTHCARE SPENDING: COULD STATE RATE SETTING WORK?* 1, 8 (2017), <http://www.cshp.rutgers.edu/Downloads/11170.pdf> [https://perma.cc/Z2UG-8LB5].

336. See *FTC. v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1299 (W.D. Mich. 1996), *aff'd*, No. 96–2440, 1997 WL 420543, at *1 (6th Cir. July 8, 1997); David I. Auerbach & Arthur L. Kellermann, *A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family*, 30 HEALTH AFF. 1630, 1631 (2011).

the hard edge of negotiation. When they do, they often retain excess profits for themselves, rather than passing them down the chain.

Likewise, employer and employee interests might diverge in broad ways when employers design health plans. Because of the transient nature of employment, employers may underinvest in types of care that produce long-term benefits. Employees might care most about the flexibility to go to a doctor they know and trust, but employers increasingly choose narrow network options as the mechanism to keep plan costs down. So, conceptually, even in the best-case scenario, competition may not prioritize the things end consumers most value.

Although the end consumer is often obscured by health care antitrust analysis, the value of a competitive marketplace for health care services can often only be fully realized if patient consumers can navigate options well, or if proxies do so on their behalf. Merger law, for example, often scrutinizes interactions between providers (hospitals, doctors, medical device or pharmaceutical companies), on the one hand, and the aggregators (usually insurers and employers), on the others. Yet, an imaginary patient consumer is ever present. Courts factor in idealized models of how patients navigate health plan options or medical care options within a health plan, or how they might do so in a changed landscape, which is problematic for all of the reasons discussed above.³³⁷ In the end, the consumer's imagined behavior—for example, whether she will buy a health plan that fails to include a particular hospital in network or how far she might travel for good care or to save money—deeply influences legal analysis.³³⁸ Reliance on the idea of how a hypothetical patient will respond to choices and

337. See, e.g., *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1046–55 (8th Cir. 1999) (considering how people in the Poplar Bluff community do and might navigate provider options across geography).

338. See, e.g., *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 343 (3d Cir. 2016) (“Patients, of course, are relevant. For instance, an antitrust defendant may be able to demonstrate that enough patients would buy a health plan marketed to them with no in-network hospital in the proposed geographic market. It would necessarily follow that those patients who purchased the health plan would have to turn to hospitals outside the relevant market (lest they pay significant out-of-pocket costs for an out-of-network hospital.)”; *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke’s Health Sys.*, 778 F.3d 775, 784–85 (9th Cir. 2015) (recognizing that insurers are considered the “consumer” for market analysis, but then asserting that because residents in Nampa would resist going outside the local areas for primary care, the insurers would include local primary care services in the plan even in light of a price increase); *Butterworth Health Corp.*, 946 F. Supp at 1291 (“[T]he FTC must present evidence of practical alternative sources to which consumers of general acute care and primary care inpatient hospital services would turn if the merger were consummated and the merged entity raised prices beyond competitive levels. Determination of the relevant geographic market is a pragmatic, highly fact-driven undertaking.”).

incentives has embedded into antitrust analysis all of the problems discussed above.

b. The Strained Application of Antitrust Law to Health Care

Application of the law in an imperfect judicial and regulatory environment only draws further from the cramped theoretical ideal. After four decades of antitrust enforcement in the health care industry, the provider market is more consolidated than ever, sending prices on a steep upward trajectory without notable increases in quality.³³⁹

Scholars have advanced a host of explanations for consolidation, from regulatory failure to misguided judicial decisions, all of which are likely true to some degree.³⁴⁰ Some scholars suggest that health care regulations, especially state regulations, prevent potentially useful cooperation, integration, and entry.³⁴¹

Another common explanation is that courts and regulators misapplied antitrust law.³⁴² Tim Greaney describes that with respect to litigation, the “principal shortcoming was the courts’ tendency to oversimplify antitrust analysis by adopting simplistic, Chicago-school assumptions about markets while failing to incorporate the effects of market imperfections in their analyses of health markets.”³⁴³

Courts, like consumers, have found health care products harder to define than cars or computers, for all of the reasons outlined in Part I. Reasonable substitutes are often not obvious. For example, any one condition might be

339. See MARTIN GAYNOR & ROBERT TOWN, *THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE 2–3* (2012) (reporting that hospital consolidation increased the price of hospital care and sometimes decreases quality); WILLIAM B. VOGT & ROBERT TOWN, *HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE?* 1, 6–7 (2006) (documenting changes in concentration and the upward effect on prices during the 1990s); Leemore Dafny, *Hospital Industry Consolidation—Still More to Come?*, 370 *NEW ENG. J. MED.* 198, 198 (2014) (“[T]he last hospital-merger wave (in the 1990s) led to substantial price increases with little or no countervailing benefit.”).

340. Coverage of these failures and explanations for them are numerous. See, e.g., Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 *U. PA. L. REV.* 121, 122–24 (2007) (cataloging reasons like court nullification of regulatory actions, complexity of analysis, and hostility among courts to competition in health care).

341. See Einer Elhauge, *Obamacare and the Theory of the Firm*, in *THE FUTURE OF HEALTH CARE REFORM IN THE UNITED STATES* 202 (Anup Malani & Michael H. Schill eds., 2015); Greaney *supra* note 319, at 225–28.

342. See, e.g., Thomas L. Greaney, *Efficiencies in Merger Analysis: Alchemy in the Age of Empiricism?*, in *ECONOMIC THEORY AND COMPETITION LAW* 191 (Josef Drexler et al. eds., 2009) (arguing that regulators and judges should be more realistic about the uncertainty in the application of the “efficiencies defense”).

343. Greaney, *supra* note 319, at 227.

treated in a range of ways, from taking a pill to surgery to waiting and seeing, all which might be reasonable treatments depending on the age of the patient, health history, or genetics, among other factors. Furthermore, health care is sold in disaggregated process parts and inputs (for example, appointment with surgeon, hospital bed, anesthesia), rather than as “assembled products” (for example, knee surgery), which makes it more difficult for courts and customers, alike, to scrutinize the product being sold.³⁴⁴ In response, courts have defined markets coarsely, in clusters, such as by level of inpatient care (primary, secondary, or tertiary care), rather than service-by-service (cardiac care vs. orthopedic care), which can mask anticompetitive effects at the service level.³⁴⁵ Courts also struggle with how and whether to consider quality in their analysis.³⁴⁶

Others blame a pro-professionals bias that survived the formal rejection of the learned professions exemption, causing regulators and judges to balk at strict application of antitrust doctrine to hospitals, especially nonprofit hospitals, and doctors.³⁴⁷ Regulators devised various exceptions to *per se* illegality and are more willing to consider surrounding facts and circumstances when it comes to the health care industry,³⁴⁸ especially if in the service of protecting hospitals or doctors from the forces of managed care.³⁴⁹ Judges' inclination to protect hospitals threatened by managed care companies sometimes led courts to permit

344. William M. Sage, *Assembled Products: The Key to More Effective Competition and Antitrust Oversight in Health Care*, 101 CORNELL L. REV. 609, 617–21 (2016).

345. See Havighurst & Richman, *supra* note 318, at 868–69.

346. See Sage & Hammer, *supra* note 333, at 258 (assuming that competition will drive up quality, while it also mediates price).

347. See Spencer Weber Waller, *How Much of Health Care Antitrust is Really Antitrust?*, 48 LOY. U. CHI. L.J. 643 (2017).

348. *Id.* at 657–59. See also, e.g., U.S. DEP'T OF JUSTICE & FED. TRADE COMMISSION, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE 3–4 (1996) (discussing ways that “efficiencies,” in the forms of financial and clinical integration will be considered with respect to physician joint venture arrangements).

349. See Greaney *supra* note 319, at 228. Courts overrode regulators' well-justified challenges to hospital mergers in dozens of decisions in the managed care era, starting in the 1990s, which led to a period of chilled enforcement, ending only recently. See, e.g., *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (8th Cir. 1999); *FTC v. Freeman Hosp.*, 69 F.3d 260, 273 (8th Cir. 1995); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1085 (N.D. Cal. 2000), *amended by* 130 F. Supp. 2d 1109, 1137 (N.D. Cal. 2001), *aff'd*, 217 F.3d 846 (9th Cir. 2000); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1302–03 (W.D. Mich. 1996), *aff'd*, No. 96–2440, 1997 WL 420543, at *1 (6th Cir. July 8, 1997); *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 989 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632, 637 (8th Cir. 1997); *Adventist Health Sys./West*, 117 F.T.C. 224, 285 (1994). See also Peter J. Hammer & William M. Sage, *Critical Issues in Hospital Antitrust Law*, 22 HEALTH AFF. 88, 90 (2003) (describing the ways in which courts have disfavored health care regulation).

providers to consolidate to bolster their relative bargaining power.³⁵⁰ This judicial gerrymandering proved to be playing with fire, as evinced by the current disproportionate level of market concentration among providers.³⁵¹

For all of these reasons and more, it is clear that antitrust regulation has failed to achieve the above-quoted DOJ ideal for consumers and faces a steep climb to ever do so, even if there is room for improvement. To the contrary, it has not stopped harmful consolidation among hospitals and providers, and health care costs continue to grow faster than the rest of the economy.³⁵²

Faith that competition will magically generate high-value options for consumers is getting hard to defend. Policy is necessarily implemented in an imperfect judicial and regulatory environment, and inconsistent courts and stifling state regulations predated the take up of antitrust enforcement in health law in the 1970s. The problem may be as much the results we expect from regulating competition as the imperfect environment itself.

3. The Implications: Antitrust's Market Bureaucracy

It is difficult to know exactly the size of the apparatus created to evaluate and litigate anticompetitive activity in the health care sector, but it is sizeable. Between 2009 and 2013, over one-third of all Federal Trade Commission investigations involved hospitals.³⁵³ From 1996 to 2017, the FTC initiated 211 cases or proceedings to enforce health care antitrust matters—ninety-two of those after 2010.³⁵⁴ Between 1976 and 1996, the FTC and DOJ settled by consent decree an estimated sixty-five enforcement actions against price fixing.³⁵⁵ The federal health care division of the FTC alone employs several dozen attorneys. In 2015, the FTC Chairwoman Edith Ramirez reiterated that health care was a major area of focus: “the FTC devotes significant resources to preventing mergers that threaten to raise prices or undermine cost-containment efforts in a variety of health care markets.”³⁵⁶ And most states have their own regulatory agencies,

350. See Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 HEALTH AFF. 185 (2002).

351. See *supra* note 339.

352. *Id.*

353. Richard B. Benenson & Kerry J. LeMonte, *FTC's Focus on Healthcare Mergers and Consolidation*, 45 COLO. LAW. 15, 15 (2016).

354. *Cases Tagged with Healthcare*, FED. TRADE COMM'N, <https://www.ftc.gov/enforcement/cases-proceedings/terms/282> [<https://perma.cc/88U2-H7JT>].

355. Greaney, *supra* note 319, at 232.

356. *Oversight of the Enforcement of the Antitrust Laws: Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law, H. Comm. On the Judiciary*, 114th Cong. (2015) (prepared statement of Edith Ramirez, Chairwoman, Fed. Trade Comm'n).

working in parallel. Calls by experts for better enforcement would require a doubling down.

Antitrust cases are expensive to investigate and litigate, relying deeply on the opinions of high-priced experts in economics and law. Leemore Dafny describes pre-merger analysis:

[E]nforcers must devote substantial time and resources to evaluating these individual transactions and—if appropriate—to satisfying the legal standards for challenging them. Economics experts must comb through reams of claims data, using complex statistical methods to assess the extent to which the merging hospitals compete and, where possible, to predict the magnitude of likely price increases. On the other side of the scale, enforcers must weigh the potential benefits that would accrue from the merger (and that cannot otherwise be realized), which may arise from cost reductions, improvements in quality or access to care, or all of the above.³⁵⁷

These direct costs may be relatively small compared to overall health spending, but they represent a significant investment for the lukewarm results they have produced to date.

The larger cost is opportunity costs and distraction from alternatives. As experts focus on markets to regulate prices, prices have skyrocketed on everything from medical devices to pharmaceuticals to outpatient care.

Furthermore, as with managed competition and CDHC, experts and the media pour over health care mergers. Antitrust law and the potential of competitive markets has captured the attention of academics and the imagination of news sources. From 2001 to 2015, over 1600 law review articles included in depth discussion of health care antitrust enforcement.³⁵⁸ In that same period, the *Wall Street Journal* published 1500 articles that mention the topic, with the *New York Times* and *Washington Post* contributing over 500 each.³⁵⁹ The *New England Journal of Medicine* had over fifty articles on the topic.³⁶⁰ This level of attention to a technocratic endeavor is striking.

4. Redux: Proposals to Bolster Competition and the Consumerist Turn

In light of the shortcoming of antitrust merger enforcement, experts now pour energy into legal reforms to spur competition and to disrupt

357. Dafny, *supra* note 339, at 198.

358. Search criteria and results on file with author. Search conducted through December 2016.

359. *Id.*

360. *Id.*

consolidation.³⁶¹ Some advocate for better antitrust enforcement, including increased oversight and improved legal analysis.³⁶² Such suggestions are often paired with Medicare payment policies that could support more competition.³⁶³ Others propose deregulation or federal preemption or repeal of state laws that lessen competition.³⁶⁴

Some experts, including Leemore Dafny and Tim Greaney, remain circumspect about getting the legal analysis right and acknowledge the intensive investment that would be needed to do so.³⁶⁵ Furthermore, they acknowledge that even if better enforcement were to reduce future consolidation, it can do little to address current levels of provider concentration. Thus, increasingly, some experts are beginning to ask whether price regulation may be the singular response to current levels of consolidation.³⁶⁶

Yet, finally and ironically, other experts take a strong turn back to consumerism as the solution to reignite competition. Ideas range from new

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361. For a brief summary of many of the leading ideas, see Gaynor et al., *supra* note 317, and THOMAS L. GREANEY & BARAK D. RICHMAN, AM. ANTITRUST INST., PROMOTING COMPETITION IN HEALTHCARE ENFORCEMENT AND POLICY: AN ACTIVE COMPETITION AGENDA (2018), https://www.antitrustinstitute.org/wp-content/uploads/2018/09/AAI_Healthcare-WP-Part-II_6.18.18.pdf [<https://perma.cc/X7TH-98SQ>] (summarizing a whole host of the commonly-advanced incremental solutions, mostly focused on state deregulation).
362. See, e.g., Thomas L. Greaney, *Regulating for Efficiency in Health Care Through the Antitrust Laws*, 2 UTAH L. REV. 465, 475–82 (1995) (discussing the problems with DOJ and FTC policy statements and the inconsistent use of efficiency defenses to detrimental effect); Robert F. Leibenluft, *Antitrust and Provider Collaborations: Where We've Been and What Should Be Done Now*, 40 J. HEALTH POL., POL'Y, & L. 847 (2015); Havighurst & Richman, *supra* note 318, at 874–75 (arguing for preapproval of every proposed ACO); Sage & Hammer, *supra* note 333, at 267–89 (arguing for a “Copernican” view of antitrust, focusing more on social welfare to gauge efficiency).
363. GAYNOR ET AL., *supra* note 317, at 10–11 (arguing, for example, to eliminate “facility fees” for services that can be provided out of hospitals, and simplifying administrative and payment requirements to encourage small-group physician practices).
364. See *id.* at 22–27 (summarizing these types of laws and proposed solutions); HAVIGHURST, *supra* note 13. For example, some states have “scope of practice” laws that define the bounds of what each medical professional can do, based on licensure category, which can limit access to lower-cost providers for services (e.g., nurses for certain primary care they are qualified to provide instead of doctors). See SCOPE OF PRACTICE POLICY, <http://scopeofpracticepolicy.org> [<https://perma.cc/8XA2-JTVL>] (describing various state laws).
365. See Dafny, *supra* note 339, at 198; Greaney, *supra* note 362, at 484–85, 489–97.
366. See, e.g., Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 IND. L.J. 55, 78 (2016) (outlining methods that states can use to regulate prices); Sherry A. Glied & Stuart H. Altman, *Beyond Antitrust: Health Care and Health Insurance Market Trends and the Future of Competition*, 36 HEALTH AFF. 1572, 1576 (2017) (considering two strategies for rate regulation, based on the number of competitors in an area); Thomas L. Greaney, *Coping with Concentration*, 36 HEALTH AFF. 1564, 1568–69 (2017) (discussing rate regulation targeting dominant providers). Cf. Havighurst & Richman, *supra* note 318, at 883 (conceding that price controls may be needed to some degree).

products—medical tourism, mobile health, or telemedicine—to new incentive structures to attempt to shift the playing field.³⁶⁷

Bill Sage has critiqued, for example, how the product is defined in hospital merger enforcement.³⁶⁸ He suggests that a major flaw is that we treat health care products as process steps, rather than as assembled end products like other consumer goods.³⁶⁹ In other words, when someone goes in for surgery, she gets one bill from her surgeon, another from her anesthesiologist, and another (or several) from the hospital. Sage argues that the end good must be something that a patient values and understands, rather than disaggregated lines on a bill. He offers examples of an assembled end good including a hip surgery with a warranty, medical tourism, or end-of-life care³⁷⁰ and outlines the many ways antitrust law and other regulations would need to change to accommodate such assembled products.³⁷¹ Although he does not promote this idea as a consumer panacea, the implication is that if the regulation were better and the products were clearer, consumers and their proxies would reject options with high prices or low quality.³⁷²

In a similar consumerist turn, Clark Havighurst and Barak Richman advocate for requiring hospitals to negotiate prices individually for each service, rather than in a bundle of all services they offer (a common practice known as tying).³⁷³ Havighurst and Richman imagine that once insurers focus on the price of an individual service at one hospital versus another, they could institute more favorable coverage terms, such as lower copayments, to encourage patients to travel to providers farther from home or in a new facility.³⁷⁴

367. See, e.g., Sage, *supra* note 344 (seeking to define products in “assembled” way that make sense to end consumers); Leemore S. Dafny & Thomas H. Lee, *Health Care Needs Real Competition*, 94 HARV. BUS. REV. 76, 76, 87 (2016) (“Consumers can energize the marketplace by creating real consequences for the winners and losers. If patients choose to receive care from high-value providers, which may mean traveling farther, then providers will focus their energy on improving care delivery.”); David M. Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 J. AM. MED. ASS’N 1964, 1969 (2013) (suggesting higher cost-sharing for health care at a “dominant health system” than at a less expensive one in the market).

368. Sage, *supra* note 344.

369. *Id.*

370. See *id.* at 634.

371. See *id.* at 637.

372. See *id.* at 694–95 (discussing how assembled products would enable people to comparison shop).

373. Havighurst & Richman, *supra* note 318, at 876–77.

374. *Id.* at 877. See also Cutler & Morton, *supra* note 367, at 1969 (suggesting higher cost-sharing at higher-priced providers as a solution to problems of consolidation).

These solutions simply come back to the idea that the right decisionmaking architecture can solve structural problems—here anticompetitive prices wrought by provider consolidation.³⁷⁵ But, the reality of how people really make medical care choices and how they fail to respond to insurance policy incentives strongly suggests otherwise.³⁷⁶ Even if process steps were assembled into end products, legal barriers were lifted to allow new entrants, and consumers could save money under the terms of their insurance policies by traveling farther for care, this reshaped market would still face an imperfect consumer who has shown an inability and unwillingness to navigate such options.

Imagine that a patient—or her purchasing proxy—has a choice between two assembled products. The first is hip replacement surgery with Dr. A at a large, well-known academic medical center. Dr. A has a 90 percent success rate, offers a thirty-year warranty, and charges \$30,000. The second is the same hip replacement surgery with Dr. B at a small local hospital. Dr. B has an 80 percent success rate and offers a fifteen-year warranty, but charges only \$20,000. Patients would struggle to determine whether the slightly higher rate of success and additional fifteen years on the warranty are worth \$10,000 more. And proxies like insurers or employers who aggregate such services into plans and networks may do no better. There may be some easy choices. Some people will not be able to afford the more expensive surgery, and will go with Dr. B. If the surgeries were the same price, it might be easier to choose the one with a higher success rate but, even in that case, the patient would have to understand this data and, if she did, still might wonder if some aspect of quality were not captured in the numbers. Maybe one doctor's success rate is lower because he is especially skilled and is referred the most challenging cases. Such choices are considerably more complicated than the simple price comparisons that patients in the studies above did not embrace and would likely boggle most purchasers, even more sophisticated ones.

The above discussion in Part II has illustrated how in the past several decades scholars and policymakers have embraced economic theory and market-based solutions to attempt to solve some of health care's most intractable and structural challenges by looking to forces of market competition and to consumers. Yet, this embrace has been too full. Market-based policies have not resulted in a utopia where smart consumers approach a plethora of options, reject

375. See Sage, *supra* note 344, at 694 (“As in other commercial sectors, however, consumers become motivated when they understand what they are buying and can compare their options.”).

376. See *supra* Part II.B.

wasteful care, and send signals so that competition among industry players drives down prices. Even more, attempts to create some semblance of this ideal by chipping away at market failures and boundedly-rational consumers have required intense regulatory scaffolding and constant refinement to little avail. The job of health law has become to bolster markets. As illustrated above, this market bureaucracy comes with high costs, direct and indirect, and is not making people better off. Quite the opposite.

Some object by saying that the problem is not the markets, themselves, but the overregulation of markets that has caused the problem by impeding health competition.³⁷⁷ In fact, legal scholars, such as Charlie Silver and David Hyman, argue for a doubling down on market-based approaches that would displace regulation.³⁷⁸ These market loyalists argue that the problem is that we have not let markets operate freely enough or demanded enough of health care consumers. Hyman shared this view in testimony before the Senate Committee on Health, Education, Labor, and Pension on reducing health care costs in June 2018,³⁷⁹ suggesting it still holds purchase in policymaking.

There are several problems with this reasoning. First is that we have already seen the effects of unregulated markets. They serve the wealthy and healthy and leave the rest uninsured. In turn, providers have to scramble for payment and cherry pick patients. Second, the evidence cited above makes clear that health care consumerism fundamentally does not work and, thus, demanding more of it makes little sense.

Even more, a world of increasing choices is actively making people worse off.³⁸⁰ Although there are exceptions to the rule (likely disproportionately among academic readers of this Article), most people do not prefer to make decisions about their own health insurance or, in many cases, their medical care.³⁸¹ People dread shopping for health insurance; 30 percent of respondents to one survey report they would rather prepare their taxes than shop for health insurance.³⁸² In a book on choice by one legal expert, the very example he uses to illustrate people not wanting to have to make choices is when a doctor asked him if he wanted to

377. See, e.g., SILVER & HYMAN, *supra* note 13; HAVIGHURST, *supra* note 13.

378. SILVER & HYMAN, *supra* note 13.

379. *How to Reduce Health Care Costs: Understanding the Cost of Health Care in America: Hearing Before the S. Comm. on Health, Educ., Labor & Pensions*, 115th Cong. (2018) (testimony of David A. Hyman, Professor of Law, Georgetown University Law Center). Thank you to Matt Lawrence showing me this testimony.

380. SCHWARTZ, *supra* note 137.

381. See sources and text accompanying *supra* note 47.

382. eHealthInsurance, *supra* note 58.

get an MRI or not.³⁸³ He wrote: “Sometime we want to be told what’s best.”³⁸⁴ Health law experts Carl Schneider and Mark Hall quipped: “So, we are increasingly freed from paternalism, for we have proliferating choices about proliferating things, but we are increasingly prisoners of the need to learn enough to handle decisions that we make badly, that we would like to escape, and that divert us from things we would rather devote ourselves to.”³⁸⁵ The very existence of a market-based system is contrary to many people’s preferences. Increasing retail health care or medical tourism will do nothing to address this fact.

In a poignant memoir written as he was dying from lung cancer and published posthumously, Dr. Paul Kalanithi, a Stanford neurosurgeon, cedes decisionmaking to his doctor, a peer and colleague, as his body weakens during the course of cancer treatment.³⁸⁶ He still had the capacity to weigh prognoses and side effects and costs, but he did not want to do so any longer.³⁸⁷ He wanted a trusted expert to guide him, once he had made the initial decision to begin aggressive treatment to slow the advancement of his terminal lung cancer.

We have over relied on policies that look to consumer choices and market forces to solve system-level failures, especially in light of mounting evidence of the limitations of these approaches in practice. Many scholars and policymakers have gone so far in the direction of market-based health policy that they cannot find the brakes, even when evident that the road is a dead end.

This Part’s comprehensive review of empirical evidence highlighted this fact to make the following case: If market-based approaches are no more efficient and are as bureaucratic as any other approach, it is time to end our reflexive reliance on them. The law has normalized market-based approaches and deflects attention from alternatives. If instead, we assessed different policy approaches based on what they produce, rather than on the hope of what they will produce, the dominance of market-based ideas in health care, and likely in other fields too, will recede and create space for alternatives. Then, the hard work begins.

III. COMPARING BUREAUCRACIES AND CONSIDERING CHOICE

This final Part considers why market-based approaches proliferate despite mounting empirical proof of their failings. It looks first briefly at the deep problems of politics and political economy, which have been examined in more

383. KENT GREENFIELD, *THE MYTH OF CHOICE* 133 (2011).

384. *Id.*

385. Schneider & Hall, *supra* note 3, at 51.

386. PAUL KALANITHI, *WHEN BREATH BECOMES AIR* (2016).

387. *Id.* at 190–91.

detail elsewhere.³⁸⁸ It then turns to a second, under-examined driver, contending that their durability lies also in the way these approaches have elevated the value of choice—a particular version of choice defined in individual, microeconomic terms. Finally, it concludes by suggesting that this sanctification of choice has gone too far. For health policy and regulation to advance demands seeking a more capacious understanding of when, and what, expressions of choice are meaningful and rejecting the privileging of choice when it is not.

A. Understanding the Loyalty to Faltering Market-Based Policies

1. Politics and Political Economy

Economists readily admit that health care markets don't work. Simultaneously, they—and others to whom that fact might not be so obvious—continue to pour their efforts into testing and attempting to mend health care markets, at best making incremental improvements. This Subpart considers why, looking at both the political economy of these policies and their rhetorical resonance.

Consider the ACA exchanges as an example. Before they were adopted as part of the ACA and before resources were devoted to building and bolstering a new marketplace, there was enough evidence on literacy, numeracy, and earlier experiments with managed competition to foreshadow that consumerism in a managed marketplace would fail. If the end goal was simply to get more people insured, which the exchanges have in fact done adequately well, there were certainly simpler and less expensive options to do so.

One explanation is that the average policymaker may genuinely have thought that competition among private plans in a new marketplace would work, unaware of the empirical evidence otherwise. Others were laser focused on getting more people insured, and the exchanges may have seemed the only path forward politically.

Since the 1970s, markets are a language that both Democrats and Republicans have increasingly become willing to speak.³⁸⁹ Market-based approaches, the product of a political movement beginning in the Reagan era, have come to be perceived as more neutral, scientific, or measurable than other approaches. They focus on metrics. We measure numbers of competing health plans and insured lives with managed competition. With moral hazard,

388. See *supra* note 23.

389. Lily Geismer, *Democrats and Neoliberalism*, Vox (June 11, 2019), <https://www.vox.com/polyarchy/2019/6/11/18660240/democrats-neoliberalism> [https://perma.cc/Y3B6-HA48].

economic experts measure the effects of different levels and types of cost-sharing on consumption. With antitrust, economic experts scrutinize the market share a combined entity will have, using complex indices. All this measuring and managing of numbers casts the project as an objective science.³⁹⁰

Yet, this so-called objective science is far from neutral. It obscures the morality of an end result defined by aggregation of individual decisions. People with more purchasing power have more influence and people with more education, time, and resources navigate the system more successfully. It surreptitiously lubricates a distribution of care that favors the wealthiest and educated.

These models also allow policymakers to avoid making unpopular rationing decisions, while still claiming they have acted to solve spending problems. If competition and consumerism cuts spending and reduces industry revenue, it happens a step removed from legislators. If the exchanges had worked as Enthoven envisioned, providers eventually would have received lower reimbursements, and reliance on specialists slowly would have decreased. But it would have been consumers and insurers, not elected officials, to blame.

More likely, these solutions will not reduce spending and will affirmatively benefit influential constituents.³⁹¹ The winners from market-based policies are the health care industries and members who have accreted political power over past decades and now exert it on the political process through high spending on lobbying.³⁹² With the ACA exchanges, for example, insurers gain business, and hospitals and providers gain a larger share of insured patients, some with relatively well-paying private plans.³⁹³ The aggregation of years of reliance on

390. See Frankford, *supra* note 24 (describing how the field of health services research and neoclassical health economics look to technocratic solutions and make what are often political or humanitarian questions seem more positivist); JOST, *supra* note 3, at 89 (describing the claim that economists see mathematics as conferring special authority, allowing them to “get away with a good deal of nonsense” (quoting Robert Evans, *Toward a Healthier Economics*, in HEALTH, HEALTH CARE, AND HEALTH ECONOMICS: PERSPECTIVES ON DISTRIBUTION 492 (M.L. Barer et al. eds., 1998))).

391. See Megan R. Wilson, *Lobbying's Top 50: Who's Spending Big*, THE HILL (Feb. 7, 2017), <http://thehill.com/business-a-lobbying/business-a-lobbying/318177-lobbyings-top-50-whos-spending-big> [<https://perma.cc/F94L-CZA8>] (showing that many of the top spenders on lobbying are in health care, including Blue Cross Blue Shield in third place, the American Hospital Association in fourth place, the Pharmaceutical Research & Manufacturers of America in fifth place, and the American Medical Association in sixth place).

392. *Id.*

393. Anna Wilde Mathews, *Health Insurers Set to Expand Offerings Under the ACA*, WALL ST. J. (Aug. 22, 2019), <https://www.wsj.com/articles/health-insurers-set-to-expand-offerings-under-the-aca-11566468120> [<https://perma.cc/8NBS-944L>]; Robert Pear, *Health Care and Insurance Industries Mobilize to Kill Medicare for All*, N.Y. TIMES (Feb. 23, 2019),

market-based approaches to control prices, to no avail, has helped to spur a massive health care industrial complex with layers of highly-salaried executives and consistently high profits. Although this investment in health care has yielded benefits, including significant employment of health care workers, it is difficult to justify spending that does not result in demonstrable improvement to Americans' health.³⁹⁴

These policies, in turn, also have become a way to keep public spending from growing as health care costs balloon. But they have done so by shifting spending from the public budget to individual household budgets. As Enthoven initially envisioned, if competition does not drive down prices and insurance voucher values grow more slowly than costs, individuals will finance the increasing gap.³⁹⁵ Most versions of policy based on Enthoven's ideas are in part such a strategy to control public spending, by covertly moving shortfalls onto individuals, simultaneously transforming the project of insurance from one of social solidarity to individual responsibility.³⁹⁶

Likewise, when employers adopt high deductible health plans, they leave the rationing and bargain hunting to their employees, even if the employees might not trim or shop wisely, or at all. At the end of the day, the employer can control health benefit spending, and the employee either reduces medical care or spends more out of pocket on it.

Enthoven explicitly envisioned that managed competition would produce—or preserve—a two-tiered system, where wealthier people topped off their vouchers to buy better plans. Defending this aspect of his proposal, Enthoven wrote, “I believe it would be foolish to reject it on the grounds that it does not reach a hypothetical egalitarian ideal that has never been attained in any society and is surely not supported by the American people today.”³⁹⁷ While he might be right that many people think egalitarianism is un-American, managed competition—and other market-based approaches—obfuscates the choice of values like budgetary frugality over equality.

<https://www.nytimes.com/2019/02/23/us/politics/medicare-for-all-lobbyists.html>
[<https://perma.cc/2CCA-X9KW>].

394. See SILVER & HYMAN, *supra* note 13, at 21–22 (providing an overview of their chapters that document excessive industry profit and a lack of concomitant health outcomes).

395. See Enthoven, *Second Part*, *supra* note 85, at 716.

396. See Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 14 (1999).

397. *Id.* The structure of the proposal, however, conceals egalitarian shortcomings of the idea because everyone gets an equal voucher, adjusted only to account for age.

2. The Role of Choice

This story of winners and losers is critical to the perpetuation of ill-fated market-based solutions. Yet, it is not the whole story. An underexamined, but perhaps as important, reason for their durability is that these policies align with a relatively recent American obsession with choice, since at least the 1970s, when a generation defined itself in protest to the draft and Vietnam War. Early kernels in health care might be traced to tomes like *Our Bodies Ourselves*, published first as a course booklet in 1970 by a group of women called the Boston Women's Health Book Collaborative, who were seeking to help women find self-empowerment over their bodies.³⁹⁸ Choice takes legal root in cases like *Griswold v. Connecticut* in 1965 and *Roe v. Wade* in 1973, which recognized control through language prohibiting government intrusion over individual reproductive choices.³⁹⁹ Although this choice revolution does not spark from neoliberalism, it may have helped to fuel it, by centering on a particularized and individual version of choice.

In health care, the sanctification of choice was an understandable response to many years when patients' preferences came second. For most of the twentieth century, doctors largely controlled medical care decisions.⁴⁰⁰ After the passage of Medicare and Medicaid in 1965 and the concurrent growth of private insurance, spending grew, prompting the rise of more central planning and of managed care in the 1970s and 1980s, and insurers increasingly held the reins to control patients' access to doctors and medical care.⁴⁰¹ Since then, however, consumer choice has come to be something of a "sacred value," or one that "a community treats as possessing transcendental significance that precludes comparisons, trade-offs, or indeed any mingling with secular values."⁴⁰² Simply put, choice always wins.

398. See *Our Story, OUR BODIES OURSELVES*, <https://www.ourbodiesourselves.org/our-story> [<https://perma.cc/3N49-HFC4>]. Thank you to Tom Baker for highlighting this aspect of the choice movement.

399. *Griswold v. Connecticut*, 381 U.S. 479, 483 (1965) (invalidating a law that prohibited the use of contraception as an unconstitutional "governmental intrusion"); *Roe v. Wade*, 410 U.S. 113, 170 (1973) (right to abortion is "embraced within the personal liberty protected by the Due Process Clause").

400. STARR, *supra* note 1, at 27 ("Throughout the medical system, the profession was able by 1920—and for the next half century—to establish organizational structures that preserved a distinct sphere of professional dominance and autonomy.").

401. *Id.* at 8 ("More recently, that system has begun to slip from their control, as power has moved away from the organized profession toward complexes of medical schools and hospitals, financing and regulatory agencies, health insurance companies, prepaid health plans, and health care chains, conglomerates, holding companies, and other corporations.").

402. Tetlock, *supra* note 14, at 320.

In this vein, informed consent gained steam, seeking to put medical decisions back in the hands of patients, for better or for worse. Market-based policies grew up in parallel, elevating the value of choice and defining choice narrowly—in microeconomic terms of preferences and purchases. An individual's agency came to be measured by her buying power and self-interest.

Even if laudable in concept, however, choice can obfuscate what a polity genuinely values when defined so narrowly. For example, measuring what people value by how they act individually in a market can undermine tools that by their very purpose serve collective goals. Health insurance aims to make health care spending a collective endeavor, spreading the costs of medical care among an insured population, regardless of any one person's individual medical needs in a particular year.⁴⁰³ Although it might have been otherwise,⁴⁰⁴ the downfall of the ACA's individual mandate that required most Americans to carry health insurance came in part because it sought to achieve a collective goal through individual choices and purchases. It prompted Americans to think not about the goal of guaranteed and universal coverage but instead about their own bottom line—exactly how much their insurance policy cost and what they got in return. Choice centered the policy discussion in the wrong ideological place.

The political economy of health care is notoriously sticky, but the obsession with choice—and, in particular, the narrow market conception of choice—may be less so. Americans in recent decades may have become enamored of the idea of choice and critical of big government, but views on such issues can likely change.

There is evidence that these views are, in fact, not as strong as they are sometimes made out to be. Studies show many conservative voters disliked Obamacare and exchanges not because they didn't want government involvement in health care but rather because they wanted Medicaid instead of private insurance.⁴⁰⁵ The recent surge in popularity of the idea of single payer systems, even if rooted in an incomplete understanding of what such a policy would mean, signals an increasing openness to new regulatory approaches that are less focused on individualism.

403. See Deborah Stone, *Health Equity in a Trump Administration*, 42 J. HEALTH POL., POL'Y, & L. 995, 997 (2017).

404. See Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED 7, 31 (2010).

405. See Sarah Kliff, *Why Obamacare Enrollees Voted for Trump*, VOX (Dec. 13, 2016, 8:10 AM), <https://www.vox.com/science-and-health/2016/12/13/13848794/kentucky-obamacare-trump> [<https://perma.cc/7HE2-72CR>] (reporting that interviews with Trump supporters, enrolled through the exchanges, reveal a pattern of frustration that those on Medicaid are “getting even better, even cheaper benefits”).

B. Considering the Meaning of Choice Beyond Markets

If health policy and law are to progress, it is imperative to examine the proper place of individual choice. In many cases, individual choice is altogether the wrong organizing principle to animate health regulation. In other cases—way fewer than imagined—it may be meaningful. And in many cases, even if the principle of choice is meaningful in concept, looking to individual market activity to measure what people value is flawed in practice. Dismantling the ineffective market bureaucracy lies in untangling these spaces.

1. Questioning the Sanctity of Choice

In many cases, better regulatory responses, including to inefficiencies in the system, reveal themselves only through pushback on the modern sanctification of choice.⁴⁰⁶ When choice is illusory, unnavigable, or makes people miserable, it is not worth elevating. Sometimes there is only one right option. When one treatment option is far superior to another, enabling choice between the two is illogical, and arguably cruel. If a particular treatment does not work, or when it is very expensive and does little good, having it as an option is a rouse.⁴⁰⁷

Insurers, with public insurers in the lead, must begin to exclude such treatments from coverage, even if doing so provokes resistance. Further, the FDA and other regulatory bodies should take a hard line and reject treatments and therapies without marginal value.⁴⁰⁸ Where to draw the line can be difficult, but even a conservative attempt would be progress. Although this kind of regulatory hardline will undoubtedly garner backlash from some vocal interest

406. Some scholars wholly reject the idea of choice in favor of justice, such as rejecting “reproductive choice” for “reproductive justice.” See, e.g., Dorothy Roberts, *Reproductive Justice, Not Just Rights*, DISSENT (Fall 2015), <https://www.dissentmagazine.org/article/reproductive-justice-not-just-rights> [<https://perma.cc/8GU9-LSG7>].

407. As one example, studies have exposed excessive overuse of Cardiac stents that is expensive and possibly harmful. See, e.g., Aaron E. Carroll, *Health Stents are Useless for Most Stable Patients. They’re Still Widely Used*, N.Y. TIMES: THE UPSHOT (Feb. 12, 2018), <https://www.nytimes.com/2018/02/12/upshot/heart-stents-are-useless-for-most-stable-patients-theyre-still-widely-used.html> [<https://perma.cc/Y4ER-VKF9>]; see also ORG. ECON. COOPERATION & DEV., TACKLING WASTEFUL SPENDING ON HEALTH (2017), https://read.oecd-ilibrary.org/social-issues-migration-health/tackling-wasteful-spending-on-health_9789264266414-en#page1 [<https://perma.cc/7NMP-T6U8#page5>] (describing practices ranging from overdiagnosis and overtreatment to underuse of generic drugs).

408. See, e.g., SILVER & HYMAN, *supra* note 13, at 120–21 (citing examples of wasteful care that Medicare reimburses, including colonoscopies for patients over age 75, prostate cancer screening for men over 75, and procedures for vertebral fractures that were shown to be both ineffective and risky and cost Medicare about \$1 billion annually).

groups, it is nonetheless the sounder regulatory option in the end.⁴⁰⁹ It may be more justifiable in light of the failure of subtler efforts to get people to stop using such services.

Likewise, if one insurance plan dominates another in all or most cases, it would be better simply to issue beneficiaries the better plan, rather than to create a false semblance of choice. At the very least, employers should stop offering dominated plans or be penalized for doing so. Medicare should work to cull out dominated Part D and Medicare Advantage plans and regulators should significantly narrow the proliferation of options in these spaces, which would make the project of periodically eliminating dominated plans much easier.

Paternalism, even if unpopular, is preferable in these cases to creating complex regulatory structures that set people up to make poor choices. The reality is that, in health care, market-based approaches are themselves moving in a paternalistic direction with the layering of increasingly directive decision aids and default rules. This idea, coined “libertarian paternalism,” has been sold as a means to preserve choice.⁴¹⁰ Yet, it struggles to maintain its libertarian dimension in health care, where decisionmaking challenges run deep, and softer nudges fall short.

Decentering the discussion away from choice prompts consideration of alternatives that have been pushed aside to avoid political struggles or hard, normative debates. If consumer choice among health plans will never rationalize overreliance on highly-paid specialists, then maybe it is time to reckon with this problem directly. If consumers cannot—or will not—root through options to choose the cheapest provider and market competition has not checked prices sufficiently, then it may be time to deal directly with the outsized prices in the U.S. health care system.

409. Such resistance surfaced in ACA debates when Congress created a new organization called the Patient-Centered Outcomes Research Institute (PCORI) to consider comparative effectiveness of different treatments. In response to initial backlash, PCORI's power was limited, and Medicare cannot rely on comparative-cost effectiveness assessments for payment decisions, but it is still collecting potentially valuable data. See ZEKE EMANUEL ET AL., CTR. FOR AM. PROGRESS, RE-EVALUATING THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE (2016), <https://cdn.americanprogress.org/wp-content/uploads/2016/05/25103643/PCORI-brief1.pdf> [<https://perma.cc/FE97-QFJQ>]. Some of the backlash arises from groups who argue that research is not conducted evenhandedly and could disproportionately harm certain people, but instead of using such input to reject data-based policymaking, it should motivate efforts to improve research quality.

410. See, e.g., THALER & SUNSTEIN, *supra* note 63, at 5–6.

Fortunately, there is a roadmap with a variety of alternatives to address these kinds of systemic problems.⁴¹¹ Other OECD countries rely on a range of regulatory mechanisms to control prices and to ration.⁴¹² Even if some of these countries' approaches work better than others, they all work better than the ineffective consumerist approaches currently prioritized in the United States.

Most peer nations, for example, have some version of central price setting or ceiling to keep spending down, even those countries that are often celebrated as market success stories, such as Singapore, Switzerland, or China.⁴¹³ These systems' designs all include elements of choice, but none of them relies on consumerism for price control.⁴¹⁴ Even some individual states have shown successful experimentation with price controls in the United States, suggesting its feasibility within the U.S. health care system.⁴¹⁵ Maryland has been centrally setting payment rates for hospitals for over forty years and updated its payment structure in 2018, estimating savings of as much as \$1 billion over the next five years.⁴¹⁶

Likewise, peer countries offer various more thoughtful ways to conduct rationing. The British system is perhaps the best known, where the National Institute for Health and Clinical Excellence (NICE) explicitly makes decisions about what treatment will be reimbursed by the National Health Service based on cost-effectiveness and other social values, including factors like clinical need and innovation potential.⁴¹⁷ Other countries like France and Germany have a less formal system, yet have developed centralized processes for identifying and not paying for unnecessary or low-value services.⁴¹⁸

411. WORLD HEALTH ORGANIZATION, OECD, PRICE SETTING AND PRICE REGULATION IN HEALTH CARE (2019), <https://www.oecd-ilibrary.org/docserver/ed3c16ff-en.pdf?expires=1575553830&id=id&accname=guest&checksum=6A646FC3C924020558D08BB6FFCDBD794>

[<https://perma.cc/CLS6-TYDC>]; see also discussion and sources cited *supra* note 277 on the point that other countries do not rely on consumerism to drive down prices, even if they include elements of choice in their systems.

412. *Id.* at 3–4.

413. See *supra* note 273.

414. *Id.*

415. See Frankford & Rosenbaum, *supra* note 335, at 11; Aaron Baum et al., *Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers*, 38 HEALTH AFF. 237 (2019); Carmela Coyle, *Maryland's Progress on the Path to the Triple Aim*, HEALTH AFF. BLOG (Nov. 12, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20151112.051749/full>.

416. See Coyle, *supra* note 415.

417. See generally Peter Littlejohns et al., *Social Values and Health Priority Setting in England: "Values" Based Decision Making*, 26 J. HEALTH ORG. & MGMT. 363 (2012).

418. See Katharina Kieslich, *Social Values and Health Priority Setting in Germany*, 26 J. HEALTH ORG. & MGMT. 374 (2012); see also Monika Steffen, *Universalism, Responsiveness*,

Finally, pushing back on the sanctity of choice would not only unlock consideration of better solutions that are not choice centric, it would also prevent further construction of ineffective market-based bureaucracy. If prices were regulated centrally, for example, there would be no need for CMS and states to invest in a web of transparency laws to try to track and understand the variance in prices across the states. Likewise, imagine if the ACA had created—or a future policy creates—a baseline health plan for all uninsured low- and middle-income Americans that is issued to anyone who qualifies. It would eliminate the need for the entire market bureaucracy produced by the exchanges.

Admittedly, any regulatory approach has its own complexities and its own bureaucratic needs. Design of a baseline health plan would demand navigating the state-by-state nature of insurance and provider networks and contests over what benefits to include and how much to reimburse for care. Yet, regulatory efforts could and should focus on these kinds of critical questions that might produce valuable results, rather than on technocratic tinkering to scaffold competitive structures that are not producing, and will never produce, the desired results.

2. Reinvigorating Meaningful Choice

Deemphasizing the supremacy of individual choice does not reduce all health regulation to paternalism. In limited circumstances and on careful scrutiny, individual choice may indeed be valuable and thus should be honored and supported by regulation. However, in the many cases when individual, especially market, choice is a poor proxy for what people value, it is imperative to develop better proxies.

Fortunately, a wealth of collective engagement on issues of health care could inform policies that are more in line with shared priorities and popular will. This Article merely scratches the surface of this topic to suggest the possibility of developing responsive policies without relying on individual choice.

a. Individual Choice

Choice in an individualized sense may be valuable in some, limited, ways, where it does genuinely enhance autonomy. Market based health policy has generated myriad layers of choice. An individual must choose whether to have insurance and, if yes, then among health plan options. She then must choose her

providers, including her doctor, hospital, imaging center, pharmacy, lab, physical therapist, and so on. Then, she must choose what care to seek from each of these providers. Yet, most people do not value, or want to make, most of these choices and do not navigate them well, as shown above.

That said, some people in the United States deeply care about having a doctor they know and trust. This particularly American attachment sparked resistance to managed care in the 1990s. Deliberations and town hall meetings debating the ACA in 2010 likewise made clear that people do not want to lose access to their doctors.⁴¹⁹

Choosing a doctor differs from many choices the market bureaucracy has asked people to make. It can be deeply personal. For many, it is not about prices or finding an objectively best physician. Rather, it may be about shared values or morals or about finding someone who will take the time to communicate in a way that makes sense. For others, it is about convenience of location, scheduling, or office hours. This is the type of decision that may be heterogenous and that people could more plausibly make in a way aligned with their own interests.

Ironically, as health care choices proliferate in so many ways, choice of provider has diminished.⁴²⁰ Even though President Obama promised that people could keep their doctors, his promises proved empty for some people (and earned him PolitiFact's lie of the year).⁴²¹ Insurers cancelled existing individual plans to accommodate the development of new ACA exchange plans, cutting people off from their existing providers, and new plans had notoriously narrow provider networks.⁴²² Medicaid and Medicare are both increasingly moving toward managed care, where provider networks are often more limited.⁴²³ If

419. See DAVID BETTS ET AL., DELOITTE, WHAT MATTERS MOST TO THE HEALTH CARE CONSUMER 3 (2016), <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-cx-survey-pov-provider-paper.pdf> [https://perma.cc/48QL-LZVE] (explaining that what consumers most want is “to be known and understood in order to get a personalized health care experience”).

420. I thank Zach Liscow for helping highlight this irony.

421. See Louis Jacobson, *Barack Obama Says That What He Said Was You Could Keep Your Plan If It Hasn't Changed Since the Law Passed*, POLITIFACT (Nov. 6, 2013, 11:35 AM), <https://www.politifact.com/truth-o-meter/statements/2013/nov/06/barack-obama/barack-obama-says-what-hed-said-was-you-could-keep> [https://perma.cc/RTL2-MZFN].

422. *Id.* See also Jason Millman, *This is Obama's Explanation for Why You Might Not Get to Keep Your Doctor*, WASH. POST (Mar. 14, 2015), <https://www.washingtonpost.com/news/work/wp/2014/03/14/this-is-obamas-explanation-for-why-you-might-not-get-to-keep-your-doctor> [https://perma.cc/GYP9-E4J3].

423. See GREG SCOTT ET AL., DELOITTE, HEALTH PLAN FINANCIAL PERFORMANCE 2011–2016 2 (2018), <https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/government-health-plan-financial-trends.html> [https://perma.cc/N77L-MSQD] (noting significant increase in private insurer revenue from Medicare Advantage and Medicaid from 2011–2016).

health care regulation honored those places when individual choice genuinely matters, it would preserve the ability to find and keep doctors we like and trust.

As another more contentious example, polling suggests that a majority of people—and a large majority of women—support reproductive choice.⁴²⁴ Yet, state legislatures continue to pass counter majoritarian legislation that dramatically limits reproductive choice.⁴²⁵

b. Collective Choice

Finally, in most cases, what people value most is more complicated than what is suggested by their market purchases. Going forward, these two must be disaggregated. This Subpart offers one last reflection, turning back to the reason we elevated choice in the first place. At its core, a regulatory system that is designed to support market choices was supposed to enable us to use our resources on the things we most value, which is an admirable goal in concept. Yet, when what people care about cannot be expressed in what they buy, it is necessary to work to understand priorities in a more capacious way.

It is common refrain that a lack of consensus is what led us to market-based policies in the first place, but such pronouncements are overstated. Some clear threads of agreement weave broadly among the populace. Most people value universal health care coverage.⁴²⁶ They want—and want others to have—access to health care without incurring financial insecurity.⁴²⁷

Contentious moments especially reveal consensus, and, in this era of health policy turmoil, people are actively deliberating over values and priorities in public fora. When Congress tried to repeal the ACA in the summer of 2017, people rose up against the roll back of the law and its coverage expansion.⁴²⁸ Similarly, public

424. See *Public Opinion on Abortion, Views on Abortion, 1995–2019*, PEW RES. CTR. (Aug. 29, 2019), <https://www.pewforum.org/fact-sheet/public-opinion-on-abortion> [<https://perma.cc/S8JR-J997>].

425. See, e.g., Lydia Saad, *Alabama Bill at Odds with Public Consensus on Abortion*, GALLUP BLOG (May 15, 2019), <https://news.gallup.com/opinion/gallup/257627/alabama-bill-odds-public-consensus-abortion.aspx> [<https://perma.cc/E2JD-HDFF>].

426. *Poll: Most Back Public Health Care Option*, CBS NEWS (June 19, 2009, 4:50 PM), <https://www.cbsnews.com/news/poll-most-back-public-health-care-option>, [<https://perma.cc/JP3G-CZ2E>] (finding that 64 percent of surveyed think the government should guarantee universal coverage and 57 percent would be willing to pay more taxes to ensure it).

427. See *id.* (concluding that 50 percent were satisfied with their own costs but only 19 percent were satisfied with costs for the country as a whole).

428. Perry Bacon Jr., *Why the GOP Is So Hell-Bent on Passing an Unpopular Health Care Bill*, FIVETHIRTYEIGHT (June 15, 2017, 9:48 AM), <https://fivethirtyeight.com/features/why-the->

outrage percolates regarding exorbitant drug pricing and the bind in which it has put many American families, causing Americans to identify lowering drug prices as a top 2017 Congressional priority.⁴²⁹

Health care is a ripe forum to reexamine how we understand Americans' priorities. We have turned to markets in part because of skepticism of democracy's ability to fix entrenched problems at a moment of deep political dysfunction.⁴³⁰ In health care, problems of vested interests and political capture are especially acute.⁴³¹

Yet, even at this moment when democracy limps along, examples have emerged where democratic deliberation over health care priorities is vibrant, even if not resolved. This final Part offers a few examples—themselves admittedly imperfect—of ways that people have collectively discovered or expressed what they most value in a health care system. It does not imply these are the best or only examples but rather aims to illustrate the possibility that deliberative or democratic processes can productively shape health regulation.

C. A Few Illustrations to Suggest a Path Forward

Assuming consensus indeed exists that it is a social priority to identify and reduce spending on low-value care, there are many possible ways to do so.⁴³²

[gop-is-so-hell-bent-on-passing-an-unpopular-health-care-bill](https://perma.cc/W2KH-A7DG) [https://perma.cc/W2KH-A7DG].

429. See COUNCIL OF ECON. ADVISERS, REFORMING BIOPHARMACEUTICAL PRICING AT HOME AND ABROAD 2f (2018), <https://www.whitehouse.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf> [https://perma.cc/5RMB-5RBQ].

430. More generally, political scientists have documented how policymaking has become less democratic, for reasons ranging from a bias in what policymakers hear to more complex policy feedback effects that discourage certain groups of people from active civic engagement. For an overview of both of these lines of study, see Suzanne Mettler & Joe Soss, *The Consequences of Public Policy for Democratic Citizenship: Bridging Policy Studies and Mass Politics*, 2 PERSP. ON POL. 55 (2004) (outlining systems theory in political science and the rise of research on policy feedback and its effects on mass political behavior); Joe Soss & Lawrence R. Jacobs, *The Place of Inequality: Non-Participation in the American Polity*, 124 POL. SCI. Q. 95 (2009) (documenting the effects of rising economic inequality on political participation).

431. Over the past twenty years, pharmaceutical companies have consistently topped industry spending on lobbying activity followed by insurance (#2), hospitals and nursing homes (#8), health professionals (#13), and health services/HMOs (#16). *Top Industries*, OPENSECRETS.ORG, <https://www.opensecrets.org/lobby/top.php?indexType=i> [https://perma.cc/8432-FVW7]. Adding all of these categories, combined health care industry spending dwarfs that of all other industries.

432. See, e.g., MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS (1997) (discussing the ethics and economics of different systems of rationing).

Some doubt the value of collective deliberation on rationing,⁴³³ which may be legitimate when thinking of rationing treatment-by-treatment. Yet, deliberation over principles that can guide priorities and tradeoffs may be more productive. A first step might be to define more broadly how voters, citizens, and patients define value.⁴³⁴

1. Examining Shared Values

Oregon attempted such deliberation in order to expand its Medicaid program in the early 1990s.⁴³⁵ Through a public, iterative process, it developed the Oregon List, a prioritized list of medical care for its Medicaid program in order to cover more people by covering fewer services.⁴³⁶ The state Health Services Commission held eleven public hearings, conducted 1000 random-digit-dialed telephone surveys, and authorized a citizens' advocacy group, Oregon Health Decisions, to hold forty-seven community forums, soliciting input on a questionnaire about the relative importance of certain health conditions or services and engaging in public discussion.⁴³⁷

Based on public input, clinical data, and outcomes research, the state developed an algorithm to array medical conditions in rank order of priority.⁴³⁸ Medicaid dollars would be allocated based on rankings, starting by paying for items at the top of the list and moving down the list as far as funds for a particular year would allow.⁴³⁹

433. See, e.g., Jonathan Oberlander et al., *Rationing Medical Care: Rhetoric and Reality in the Oregon Health Plan*, 164 CAN. MED. ASS'N J. 1583 (2001).

434. See Frank Pasquale, *The Hidden Costs of Health Care Cost-Cutting: Toward a Postneoliberal Health-Reform Agenda*, 77 LAW & CONTEMP. PROBS. 171, 173 (2014) ("How much should our society spend on health care? That is a deep and difficult, political and economic (and fundamentally politico-economic) question. Yet it ought to be addressed before policymakers point to high health care spending in itself as a rationale for reducing the purchasing power of patients, reducing compensation of physicians, nurses, and other providers, or deterring investment in hospitals, drugs, and devices."); cf. Richard H. Pildes & Cass R. Sunstein, *Reinventing the Regulatory State*, 62 U. CHI. L. REV. 1, 8 (1995) ("A special goal is to incorporate public judgments about risk so long as they are appropriately informed and reasonable, even when those judgments diverge from expert understandings. . . . [P]ublic judgments often reflect a distinctive kind of rationality, one that rejects some conventional forms of cost-benefit balancing.")

435. Oberlander et al., *supra* note 433, at 1584–85.

436. *Id.*; see also Daniel M. Fox & Howard M. Leichter, *Rationing Care in Oregon: The New Accountability*, 10 HEALTH AFF. 7 (1991).

437. Fox & Leichter, *supra* note 436, at 20–21.

438. *Id.* at 21–22.

439. *Id.*

One of the insights in Oregon was that the public gave relative priority to preventive services and dental care, and services such as dental checkups were, in turn, ranked higher than the physician members would have placed them.⁴⁴⁰ Further, the public and experts both rejected some of the ways that the algorithms prioritized low-cost yet nonessential services over high cost but potentially lifesaving ones, even if the former scored higher on a total dollar per outcome measure.⁴⁴¹ For example, on the initial list, addressing thumb sucking (presumably not that expensive) ranked above hospitalization for a starving child (expensive).⁴⁴² Such priorities were changed in a second list.⁴⁴³

Even though the list was first rejected by the Bush Administration in a waiver application and later haphazardly revised to accommodate federal administrators' demands and concerns of disability discrimination, and even though the list has not been used as anticipated as a rationing tool, the process to create it nevertheless illustrates the potential for understanding collective preferences, even on sensitive questions. People assembled in community meetings and hashed out concerns and priorities, which directly informed state policymaking.⁴⁴⁴

Even critics of the Oregon List recognize that the process of developing it built public support for raising taxes to fund expanded insurance for the poor, a valuable end in itself.⁴⁴⁵ The discussion thus created spending priorities that at least marginally better reflected community values and had community support.

Deliberation over health care values has occurred in other fora—both experimental and organic. Over the past two decades, federal agencies have asked how to get better public engagement on important health care matters. On the question of how evidence should inform health care decisionmaking, the Agency for Healthcare Research and Quality created a community forum under the American Recovery and Reinvestment Act to increase public deliberation.⁴⁴⁶ The project relied on a range of tools, including James Fishkin's Deliberative

440. *Id.* at 22.

441. *Id.*

442. *Id.*

443. *Id.*

444. Some criticize that the meetings were over representative of interest groups, especially physicians. *Id.* at 25–26.

445. Oberlander et al., *supra* note 433, at 1586.

446. See KRISTIN CARMAN ET AL., AM. INSTS. FOR RES., COMMUNITY FORUM DELIBERATIVE METHODS DEMONSTRATION: EVALUATING EFFECTIVENESS AND ELICITING PUBLIC VIEWS ON USE OF EVIDENCE (2013), https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/deliberative-methods-demonstration-executive-131125.pdf [https://perma.cc/S72V-MSGD].

Polling,⁴⁴⁷ designed to gauge and build consensus on complex issues in small-group settings.

For one part of the demonstration, investigators convened seventy-six deliberative groups for various durations of time with 907 sociodemographically diverse participants in four locations across the United States.⁴⁴⁸ They posed the following question to try to gauge values about the respective roles of patients and physicians in making medical decisions: “Should individual patients, their doctors, or both be able to make any health decisions no matter what the evidence of medical effectiveness shows, or should society ever specify some boundaries for these decisions?”⁴⁴⁹

Research surfaced several important values, including that people found evidence of harm to communities or individuals as a more compelling reason to accept limits on choices than evidence of ineffectiveness of treatment.⁴⁵⁰ It also found that even though people resisted cookie cutter medical decisions, a majority thought that doctors should not be able to provide a medical treatment that will not work for a patient.⁴⁵¹ Over the course of the discussion, the proportion of participants taking this position increased.⁴⁵² Furthermore, participants voiced comfort with restrictions on ineffective treatments, including that insurance should not pay for them.⁴⁵³ Finally, deliberation increased knowledge of medical evidence and comparative effectiveness research.⁴⁵⁴ This type of deliberative process can provide input for shaping policies and may also help participants solidify their support for such policies.

Another less discrete and more organic example where public deliberation is both shaping and revealing a dynamic understanding of larger values is on palliative and end-of-life care, which aim to make people more comfortable during illness and before death. Again, productive engagement resulted from discussion one level removed from decisions on specific treatments and focused more conceptually on values like pain versus comfort, or longer versus more able life.

447. James S. Fishkin, *Consulting the Public Through Deliberative Polling*, 22 J. POL’Y ANALYSIS & MGMT. 128 (2003).

448. Kristin L. Carman et al., *Understanding an Informed Public’s Views on the Role of Evidence in Making Health Care Decisions*, 35 HEALTH AFF. 566, 567 (2016).

449. *Id.*

450. *Id.* at 571 (“Evidence of physical harm was the most persuasive factor in increasing participants’ acceptance of limits to patients’ and clinicians’ choices.”).

451. *Id.* at 569–71.

452. *Id.*

453. *Id.* at 571.

454. *Id.* at 569.

Conventional wisdom says that Americans have a taste for expensive lifesaving interventions. Yet, efforts to engage with people on this question in more conceptual ways—and outside of life and death moments—have revealed otherwise. Hospice care is a half century old,⁴⁵⁵ but active efforts to engage people in discussion on what is desirable and possible in the case of terminal illness or at the end of life have been slower to develop.

One community that has been ahead of the curve is the Wisconsin city of La Crosse, where 96 percent of people who die have an advance directive in place.⁴⁵⁶ The movement in La Crosse began in the late 1980s and early 1990s when Bud Hammes, an ethicist who worked in the Gunderson Health System, developed a template for providers to talk to their patients about end-of-life preferences as part of routine medical care.⁴⁵⁷ The program, which began with a successful small pilot run by nurses trained to have end-of-life conversations, later scaled, first in the Gunderson System, and into other communities as an independent organization.⁴⁵⁸ This effort, even though it began in a very individualized way, spurred collective community deliberation over the value of invasive and expensive life-prolonging interventions.

In parallel, other organizations have aimed to start and shape conversations about dying. One of the earliest such programs, Five Wishes, was started in 1996 in Florida by a nonprofit called Aging with Dignity, with support from the Robert Wood Johnson Foundation.⁴⁵⁹ These types of programs attempted to normalize talking and thinking about death and to resist overmedicalization by using more generalized and plain language that asks people to consider, for example, who they want help with their care and how comfortable they want to be.

What is most interesting about these examples is not the legal documents that they have generated, but rather how they show people and communities discussing what values could shape the way someone thinks about serious illness or death. Does someone care most about survival or about being comfortable?

455. Nicole Fisher, *The History of Hospice: A Different Kind of Health 'Care'*, FORBES (June 22, 2018), <https://www.forbes.com/sites/nicolefisher/2018/06/22/the-history-of-hospice-a-different-kind-of-health-care/#6aa3495f660c> [https://perma.cc/EG67-VYNJ].

456. Sarah Kliff, *Wisconsin Is Learning How to Die*, VOX (May 28, 2015, 7:00 AM), <https://www.vox.com/2015/5/28/8672527/death-la-crosse-wisconsin> [https://perma.cc/VF8H-Z3XQ].

457. *Id.*

458. Larry Beresford, *Advance Directives: Planning for the End*, LANCET U.S. STATE OF HEALTH BLOG (Aug. 24, 2017, 7:28 PM), https://marlin-prod.literatumonline.com/pb-assets/Lancet/lancet/TL_USA_Posts.pdf [https://perma.cc/MN5K-BTHE].

459. See ROBERT WOOD JOHNSON FOUND., “FIVE WISHES:” AN EASY ADVANCE DIRECTIVE PROMOTES DIALOGUE ON END-OF-LIFE CARE (1998); *About Us*, AGING WITH DIGNITY, <https://agingwithdignity.org/about-us> [https://perma.cc/PG6Q-9CME].

How does someone like to make important decisions, and with whom? Concurrently, clinical trials have shown the potential of palliative care and counseling to avoid unnecessary medical care and to improve outcomes and sometimes even prolong life.⁴⁶⁰ These efforts have both raised and revealed different ways a health care system—and the people in it—might approach death.

Undoubtedly, people remember vividly when payment for end-of-life counseling was proposed as part of the ACA in 2009, and opponents of health care reform famously decried it as a move toward death panels; the payments were thus withdrawn from the health care reform package.⁴⁶¹ Yet, only six years after the death panels outcry, CMS faced little opposition to the proposed rule to authorize Medicare reimbursements for advanced care planning discussions.⁴⁶² Indeed, comments on the proposed rule submitted by both individuals and health care organizations overwhelmingly supported the change in policy, once considered on its terms and not as a pawn in a larger battle.⁴⁶³ The percentage of larger hospitals with palliative care programs is now 90 percent, compared to only 15 percent of hospitals with over 50 beds in 1998.⁴⁶⁴

This example suggests that, even on one of the most sensitive topics—targeted for attack by overly vocal interest groups—people and communities can engage productively on discussion of tradeoffs between, for example, extending life and quality of life, if engaged in the right settings and at the right level of conceptual abstraction. And these conversations can then begin to support policymaking that increases investments in palliative care, further weaving it into the fabric of medical practice. Although not the primary goal, in the end, this kind of thoughtful consideration of how people want to deal with serious illness,

460. See Preeti N. Malani & Eric Widera, *The Promise of Palliative Care: Translating Clinical Trials to Clinical Care*, 316 J. AM. MED. ASS'N 2090 (2016) (reviewing research on palliative care); Jennifer S. Temel et al., *Early Palliative Care for Patients With Metastatic Non-Small-Cell Lung Cancer*, 363 NEW ENG. J. MED. 733 (2010) (finding better quality of life, fewer depressive symptoms, and longer median survival among patients with metastatic non-small-cell lung cancer receiving early palliative care).

461. Paula Span, *A Quiet End to the 'Death Panels' Debate*, N.Y. TIMES (Nov. 20, 2015), <https://www.nytimes.com/2015/11/24/health/end-of-death-panels-myth-brings-new-end-of-life-challenges.html> [<https://perma.cc/KJ44-N89Z>].

462. *Id.*

463. Search Results Displaying Public Comment Submissions for Advance Care Planning, 81 Fed. Reg. 46161 (proposed July 15, 2016) (to be codified at 42 CFR Parts 405, 410, 411, 414, 417, 422, 460), <https://www.regulations.gov/docketBrowser?rpp=25&so=DESC&sb=commentDueDate&po=0&s=%22advance%2Bcare%2Bplanning%22&dct=PS&D=CMS-2016-0116> [<https://perma.cc/26C8-MFX2>].

464. Tamara Dumanovsky et al., *The Growth of Palliative Care in U.S. Hospitals: A Status Report*, 19 J. PALLIATIVE MED. 8, 13–14 (2016).

pain, and death could simultaneously spur policymaking that roots out wasteful, invasive end-of-life expenditures.

2. Access, Ballot Initiatives, and Medicaid Expansion

Finally, separating the discussion about what people most value from market mechanisms can reveal that people might care most about others, and the distribution of resources to others. The fight over Medicaid expansion is revealing the depths of insight into a shared commitment to access that is being expressed through a more traditional democratic tool: ballot measures.

The ACA intended to expand Medicaid access in all states to people earning up to 138 percent of the federal poverty level, but was thwarted in the courts.⁴⁶⁵ The first major legal challenge to the ACA, *NFIB v. Sebelius*, in effect made this expansion optional, so states could keep their pre-ACA eligibility categories or expand and, in turn, receive federal matching funds for upwards of 90 percent of the spending on newly qualified enrollees.⁴⁶⁶ As of September 2018, thirty-six states and the District of Columbia had adopted the expansion.⁴⁶⁷

What is remarkable is that in the fourteen opt out states, voters have begun to directly override their representatives' decision with ballot initiatives.⁴⁶⁸ Maine was the first to pass a ballot initiative to expand Medicaid in November 2017. Voters in Idaho, Nebraska, and Utah followed in November 2018. Ironically, and illustrating that implementing laws people value may be more challenging than gauging what they value, politicians, including former Republican Governor LePage in Maine and current legislators in Utah, have dug their heels in to resist implementing the referenda.⁴⁶⁹

465. Nat'l Fed. Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

466. *Id.*

467. *Status of State Action on the Medicaid Expansion Decision*, KAISER FAM. FOUND., <https://www.kff.org> [<https://perma.cc/4MQK-KTHV>] (follow "State Health Facts" hyperlink; then follow "Health Reform" hyperlink; then follow "Status of State Action on the Medicaid Expansion" hyperlink).

468. Larisa Antoinisse & Robin Rudowitz, *An Overview of State Approaches to Adopting the Medicaid Expansion*, KAISER FAM. FOUND. (Feb. 27, 2019), <https://www.kff.org/report-section/an-overview-of-state-approaches-to-adopting-the-medicaid-expansion-issue-brief> [<https://perma.cc/L2VG-3A6R>].

469. Michael Shepherd, *Maine's Top Court Backs Ruling That LePage Must Send Medicaid Expansion Plan to Feds*, BANGOR DAILY NEWS (Aug. 23, 2018, 1:54 PM), <https://bangordailynews.com/2018/08/23/politics/maines-top-court-backs-ruling-that-lepage-must-send-medicaid-expansion-plan-to-feds> [<https://perma.cc/QSU9-TBSE>]; Medicaid Expansion Adjustments, S.B. 96, 2019 Gen. Sess. (Utah 2019) (as enrolled by Legislature, Feb. 11, 2019), <https://le.utah.gov/~2019/bills/sbillenr/SB0096.pdf> [<https://perma.cc/T2RB-2FVP>] (bill scaling back expansion in Utah).

A takeaway from these initiatives is that people deeply value access to medical care in their communities—especially for lower-income community members. These initiatives passed because people who would not directly benefit personally from the expansion voted in its favor. Health regulation should focus on gauging and realizing such expressions of shared commitments. Bureaucracy is inevitable, but it should bolster a health care system that can fulfill, rather than frustrate, what people and communities genuinely care about.

These examples will not—in and of themselves—transform the U.S. health care system, but they illustrate different ways to develop health system priorities that reflect shared commitments. None of health care's problems is easy. But the hope that the market will simultaneously fix escalating, wasteful spending and also produce what people want has pushed aside working on alternatives that could more effectively achieve these two important and sometimes distinct goals. Relinquishing the false hope in markets can clear space for solutions that could genuinely improve the value of health care spending and make people healthier and more secure.

CONCLUSION

Market-based solutions preserve an aura of choice and autonomy and have garnered widespread appeal in recent decades. They may be appropriate when there is no right answer; when heterogeneity of wants can genuinely be accommodated by the market; when people are reasonably good decisionmakers; and when the subject in question is not life or death. Then, consumers may be the best arbiters. But such moments are fewer than imagined, especially in the realm of health care.

The growing body of evidence discussed in this Article shows that market-based approaches have largely failed health law and suggests we can do better. It is time to let go of the false hope that market-based solutions will solve U.S. health care woes.

Eschewing market-based policymaking is a refusal to continue to create structures that do not work and that set people up to fail, knowing they will likely do so, and then labeling that failure as choice. As Deborah Stone wisely cautioned, “[i]t is cynical to think that people will feel better about deprivation or bad outcomes as long as they believe they have had a hand in choosing their fate [C]onsumer choice offers citizens procedural comfort but less substantive help.”⁴⁷⁰ We must relinquish fleeting and shallow procedural

470. Stone, *supra* note 8, at 486.

comfort for sounder answers. In some cases, that might mean deprioritizing choice. In other cases, once we divorce choice from markets, we can ask what the polity genuinely values and can work to overcome the barriers to realize such ends, whether those barriers are technical, political, or sociological.

In the end, it is possible that the social and political price of taking on these harder conversations is too high. Collective engagement on hard problems may seem naïve at a moment in time with extraordinarily high political divisiveness, a breakdown in representative government, and concentrated wealth and interests controlling policy. Trying to gauge shared priorities in a deeper way will of course be contentious and divisive, particularly if it reveals that what some people want is discriminatory or rights threatening. One possibility is that ineffective, bureaucratic market-based policies may be the price we pay to keep the peace.

Yet, this Article has shown that this price is extremely high. And, at the end of the day, these market-based policies, as battles over the ACA have most recently illustrated, have not been mollifying. They have merely buried contentious issues to reemerge later.

We must take on political challenges and uncomfortable conversations to make real progress on the most intractable health policy problems. As long as we continue painstakingly to build health care's market bureaucracy, we are too distracted and too tired to have these conversations. This Article has argued that we must put down the technocratic tools and turn our collective efforts to building more productive intellectual foundations for the next era of health policy, law, and regulation.