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Article 1

Efficiency of Managed Care Patient Protection Laws: Incomplete Contracts, Bounded Rationality, and Market Failure

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THE EFFICIENCY OF MANAGED CARE "PATIENT PROTECTION" LAWS: INCOMPLETE CONTRACTS, BOUNDED RATIONALITY, AND MARKET FAILURE†

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INTRODUCTION

Proposals to regulate the provision of medical care by managed care organizations (MCOs) have dominated the agendas of state legislatures more than any other issue during the 1990s. Nearly every state has enacted laws designed to protect consumers from the perceived ill-effects of managed care.[1] State legislatures have enacted perhaps as many as 1000 patient protection laws nation wide,[2] and lawmakers are introducing new legislation at a rate of as many as 1000 bills per year by some estimates.[3] The most active state, Vermont, alone has passed more than 100 different managed care regulations.[4] In 1999, every state has considered new legislation to regulate MCOs.[5]

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1 In a recent study, Families USA, an advocacy organization for health care consumers, surveyed the prevalence of 13 different managed-care-patient protection laws across the country and found that only South Dakota had failed to enact at least one of the 13 laws. *See* FAMILIES USA FOUND., HIT AND MISS: STATE MANAGED CARE LAWS 4 (1998). According to the National Council of State Legislatures, 42 states enacted managed-care-patient protection laws in 1997 alone. *See* Steve Lewis, *Mandated Benefits*, HEALTH POL'Y TRACKING SERVICE (Nat'l Conference of State Legislatures, Wash., D.C.), Dec. 31, 1997, at 2.

2 *See, e.g.*, Alain C. Enthoven & Sara J. Singer, *Markets and Collective Action in Regulating Managed Care*, HEALTH AFF., Nov.-Dec. 1997, at 26, 30.

3 *See* Thomas Bodenheimer, *The HMO Backlash—Righteous or Reactionary?*, 335 NEW ENG. J. MED. 1601, 1601 (1996) ("In 1996 alone, 1000 pieces of legislation attempting to regulate or weaken HMOs were introduced in state legislatures . . . ."); Milt Freudenheim, *Baby Boomers Force New Rules for H.M.O.'s*, N.Y. TIMES, Nov. 27, 1997, at A1 ("More than 1,000 managed-care bills were introduced in state legislatures [in 1996].").

4 *See* Bryan Pfeiffer, *Vermont Tracks Compliance with Managed Care Regs by Using Measurable Standards and Report Cards*, ST. HEALTH WATCH, Aug. 1998, at 1.

5 *See Managed Care Bills Top State Agendas in 1999; Legislation Pending in Every State*, 7 Health L. Rep. (BNA) No. 49, at 1996 (Dec. 17, 1998) [hereinafter *Managed Care*] (citing a survey conducted by the National Conference of State Legislatures).

The federal government has joined the legislation bandwagon as well, enacting laws that limit the ability of MCOs to exclude coverage for preexisting medical conditions[6] and require them to permit women to remain in hospitals at least forty-eight hours after giving birth.[7] President Clinton proposed comprehensive federal managed care regulation in 1997[8] and called for the enactment of a Patients' Bill of Rights in his 1999 State of the Union address.[9] Over the past several years, Congress has debated a plethora of bills, sponsored by Republicans as well as Democrats,[10] that would legislate more comprehensive consumer protection from MCOs.[11] In late 1999, the Senate

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6 *See* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.). The law provides that group health insurers may impose a preexisting-condition exclusion only if

> (1) the exclusion relates to a condition . . . for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date; (2) such exclusion period extends for a period of not more than 12 months . . . ; and (3) the period of exclusion is reduced by the aggregate periods of creditable coverage . . . .

§701(1)-(3), 110 Stat. at 1939-40.

7 *See* Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.). The law provides that group health insurance plans may not restrict postpartum hospital stays for a mother or a newborn to less than 48 hours in the case of a vaginal delivery and 96 hours in the case of a Ceasarean section delivery. *See* § 711(a)(1), 110 Stat. at 2936; *see also* Eugene Declercq & Diana Simmes, *The Politics of "Drive-Through Deliveries": Putting Early Postpartum Discharge on the Legislative Agenda*, 75 MILBANK Q. 175, 176 (1997) (noting that President Clinton signed the bill into law in September 1996).

8 *See* Robert Pear, *Clinton Plans New Health Care Fight*, N.Y. TIMES, Nov. 24, 1997, at A18; Robert Pear, *Panel of Experts Urges Broadening of Patient Rights*, N.Y. TIMES, Oct. 23, 1997, at A1. The President based his proposal on the recommendations of his presidential advisory commission, whose report is available online. *See* President's Advisory Comm'n on Consumer Protection and Quality in the Health Care Indus., *Quality First: Better Health Care for All Americans* (last modified July 8, 1998) <http://www.hcqualitycommission.gov>.

9 *See, e.g.*, Jennifer Combs & David Nather, *Health Care Proposals Help Form Backbone of Clinton Domestic Agenda, Speech Reveals*, 8 Health L. Rep. (BNA) No. 3, at 100-01 (Jan. 21, 1999).

10 *See, e.g.*, Romesh Ratnesar, *Bad Medicine*, NEW REPUBLIC, July 7, 1997, at 10 (noting that Republican Senator Alfonse D'Amato and Republican Congressman Charlie Norwood introduced the Patient Access to Responsible Care Act and "castigat[ed] private enterprise in tones that would make Ralph Nader proud").

11 *See, e.g.*, Patients' Bill of Rights Act, S. 6, H.R. 358, 106th Cong. (1999); Patients' Bill of Rights Act, S. 240, 106th Cong. (1999); Patients' Bill of Rights Plus Act, S. 300, 106th Cong. (1999); Patients' Bill of Rights Act, S. 326, 106th Cong. (1999); Promoting Responsible Managed Care Act, S. 374, 106th Cong. (1999); Access to Quality Care Act, H.R. 216, 106th Cong. (1999); Patient Protection Act, H.R. 448, 106th Cong. (1999); Managed Care Reform Act, H.R. 719, 106th Cong. (1999); Comprehensive Managed Health Care Reform Act, H.R. 1133, 106th Cong. (1999); Patients' Bill of Rights Act, H.R. 3605, 105th Cong. (1998); Patients' Bill of Rights Act, S. 1890, 105th Cong. (1998); Health Care Quality, Education, Security, and Trust Act, S. 1712, 105th Cong. (1998); Comprehensive Managed Health Care Reform Act of 1997, H.R. 2905, 105th Cong.; Managed Care Bill of Rights for Consumers Act of 1997, H.R. 2606, 105th Cong.; Patient Access to Responsible Care Act of 1997, H.R. 1415, 105th Cong.; Patient and Health Care Provider Protection Act of 1997,

and the House of Representatives passed competing versions of a Patients' Bill of Rights (although it remains uncertain whether a compromise between the bills will become law).[12]

Despite this flurry of activity, and the continued increase in public support for managed care regulation[13] that has accompanied it, the legal academy has engaged in no real debate over the general efficacy of what is alternatively known as "patient-protection" or "mandated-benefits" legislation. This Article seeks to spur such a debate.

* * *

The 1980s witnessed a revolution in the provision of health care services in the United States. Reeling from exploding health care costs and the resulting rise in premiums,[14] employers, who pay over eighty percent of the dollars spent on private health insurance,[15] sought to control their costs.[16] Insurers, who typically paid for virtually all costs that any insured incurred under the care of a licensed physician (a system known as fee-for-service medicine[17]), responded by clamping down on the cost of medical care itself. The result was

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H.R. 1191, 105th Cong.; Health Insurance Bill of Rights Act of 1997, S. 373, 105th Cong.; Patient Protection Act of 1997, S. 346, 105th Cong.

12 Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, 106th Cong. (1999); Patients' Bill of Rights Plus Act, S. 1344, 106th Cong. (1999).

13 A poll conducted by the Pew Research Center, a partisan research group, from January 14 to 17, 1999, found that 69% of Americans believe health care reform should be a top policy priority, up from 62% in 1998 and 56% in 1997. *See* Pew Research Ctr. for People & Press, *Public Satisfied with State of Nation, Clinton Accomplishments Outweigh Failures* (visited Aug. 25, 1999) <http://www.people-press.org/jan99rpt.htm>.

14 Between 1966 and 1993, national health expenditures increased at an average rate of 11.7% per year. *See* Katharine R. Levit et al., *National Health Spending Trends in 1996*, HEALTH AFF., Jan.-Feb. 1998. Rising costs were particularly drastic in the latter part of that period. *See, e.g.*, WALTER A. ZELMAN & ROBERT A. BERENSON, THE MANAGED CARE BLUES AND HOW TO CURE THEM 1 (1998) (noting that 15% to 20% annual increases in health care costs were common in the latter half of the 1980s). During the second half of the 1980s, unequaled technological advances in health care caused the costs of care to rise much more rapidly than in previous decades. *See* Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 503 (1997) ("[A] major stimulus to managed care is the continued increase in absolute cost of health care. Rising health costs are driven largely by technological advances.").

15 *See* Levit et al., *supra* note 14, at 35, 46 exhibit 6. A different study found that by January 1996 over 71% of individuals who received health benefits through their employers were enrolled with MCOs. *See* Milt Freudenheim, *Survey Finds Health Costs Rose in '95*, N.Y. TIMES, Jan. 30, 1996, at D1.

16 *See* FAMILIES USA FOUND., *supra* note 1, at 1 (noting that "purchasers of health coverage have turned to managed care in response to health care costs that were spiraling out of control"); Cathie Jo Martin, *Markets, Medicare, and Making Do: Business Strategies After National Health Care Reform*, 22 J. HEALTH POL., POL'Y & L. 557, 564 (1997) (noting that one cause of the rise of managed care was that "corporate America was becoming more desperate about the price of health").

17 Fee-for-service medicine entails doctors setting their own fees, charging for discrete procedures instead of for the time spent with a patient, and receiving reimbursement for the full amount of the bill from an insurance agency. The fee-for-service system is considered traditional insurance and creates an incentive for doctors to provide excessive treat-

the rise to prominence of "managed care,"[18] a variety of organizational arrangements for providing and financing medical care in which the financing entity plays an active role in monitoring and controlling the amount and types of services that physicians provide to patients. By 1995, nearly 75% of Americans with employer-provided private insurance, and more in some part of the country,[19] received their medical care from MCOs.[20] MCOs have also begun to capture a portion of the market for government-financed health care—Medicaid[21] and Medicare.[22] Although it is not clear whether the trend will be sustainable in the long run,[23] the market penetration of managed care has reduced health care inflation in recent years.[24]

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ment because they earn more with each procedure performed. *See* MARK A. HALL & IRA MARK ELLMAN, HEALTH CARE LAW & ETHICS IN A NUTSHELL 11-12 (1990).

18 For a detailed description of the various types of managed care organizations, including HMOs, PPOs, IPAs, and POSs, see generally Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL., POL'Y & L. 75 (1993).

19 *See* Henry T. Greely, *Direct Financial Incentives in Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53, 54 (1996) (describing the market penetration of managed care in California).

20 *See* Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFF., Jan.-Feb. 1997, at 125, 134.

21 At the end of 1995, approximately one third of Medicaid recipients received health care from an MCO. *See* Marsha Gold, *Markets and Public Programs: Insights from Oregon and Tennessee*, 22 J. HEALTH POL., POL'Y & L. 633, 634 (1997).

22 By 1995, approximately 10% of Medicare recipients were enrolled in MCOs, a majority of whom live in Florida and California. *See* Jonathan B. Oberlander, *Managed Care and Medicare Reform*, 22 J. HEALTH POL., POL'Y & L. 595, 598-99 (1997).

23 According to one recent estimate, while 90% of HMOs were profitable in 1994, only 35% were profitable in 1996. *See* Edward B. Hirshfeld & Gail H. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 38 (1996) (concluding that "[m]any health care economists believe that the savings achieved by [MCOs] are not sustainable on a long-term basis"); Levit et al., *supra* note 14, at 47 (suggesting that cost increases may be on the horizon); Martin, *supra* note 16, at 573 (reporting some analysts' belief that declining health care costs represent a one-time savings from initial shifts from fee-for-service plans to MCOs and that concentration in the managed care industry could spur price increases).

24 Increases in national health care spending between 1993 and 1996 averaged just 5% per year, with growth slowing each successive year during that period. *See* Levit et al., *supra* note 14, at 36. During that period, the percentage of GDP spent on health care remained constant at 13.6%. *See id.* at 37; *see also* Enthoven & Singer, *supra* note 2, at 27 ("The 1997 California Public Employees Retirement System . . . premiums are about the same in dollars as they were in 1992 for essentially the same standard benefit package, and, inflation-adjusted, they are down about 13%."); Lynn Etheredge et al., *What Is Driving Health System Change?*, HEALTH AFF., Winter 1996, at 93, 94 (discussing a "Department of Labor study indicat[ing] that employer health benefit spending rose only 0.1% from June 1995 to June 1996"); Jensen et al., *supra* note 20, at 125 (noting that in 1995, percentage increases of health insurance premiums were below the rate of inflation "for the first time in memory"). Although many factors have contributed to the decline in medical care inflation, commentators nearly always identify the exploding growth of managed care in the 1990s as one of the leading causes. *See* Levit et al., *supra* note 14, at 37. *But see* Jensen et al., *supra* note 20, at 134 (recognizing the possibility that the slowdown in health insurance

By the early 1990s, the majority of policy analysts[25] and elected leaders[26] agreed that the nation was spending far too much on medical care[27] and that a solution to the spending problem was necessary. On the other hand, consumers were understandably concerned that efforts to rein in the costs of health care could easily result in a reduction in health care quality.[28] The leading response to these twin concerns, which leading academics[29] advocated and which President Clinton's proposed Health Security Act[30] more or less embodied, was dubbed "managed competition."[31] Managed competition could simultaneously control costs and assure a high quality of care by permitting profit-maximizing health care entities to compete for the business of individual Americans within regulatory boundaries designed to correct for imperfections in the market for medical care.

Commentators have debated at length the merits of managed competition.[32] Whatever its merits, most observers agree that the

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inflation in the mid-1990s is due to cyclical profits in the health insurance industry rather than to the rise of managed care).

25 *See* Henry J. Aaron & William B. Schwartz, *Managed Competition: Little Cost Containment Without Budget Limits*, HEALTH AFF., Supp. 1993, at 204; Stuart H. Altman & Alan B. Cohen, *The Need for a National Global Budget*, HEALTH AFF., Supp. 1993, at 194; Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Supp. 1993, at 24; Paul Starr & Walter A. Zelman, *A Bridge to Compromise: Competition Under a Budget*, HEALTH AFF., Supp. 1993, at 7. *But see* Joseph P. Newhouse, *An Iconoclastic View of Health Cost Containment*, HEALTH AFF., Supp. 1993, at 152, 153 (arguing that "the rhetoric about the urgency for cost containment may well be overstated").

26 *See, e.g.*, 138 CONG. REC. S17,793 (daily ed. Oct. 8, 1992) (statement of Sen. Cohen on health care reform) ("The problem is not simply that we are spending too much. It is that we are not getting a sufficient return on our investment."); 137 CONG. REC. S15,119 (daily ed. Oct. 24, 1991) (statement of Sen. Mitchell on health care reform) ("We are already spending too much money on health care.").

27 *See* Christine Gorman, *Playing the HMO Game*, TIME, July 13, 1998, at 22, 26 (reporting that health care consumed 12.3% of GDP in 1993, up from 9.3% in 1983).

28 For a list of some of the most common consumer complaints, see David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 413-16 (1998).

29 *See, e.g.*, Enthoven, *supra* note 25, at 28-29; Jonathan E. Fielding & Thomas Rice, *Can Managed Competition Solve the Problems of Market Failure?*, HEALTH AFF., Supp. 1993, at 216; Alan L. Hillman et al., *Safeguarding Quality in Managed Competition*, HEALTH AFF., Supp. 1993, at 110; Starr & Zelman, *supra* note 25, at 8.

30 H.R. 3600, 103d Cong. (1993). For a description of the principles underlying the Health Security Act, see Paul Starr, *The Framework of Health Care Reform*, 329 NEW ENG. J. MED. 1666 (1993).

31 For a brief description of the principles of managed competition, see Enthoven, *supra* note 25, at 29 (stating that "[managed care] uses rules for competition . . . to reward with more subscribers and revenue those health plans that do the best job of improving quality, cutting cost, and satisfying patients"). For an early enunciation of the principles, see Alain C. Enthoven, *Consumer-Choice Health Plan* (pts. 1 & 2), 298 NEW ENG. J. MED. 650, 709 (1978).

32 *See* Craig Salins, Editorial, *"Cure" Is to Broaden Medicare*, SEATTLE TIMES, May 19, 1995, at B7; Paul Starr, *Look Who's Talking Health Care Reform Now*, N.Y. TIMES, Sept. 3, 1995, Magazine, at 42-43; *Single-Payer and Clinton Health Care Reform Plans Cited as Best for Senior Citizens*, BUS. WIRE, Dec. 21, 1993, *available in* Westlaw.

political failure of the Health Security Act in 1993 all but eliminated any possibility that the federal government would enact a comprehensive approach to health care reform any time in the near future. Since the Health Security Act's demise, ad hoc attempts to regulate particular aspects of the provision of health care services by MCOs have proliferated at a staggering rate. In the last four years alone, nearly all states have enacted legislation[33] that in some way dictates one or more of the following: the kinds of coverage MCOs must provide to patients,[34] the extent to which MCOs may intervene in the treatment decisions of their employed or independently contracted physicians,[35] and the methods they may use to compensate their providers.[36]

The regulatory requirements to which managed care providers are subject generally elicit one of two responses from academic commentators. Opponents of regulation—often economists or lawyers with an inclination towards economic reasoning—typically argue that the free market will more efficiently allocate resources among health care and other consumer goods than will government mandates.[37] Mandating a forty-eight hour postpartum hospital stay, to select one current example, inevitably increases the cost of providing health care and will eventually drive up the price of private health insurance. The efficiency argument posits that consumers who wish to spend their money on such services are free to do so in the marketplace, and will do so if they value the service more than its provision costs. But, the argument continues, government mandates should not prevent consumers from spending their marginal dollars on other goods and services if they so desire. The implicit basis for the anti-regulation argument is that medical care is "worth" what consumers are willing to pay for it—neither more nor less.[38]

In contrast, supporters of extensive regulation in the health insurance industry generally dismiss the underlying premise of their op-

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33 *See supra* note 1.

34 *See id.* Thirty-one states and the District of Columbia require health plans to use the "prudent layperson standard" when determining coverage for most emergency care, 15 states require plans to permit access to out-of-network providers when the plan's network is inadequate, 12 states allow enrollees to obtain standing referrals to specialists, 10 states allow specialists to serve as primary care providers, and 14 states require plans to allow some patients to see the same provider for a specified number of days when their doctor leaves the plan. *See* FAMILIES USA FOUND., *supra* note 1, at 23-24.

35 *See* FAMILIES USA FOUND., *supra* note 1, at 25.

36 *See id.*

37 *See infra* Part I.C.

38 *See, e.g.*, Danzon, *supra* note 14, at 508 ("To decide whether a particular procedure is worth performing requires comparing the value of the expected health outcomes to costs. Valuation of medical services ultimately depends on consumer preferences for alternative outcomes, including tolerance for risk and discomfort, preferences for health care versus other goods, and so forth.").

ponents' argument. They see health care—at least a certain amount of it—as a merit good rather than a normal consumer good, the provision of which should not be limited to those who are able to pay for medical care and who see the wisdom in doing so.[39]

In this Article, I take a different approach to the issue of health care mandates by challenging the opponents of mandates on their own terms. I accept *arguendo* the efficiency premise: that health care is a consumer good that must compete with other goods for society's scarce resources, and that it should be provided only to the extent that people prefer it to alternative goods that they could purchase with the same dollars. A plausible paternalist justification for mandated benefits exists in some circumstances,[40] but I will not rely on it for purposes of this Article. Although I accept the efficiency premise, I reject the conclusion drawn by the opponents of regulation that an unregulated market necessarily most closely approximates efficiency. Instead, I argue that managed-care patient-protection legislation can enhance efficiency under certain circumstances. This thesis rests on two pillars: game theory and behavioral decision theory—the former drawn from economics, the latter from cognitive psychology.

Part I of this Article provides context by describing the rise of managed care, the epidemic of patient protection laws enacted from coast to coast throughout the 1990s, and the standard free-market argument that these laws impede the efficient allocation of social resources. Part II, relying on a nonmathematical game theoretic model, examines the incentives that profit-maximizing MCOs have to provide a less-than-efficient level of insurance coverage to their enrollees. Relying on empirical evidence that consumers have cognitive limitations

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39 *See, e.g.*, RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 1-2 (1997) [hereinafter EPSTEIN, MORTAL PERIL] (classifying as "widely accepted" in health care debates the assumption "that health care is a 'right' that should be made available to all Americans . . . by virtue of their participation in society"); MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS 32 (1997) (arguing that "[o]ur country values minimally decent health care as a basic social entitlement"); Richard A. Epstein, *Why Is Health Care Special?*, 40 U. KAN. L. REV. 307, 307 (1992) [hereinafter Epstein, *Why?*] (noting "widespread agreement . . . that health care is 'special' . . . [and] that the special nature of health care calls for the intervention of government into the operation of the market"); Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1798 (1992) ("The pervasive assumption in public and private conceptions of medical care is that it could never be a consumer good . . . . Instead, health care is generally thought of as a 'merit good'—that is, as something that should be distributed equitably, not simply according to ability to pay."); David A. Hyman, Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered? 43 (Sept. 24, 1998) (unpublished manuscript, on file with author) ("The conventional wisdom on regulating managed care is to privilege quality and discount or entirely ignore cost.").

40 *See, e.g.*, Thomas Rice, *Can Markets Give Us the Health System We Want?*, 22 J. HEALTH POL., POL'Y & L. 383, 405 (1997) (questioning whether in the health care arena, consumers are the best judges of their own interests).

that cause them to make decisions in only a "boundedly rational" manner, Part III examines the ways in which even informed consumers are likely to fail to make individual health insurance purchasing decisions in a way that promotes efficiency. The strategic interests of MCOs and the cognitive limitations of health insurance consumers are likely to result in the underprovision of some health care benefits.

Once the failures of the free market to guarantee the efficient level of health care are identified, the question of which types of intervention will most likely promote the efficient allocation of social resources remains. Part IV contends that policymakers can use regulatory mandates to solve the collective-action problem that leads to the market's underprovision of health care. This strategy is currently more feasible than competing proposals that would attempt to facilitate a more efficient market for health insurance by providing more information to health care consumers.

If benefits mandates can enhance efficiency and are superior to other policy options in some circumstances, the next important question is which branch of government should issue mandates. Part V addresses this issue with a comparative institutional analysis of courts, legislatures, and specially-appointed expert commissions as potential sources of managed care regulations. To date, legislatures have promulgated the vast majority of benefits mandates, although judicial doctrines that courts rely on when adjudicating disputes about health insurance coverage can have a similar effect. I conclude that legislatures are better positioned institutionally than courts to promulgate mandates in most instances, but that expert administrative bodies are more likely than either legislatures or courts to create efficient health care mandates.

A brief note concerning what this Article does *not* argue is in order as well. I do not contend that any particular benefits mandate is efficient. The proper analysis of any individual regulation would require a fact-specific inquiry comparing the imperfections inherent in a given market with those of the regulatory decision-making process. This Article's much more modest goal is to demonstrate that government mandates are a useful tool in the arsenals of lawmakers who are concerned with ensuring that our society devotes the efficient level of resources to health care.

I

THE CURRENT STATE OF MANDATED HEALTH CARE BENEFITS

A. From Fee-for-Service Medicine to Managed Care

1. *Fee-for-Service Medicine*

Until the 1980s, most Americans received private health insurance on a fee-for-service basis.[41] Under the fee-for-service system, the patient (or, more likely, her employer) paid a monthly fee to her insurance company for comprehensive coverage of all medical care she might require. The insurance company, in turn, paid the physician of the patient's choice for each service or treatment the physician provided and questioned the cost or necessity of the treatment in only the most egregious circumstances.

This regime created two types of incentives that tended to lead to the provision of more than the efficient amount of medical care—with "efficiency" understood to mean that the marginal cost of the care provided to an individual is equivalent to the marginal benefit of that care. Both incentives fall into the category of "moral hazard" problems.[42] First, because the patient faces no marginal cost for consuming medical treatment (or perhaps a relatively modest marginal cost in the form of a copayment), she has an incentive to consume any service or treatment that might provide even a very small benefit, regardless of its cost.[43] Second, because the physician is paid only when she provides services or treatment, she also has an incentive to ignore costs and to provide, at a minimum,[44] treatment with any potential benefit to the patient.[45] In the world of fee-for-service medicine, then, the patient and physician each have an incentive to consume medical care of any marginal benefit without regard to the marginal cost of the care.[46]

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41 *See* ZELMAN & BERENSON, *supra* note 14, at 1-3.

42 For a detailed description of moral hazard in the health insurance context, see PAUL L. JOSKOW, CONTROLLING HOSPITAL COSTS 20-31 (1981).

43 *See* Danzon, *supra* note 14, at 495-96; Rice, *supra* note 40, at 412-13. Studies have demonstrated that people who have to pay for some portion of their marginal health care costs out of pocket use far fewer resources than those who can obtain care at no marginal cost. *See, e.g.*, THE EFFECT OF COINSURANCE ON THE HEALTH OF ADULTS 1-2 (Robert H. Brook et al. eds., 1984).

44 A physician actually has a financial incentive to provide useless or even detrimental care, as long as she can do so without losing the patient to a competitor. For the purposes of this Article, however, it is sufficient to assume that physicians' professional norms will constrain them to provide only beneficial care.

45 *See, e.g.*, HALL, *supra* note 39, at 181; Danzon, *supra* note 14, at 496; Donald W. Moran, *Federal Regulation of Managed Care: An Impulse in Search of a Theory?*, HEALTH AFF., Nov.-Dec. 1997, at 7, 11.

46 *Cf.* CLARK C. HAVIGHURST, HEALTH CARE CHOICES 93 (1995) ("The insurance-induced divorce of consumption decisions from the obligation to pay undoubtedly justifies concern that increased spending on health care does not truly reflect the preferences of consumers as to how their money should be spent."). One study from the early 1990s

As medical technology became vastly more sophisticated and expensive in the 1960s and 1970s, the annual costs of the fee-for-service system predictably skyrocketed. Health care spending, which consumed only 5.1% of the nation's GDP in 1960, consumed 8.9% in 1980, and 12.2% in 1990.[47] During the inflationary years of the 1970s, employers transferred the rising costs of health insurance to employees in the form of smaller increases in salaries—an effect that employees could not easily perceive.[48] In the low-inflation 1980s, however, rising costs of health insurance led to wage stagnation for many employees, which increased the level of discontent with the fee-for-service system.[49]

2. *The Rise of Managed Care*

Any alternative to fee-for-service medicine can potentially reduce the inefficient overutilization of medical care in one of three ways: (1) rationing the amount of care provided, (2) offering the health care provider an incentive to equate the marginal benefit of care with its marginal cost, or (3) giving the patient an incentive to equate the marginal benefit of care with its marginal cost. The first two approaches essentially seek to reduce the supply of medical care, while the third attempts to reduce the demand for care.

A demand-side approach to the problem would require increased health insurance deductibles and copayments, thereby placing a significant financial obligation for medical care directly on consumers of medical services. The policy of creating "medical savings accounts" (MSAs) embodies this concept.[50] Proponents of MSAs would alter the tax code to permit consumers to save money for future medical expenses on a tax-free basis (or at least at favorable rates) if they purchase health insurance policies with very high deductibles. The high deductible theoretically ensures that medical expenditures for all but the very sickest[51] come out of the patient's pocket, providing him

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estimated that moral-hazard-induced overuse of health care resources represented between 9% and 28% of all U.S. health care resources. *See* Roger Feldman & Bryan Dowd, *A New Estimate of the Welfare Loss of Excess Health Insurance*, 81 AM. ECON. REV. 297 (1991).

47 *See* Levit et al., *supra* note 14, at 38 exhibit 2.

48 *See* ZELMAN & BERENSON, *supra* note 14, at 17-18.

49 *See id.* ("Only as the relationship between stagnant wages and rising premiums grew more evident and more threatening to employer-employee relationships did employer concerns about rising contributions for health care coverage become a force to be reckoned with.").

50 *See generally* HALL, *supra* note 39, at 26-28 (describing the concept of the medical savings account); Gail A. Jensen & Robert J. Morlock, *Why Medical Savings Accounts Deserve a Closer Look*, J. AM. HEALTH POL'Y, May-June 1994, at 14 (same).

51 In 1987, for example, the sickest 1% of Americans accounted for 30% of health care spending, while the healthiest 50% of Americans consumed only 3% of health care resources. *See* Marc L. Berk & Alan C. Monheit, *The Concentration of Health Expenditures: An Update*, HEALTH AFF., Wmter 1992, at 145, 146.

with the incentive to equate the marginal costs and benefits of care.[52] To date, the MSA approach to reining in health care costs consists only of a small pilot program within the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[53] Consequently, MSAs have altered the incentives of relatively few consumers,[54] although this could change in the future.[55] MCOs tend to reduce (rather than increase) deductible and copayment levels as a method of marketing comprehensive service and encouraging customers to seek preventive care.[56] The tax code encourages this strategy by providing an incentive for employers, rather than for employees, to pay for medical care costs.[57]

Supply-side strategies, on the other hand, underlie the various approaches to medical care provision that have come to dominate the health care system under the collective moniker of "managed care." MCOs attempt to remedy the moral hazard problem of fee-for-service medicine in one of two ways or a combination of both.[58] First, MCOs indirectly seek to restrict the utilization of resources by providing their physicians with financial incentives to furnish less, rather than more, care.[59] Many MCOs compensate their primary care physicians

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52 An experiment that the RAND Corporation conducted in the early 1980s demonstrates that forcing patients to pay more out of pocket reduces health care expenditures. *See* Emmett B. Keeler & John E. Rolph, *How Cost Sharing Reduced Medical Spending of Participants in the Health Insurance Experiment*, 249 JAMA 2220 (1983) (reporting results from a RAND study).

53 Pub. L. No. 104-191, § 301, 110 Stat. 1936, 2041-42 (codified as amended in scattered sections of 26 U.S.C., 29 U.S.C., and 42 U.S.C.) (defining medical savings accounts as trusts "created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder," and exempting them from taxation).

54 According to the United States General Accounting Office, only 22,051 self-employed individuals and employees of small businesses opened medical savings accounts between January and June of 1997. *See* U.S. GEN. ACCOUNTING OFFICE, MEDICAL SAVINGS ACCOUNTS: FINDINGS FROM INSURER SURVEY 5 (1997).

55 HIPAA implemented a four-year demonstration program for MSAs, limiting participation to self-employed individuals and small business employees and capping enrollment at 725,000 accounts. *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 54, at 3. Current Republican proposals pending in Congress would eliminate HIPAA's cap on the number of MSAs, in theory making them available to a far greater number of Americans. *See* Quality Care for the Uninsured Act of 1999, H.R. 2990, 106th Cong. (passed by the House of Representatives on Oct. 6, 1999).

56 *See* Rice, *supra* note 40, at 416 (observing that "what is perhaps most noteworthy about the HMO approach to cost containment is that copayments are *lower* than in fee-for-service medicine").

57 *See* HAVIGHURST, *supra* note 46, at 138 (speculating that high deductibles might be ubiquitous in the absence of their tax disadvantage).

58 One can classify these responses more generally as "internalizing incentives for improving performance" of agents or as "external monitoring" of agents, where the agents are the physicians providing care. HALL, *supra* note 39, at 183 (emphasis omitted).

59 *See generally* Danzon, *supra* note 14, at 498-99 (describing MCO strategies that involve restricting the networks of providers and sharing insurance risk with providers); Hirshfeld & Thomason, *supra* note 23, at 27-30 (same).

through capitation payments—a physician receives a fixed amount of money per month for caring for a patient, regardless of the resources that patient requires.[60] Others use the related strategy of fee withholds. Under this arrangement, the MCO withholds part of the physician's payment for providing treatment and pays it at the end of the year only if the physician meets resource-usage targets.[61] Even the dwindling number of MCOs that pay physicians on a fee-for-service basis are particular about which physicians they will hire or contract with for services.[62] This screening process creates the implicit threat that the MCO will "deselect," or fire, a physician for providing too much care and hurting the MCO's bottom line.[63] The threat can be particularly potent in areas with an oversupply of physicians or where MCOs dominate the health care market.[64]

Second, MCOs attempt to control the supply of medical care directly by scrutinizing the care physicians provide. The most popular technique of this kind, utilization review, requires the patient or physician to obtain the MCO's approval either before treatment, or, in some cases, after treatment but before the MCO pays for it.[65] MCOs argue that, by refusing to authorize services with little or no likely benefit and expensive treatments for which there are equally beneficial alternatives, they can significantly rein in the cost of medical care without substantially reducing the quality of care. If a patient seeks treatment that fails to meet the MCO's guidelines, the MCO will deny coverage, leaving the patient with the option of going without the treatment or financing it out of pocket. To varying degrees, MCOs stress that a doctor's recommendation of a certain treatment does not obligate the MCO to pay for it, even when the MCO selects the physi-

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60 *See, e.g.*, Hirshfeld & Thomason, *supra* note 23, at 28-29. Whether the physician is financially responsible for the cost of referrals to other health care providers, such as specialists or hospital care, varies across MCOs. *See id.* at 29-30. Similarly, MCOs vary as to whether the physician has stop-loss protection, which limits the amount of the physician's liability for exceptionally expensive care. *See* Carol J. Simon & David W. Emmons, *Physician Earnings at Risk: An Examination of Capitated Contracts*, HEALTH AFF., May-June 1997, at 120, 124-25. A recent study indicates that most physicians compensated on a capitation basis have little or no protection against the large losses a patient may cause. *See id.*

61 *See, e.g.*, Hirshfeld & Thomason, *supra* note 23, at 28.

62 One pair of authors identifies the selection of a limited number of health care providers as contractors as "the feature that most defines managed care." ZELMAN & BERENSON, *supra* note 14, at 69.

63 *See, e.g*, Hirshfeld & Thomason, *supra* note 23, at 28; Robert Kuttner, *Must Good HMOs Go Bad?* (pt. 1), 338 NEW ENG. J. MED. 1558, 1558-59 (1998).

64 *See* Hirshfeld & Thomason, *supra* note 23, at 28.

65 *See* Danzon, *supra* note 14, at 498; Hirshfeld & Thomason, *supra* note 23, at 26; Arnold Milstein, *Managing Utilization Management: A Purchaser's View*, HEALTH AFF., May-June 1997, at 87, 87. Closely related direct cost-containment strategies include case management, through which the MCO decides whether patients are seriously ill, and requirements that physicians in the MCO's network follow MCO-designed practice gnidelines. *See* Hirshfeld & Thomason, *supra* note 23, at 27.

cian.[66] In what can be understood as a severe form of utilization review, MCOs often refuse ex ante to provide entire categories of services that they believe have a low benefit-to-cost ratio (e.g., autologous bone marrow transplants as treatment for some forms of cancer) or are difficult to control ex post through the utilization review process (e.g., mental health care).

The extent to which (or even *whether*) aggressive utilization review reduces the quality of care that MCOs provide is a matter of substantial dispute, but consumers have reason to be concerned. A recent study in the *Journal of the American Medical Association* shows that, according to one set of utilization review guidelines, eighty percent of tube insertions to treat a middle ear infection would have been judged unwarranted, although a panel of physician experts judged only thirty-one percent of the insertions unwarranted.[67]

Whether an MCO relies more on direct utilization review than on indirect utilization review through financial incentives tends to depend on the MCO's internal structure.[68] Health maintenance organizations (HMOs), the type of MCOs that most closely integrate the financing and provision of care, tend to compensate their providers with capitation payments or fee withholding programs (or, for a "staff model" HMO, in which the HMO employs the physicians, with salaries).[69] Consequently, HMOs tend to rely relatively less on direct utilization review and the threat of deselection than do preferred provider organizations (PPOs), which typically have broader, more loosely controlled networks of physicians.[70] All MCOs use some combination of direct and indirect methods to control the quantity and cost of medical care that physicians provide to patients. In doing so, MCOs have been able to provide health care services at a lower cost than fee-for-service plans,[71] although the extent of the actual cost savings created by managed care is the subject of some debate.

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66 *See* HAVIGHURST, *supra* note 46, at 127 (reviewing a series of health plan contracts with this and similar disclaimers).

67 *See* Lawrence C. Kleinman et al., *Adherence to Prescribed Explicit Criteria During Utilization Review*, 278 JAMA 497 (1997).

68 For a useful primer on the different types of MCOs and their precise defining characteristics, see generally Weiner & de Lissovoy, *supra* note 18, at 75.

69 *See, e.g.*, Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, 333 NEW ENG. J. MED. 1678, 1680-81, 1681 tbl.3 (showing that the majority of HMOs surveyed compensated their physicians primarily with capitation payments or salary, and that almost all HMO physicians compensated on a fee-for-service basis subject to risk-sharing arrangements, such as fee withholding).

70 *See* Hirshfeld & Thomason, *supra* note 23, at 30; *see also* HAVIGHURST, *supra* note 46, at 143 (finding that less-integrated MCOs, like PPOs, are more likely to employ independent utilization-review companies to control directly utilization of services).

71 *See, e.g.*, ZELMAN & BERENSON, *supra* note 14, at 120 (estimating that employers and employees today would be paying between 10% and 50% more for health insurance if the fee-for-service system had persisted); Robert H. Miller & Harold S. Luft, *Managed Care Plan*

B. The Mandated-Benefits Backlash

Nearly all commentators agree that the fee-for-service approach to health care provides incentives for inefficient overutilization of medical care[72] and that the rise of managed care has apparently slowed the growth of health insurance costs.[73] But many observers believe that the rise of managed care has shifted, or at least threatens to shift, the balance too far in the other direction.[74] Most critics of managed care focus on the costs of MCO attempts to reduce the amount of medical care supplied, rather than on the balance between the costs and benefits of managed care.[75] In doing so, the criticisms often deny the relevance of economic efficiency to the provision of medical care. Critics sometimes explicitly argue that high-quality health care is a "right" to which all Americans are entitled regardless of its cost.[76] Often, the denial of the value of economic efficiency is implicit when, for example, critics fail even to consider whether medical care is underprovided or overprovided relative to its social value in the brave new world of managed care.[77] This approach to evaluating the reforms of managed care is firmly rooted in the medical profes-

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Performance Since 1980, 271 JAMA 1512, 1514-15, 1517 (concluding from an analysis of multiple studies that "HMOs provide care at lower cost than do indemnity plans," mostly because of their ability to reduce the length and incidence of hospital stays and to discourage the use of costly treatments with less expensive alternatives).

72 *See supra* notes 41-49 and accompanying text. *But see* Irwin M. Stelzer, *What Health-Care Crisis?*, COMMENTARY, Feb. 1994, at 19, 19-24 (arguing that criticisms of the American health care system are misplaced).

73 *See supra* Part I.A.2.

74 Even those commentators who support managed care generally concede that the new system of medical care may cause MCOs and their physicians to provide too little care. *See, e.g.*, Danzon, *supra* note 14, at 499. A recent survey of physicians reinforces this fear. Nearly 25% of surveyed physicians whose patient base consisted of managed care enrollees reported at least some dissatisfaction with their ability to make the right medical care decisions for their patients; in contrast, only 14% of doctors with no managed care patients reported dissatisfaction on this score. *See* Karen Davis & Cathy Schoen, *Assuring Quality, Information, and Choice in Managed Care*, 35 INQUIRY 104, 104 (1998) (reporting findings of the 1997 Commonwealth Fund Survey of Physicians' Experiences with Managed Care).

75 *See, e.g.*, Walter A. Zelman, *Consumer Protection in Managed Care: Finding the Balance*, HEALTH AFF., Jan.-Feb. 1997, at 158, 159 (observing that fixed capitation payments from MCOs to physicians are "[p]articularly alarming" to consumers because "[s]uch arrangements encourage the perception that the incentive to reduce costs . . . is being transferred from the distant insurance company . . . to the physician's office").

76 *See, e.g.*, EPSTEIN, MORTAL PERIL, *supra* note 39, at 1-2 (describing the widely-accepted view of health care as a right); Alice Herb, *Market Model Fails for Health Care*, NEWS-GAZETTE (Champaign, Ill.), Aug. 9, 1998, at B3 (arguing that market approaches to health care are inappropriate because "[m]anaged care should be about taking care of people" and asserting that "[g]oing to the doctor is not the same as going to a car dealer").

77 *See, e.g.*, Debra E. Kuper, Comment, *Newborns' and Mothers' Health Protection Act: Putting the Brakes on Drive-Through Deliveries*, 80 MARQ. L. REV. 667 (1997) (arguing in favor of postpartum hospital stay mandates without any significant discussion of the costs of these mandates); Zelman, *supra* note 75, at 160 (arguing that "the anti-managed care critique tends to implicitly or explicitly idealize a now fading fee-for-service system in which . . . costs rose out of control").

sion's view of medical care: that the value of care is a scientific issue rather than an economic one, and that the provision of medical care should not be based on its value relative to other consumer goods.[78]

These criticisms have fueled the mid-1990s movement advocating the regulation of MCOs, which has become a cottage industry in virtually every state since the failure of President Clinton's proposal for global reform of the health care system in 1993. The specific features of managed care regulatory legislation vary from state to state, but the types of regulation can be divided into two categories. The first category comprises laws that govern the relationship between MCOs and health care providers. Specifically, these laws govern how MCOs may select, deselect, compensate, and control the physicians that they employ directly or contract with to provide medical care.

The most popular form of MCO-provider legislation is a restriction on so-called "gag clauses"—contractual provisions that prohibit physicians from criticizing the MCO or its utilization decisions to patients. According to a recent study, forty-five states and the District of Columbia have enacted laws that prohibit or limit the enforceability of such terms.[79] Legislation designed to limit selective contracting between MCOs and health care providers has also been popular. At least fourteen states have enacted comprehensive "any willing provider" laws, which require that MCOs admit into their networks all qualified health care providers who are willing to accept the MCO's terms and conditions.[80] At least seven states have enacted comprehensive "freedom-of-choice" laws, which require MCOs to reimburse customers for services received from providers who are not members of the MCO's network.[81] Many states have enacted legislation that limits the extent to which MCOs can hold physicians financially liable for a patient's utilization of resources or fail to renew a physician's contract based solely on the utilization of resources by that physician's patients.[82]

The second, and by far the larger, category of legislation comprises laws that regulate the relationship between MCOs and health

78 *See, e.g.*, HAVIGHURST, *supra* note 46, at 112-13 (describing the tenets of the "professional paradigm of medicine"); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 5 (1982) (pointing to the medical profession's "cultural authority, economic power, and political influence" to explain the wide acceptance of this view).

79 *See* FAMILIES USA FOUND., *supra* note 1, at 25. Congress is currently considering similar legislation. *See* Patient Right to Know Act, H.R. 586, 105th Cong. (1997) (banning gag clauses from managed-care-provider contracts).

80 *See* Jill A. Marsteller et al., *The Resurgence of Selective Contracting Restrictions*, 22 J. HEALTH POL., POL'Y & L. 1133, 1138-41, 1147, 1148 tbl.1 (1997).

81 *See id.* at 1138-42, 1147, 1148 tbl.1.

82 *See* FAMILIES USA FOUND., *supra* note 1, at 25 (reporting that 19 states have enacted legislation prohibiting plans from providing physicians with financial incentives to reduce or deny care).

care consumers. These laws, which I call "mandated-benefits" laws, are the primary focus of this Article. Some mandated-benefits laws concern whom MCOs must accept as customers, in an effort to prevent MCOs from discriminating against individuals who they fear will require more than their pro rata share of medical care. Most states have enacted legislation to limit the scope of preexisting-condition exclusions for new customers and to require MCOs to renew coverage for all of their customers who meet their payment obligations regardless of their health status.[83]

The majority of mandated-benefits laws specify benefits or coverages that MCOs doing business in a jurisdiction must provide to all of their customers. Most states have enacted laws requiring MCOs to permit forty-eight hour postpartum hospital stays,[84] and many have enacted similar minimum-stay requirements for mastectomy patients.[85] In addition, many states require MCOs either to give female patients access to an obstetrician-gynecologist ("OB-GYN") without a referral from a primary care physician or to permit OB-GYNs to serve as primary care physicians.[86] A smaller number require MCOs either to allow specialists to serve as primary care physicians for patients with chronic illnesses[87] or to permit "standing" referrals to specialists in such cases.[88]

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83 Twenty-eight states have enacted legislation to limit the scope of MCOs' preexisting-condition exclusions for new patients in the individual insurance market while all 50 have done so in the small group market. *See* Steve Lewis, *Individual & Small Group Reform*, HEALTH POL'Y TRACKING SERVICE (Nat'l Conference of State Legislatures, Wash., D.C.), Dec. 31, 1997. Thirty-eight states have enacted legislation to guarantee renewal in the individual insurance market while 49 have done so in the small group market. *See id.*; *see also, e.g.*, MASS. ANN. LAWS ch. 176J, § 5 (Law. Co-op. 1998) (providing that "[p]reexisting conditions shall not exclude coverage for a period beyond six months following the individual's effective date of coverage," and limiting the amount of time a carrier can "look back" to consider a condition as preexisting to six months).

84 Since 1995, 41 states have mandated coverage for extended postpartum hospital stays. *See* Molly Stauffer, *Inpatient Care After Childbirth*, HEALTH POL'Y TRACKING SERVICE (National Conference of State Legislatures, Wash., D.C.), Dec. 31, 1997. Colorado, Hawaii, Michigan, Mississippi, Nebraska, Utah, Vermont, Wisconsin, and Wyoming have not mandated such coverage; Hawaii and Mississippi lawmakers, however, introduced bills in 1997. *See id.*

85 Fourteen states have enacted legislation mandating minimum-stay requirements for mastectomy patients: Arkansas, Connecticut, Florida, Illinois, Maine, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, and Texas. *See* Molly Stauffer, *Mastectomies*, HEALTH POL'Y TRACKING SERVICE (Nat'l Conference of State Legislatures, Wash., D.C.), Dec. 31, 1997. New York was the first to enact such legislation, requiring every health insurance policy that provides inpatient hospital care to include inpatient hospital coverage for those who undergo a mastectomy or lymph node dissection for a length to be determined appropriate by the attending physician. *See* N.Y. INS. LAW § 4303 (McKinney, WESTLAW through L. 1999, ch. 6-13).

86 *See* FAMILIES USA FOUND., *supra* note 1, at 25 (citing 30 states).

87 *See id.* (citing 10 states).

88 *See id.* (citing 12 states). For an example, see CAL. HEALTH & SAFETY CODE § 1374.16 (West, WESTLAW through end of 1997-98 Reg. Sess. and 1st Ex. Sess.).

Some states require MCOs to provide coverage for mental health care or substance abuse rehabilitation, prenatal care, or outpatient surgery. Fewer require coverage for chiropractic treatment or hospice care. At least ten states now mandate that private insurers offer in-vitro fertilization as part of their standard plans.[89] Others require MCOs that cover prescription drugs to pay for prescription contraceptives[90] or for prescription drugs that are not part of the MCOs "formulary" (approved list of drugs) when the closest formulary drug is ineffective or causes adverse side effects in the patient.[91]

Some states specify circumstances under which MCOs must cover mammograms for young women,[92] autologous bone marrow transplants for cancer patients,[93] or participation in clinical trials.[94] At least thirty-one states have enacted legislation requiring MCOs to pay for emergency room visits for nonemergencies when symptoms would have caused a reasonable person to seek emergency care.[95] Some states require MCOs to provide some level of reimbursement for care a patient obtains outside of the MCO's network,[96] and others require MCOs to permit patients to continue to see their providers (with full coverage) for a specified transition period after the MCO terminates a provider from its network.[97] Recently, states have begun to mandate that patients who have had treatment denied by MCO utilization re-

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89 *See* Peter J. Neumann, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POL., POL'Y & L. 1215, 1215 (1997).

90 *See* FAMILIES USA FOUND., *supra* note 1, at 10-12.

91 *See id.* at 24 (citing 8 states).

92 Seven states—Alabama, Illinois, Maine, Montana, Ohio, Oregon, and Rhode Island—enacted laws in 1997 that mandated patient access to mammography. *See* ALA. CODE § 27-50-4 (WESTLAW through end of 1998 Reg. Sess.); 55 ILL. COMP. STAT. ANN. 5/5-1069 (West, WESTLAW through P.A. 91-6, apv. 5/28/1999); ME. REV. STAT. ANN. tit. 24, § 2320-A (West, WESTLAW through end of 1997 2d Sp. Sess.); MONT. CODE ANN. § 33-22-132 (WESTLAW through 1997 Reg. Sess.); OHIO REV. CODE ANN. § 1751.62 (Anderson, WESTLAW through 1999 portion of 123d G.A., Files 1 to 36, apv. 6/24/1999); OR. REV. STAT. § 743.727 (WESTLAW through end of 1997 Reg. Sess. and 1998 Cumulative Supp.); R.I. GEN. LAWS § 27-50-12 (WESTLAW through end of 1998 Reg. Sess.).

93 Six states—Arizona, Missouri, New Hampshire, New Jersey, Tennessee, and Virginia—enacted laws that mandate patient access to autologous bone marrow transplants specifically. *See* ARIZ. REV. STAT. ANN. § 36-2907 (West, WESTLAW through end of 1998 2d Reg. Sess. and the 6th Sp. Sess.); MO. ANN. STAT. § 376.1200 (West, WESTLAW through end of 1998 2d Reg. Sess.); N.H. REV. STAT. ANN. § 415:18-c (WESTLAW through end of 1998 Reg. Sess.); N.J. STAT. ANN. § 17:48-6f (West, WESTLAW through L 1999, c. 61); TENN. CODE ANN. § 56-7-2504 (WESTLAW through end of 1998 Reg. Sess.); VA. CODE ANN. § 38.2-3418.1:1 (Michie, WESTLAW through end of 1999 Reg. Sess.).

94 *See* GA. CODE ANN. § 33-24-59.1 (WESTLAW through 1999 Gen. Assembly); MD. CODE ANN., INS. § 15-827 (WESTLAW through end of 1998 Reg. Sess.); R.I. GEN. LAWS § 27-41-41.2 (WESTLAW through end of 1998 Reg. Sess.).

95 *See* FAMILIES USA FOUND., *supra* note 1, at 23.

96 *See* Marsteller et al., *supra* note 80, at 1139.

97 *See* FAMILIES USA FOUND., *supra* note 1, at 24 (citing 14 states). For an example of a state law that mandates continuation coverage, see CAL. HEALTH & SAFETY CODE § 1366.23 (West, WESTLAW through end of 1997-98 Reg. Sess. and 1st Ex. Sess.).

viewers be permitted to appeal the decision to an independent or government body that would have the power to order the MCO to fund the treatment.[98] Although this list covers the most prevalent and publicized mandated-benefits laws, it is far from complete.[99] A recent survey indicates that, in 1999, at least thirty-nine states planned to consider new legislation mandating specific minimum benefits levels.[100]

A widely known, but not widely understood, fact is that state managed care legislation protects only a minority of Americans enrolled in MCOs because of the preemptive effects of the Employee Retirement Income Security Act (ERISA).[101] In an effort to free multistate employers from inconsistent state regulations, ERISA preempts all state laws that "relate to" benefits that employers provide as part of qualifying employee benefit plans.[102] At the same time, ERISA does not preempt any state law that "regulates insurance."[103]

The United States Supreme Court has attempted to chart a course between these two somewhat conflicting principles by ruling that ERISA protects health care benefits from state regulation if they are "self-funded" by the employer, but not if a third-party provider pays for them.[104] In other words, if an employer purchases health insurance policies for its employees, that insurance coverage is subject to state regulation, but if an employer pays all of its employees' medical care costs, the medical coverage is exempt from state regulation. Although only the largest employers could shoulder the risks of uninsured employee illnesses, even small employers can achieve "self-funded" status by paying the full costs of employee medical care (usually paying MCOs to provide the care) and concurrently purchasing "stop-loss" insurance for costs that they incur above a certain level.

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98 *See* FAMILIES USA FOUND., *supra* note 1, at 25 (citing 14 states). For examples of such state laws, see MD. CODE ANN., HEALTH-GEN. I. § 19-1305.2 (WESTLAW through end of 1998 Reg. Sess.); N.Y. PUB. HEALTH LAW § 4904 (McKinney, WESTLAW through L. 1999, chs. 6-13); and VT. STAT. ANN. tit. 8, § 4089(f) (WESTLAW through end of 1997 Adj. Sess.).

99 *See, e.g.*, MD. CODE ANN., INS. § 15-818 (WESTLAW through end of 1998 Reg. Sess.) (mandating coverage for cleft lip and cleft palate treatments); MO. ANN. STAT. § 354.207 (West, WESTLAW through end of 1998 2d Reg. Sess.) (requiring MCOs to pay for second opinions for patients diagnosed with serious conditions).

100 *See Managed Care*, *supra* note 5, at 1996.

101 *See* 29 U.S.C. § 1001 (1994 & Supp. III 1997).

102 *Id.* § 1144(a); *see also* FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990) ("The preemption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern that subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." (alteration in original)).

103 29 U.S.C. § 1144(b)(2)(A).

104 *See FMC Corp.*, 498 U.S. at 61; *see also* 29 U.S.C. § 1144(b)(2)(B) ("[A]n employee benefit plan . . . shall [not] be deemed . . . to be engaged in the business of insurance . . . .").

The loophole in the system is that no federal standard exists for what constitutes the purchase of primary insurance—making employer-provided insurance subject to state insurance regulation—on the one hand, and what constitutes the purchase of "stop-loss" coverage by a "self-insured" employer on the other. The result is that, rather than purchasing insurance for their employees (which would be subject to state benefit mandates), employers can achieve self-funded status without incurring substantially greater risk by paying employees' health care costs directly and purchasing stop-loss coverage that attaches at very low levels of loss.[105] Consequently, the hundreds of state-implemented managed care protections do not affect individuals whose employers adopt this strategy.[106]

The effect of ERISA preemption on benefit mandates is, therefore, quite significant today, but will likely become less so in the near future. With polls showing that up to three quarters of Americans favor increased regulation of MCOs,[107] the federal government is demonstrating an increasing interest in enacting mandated-benefits laws.[108]

In 1996, Congress enacted HIPAA, which placed strict limitations on the extent to which MCOs can exclude preexisting conditions from coverage and choose not to renew the policies of customers who

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105 *See* American Med. Sec., Inc. v. Bartlett, 111 F.3d 358 (4th Cir. 1997) (determining that ERISA preempted an attempt by the Maryland legislature to set a minimum threshold at which it would not consider a self-funded employer's stop-loss insurance policy to be the purchase of insurance and thereby subject to state regulation).

106 The extent to which ERISA protects from state legislative and judicial oversight utilization-review decisions by MCOs that administer self-funded health benefits plans remains somewhat unclear. A utilization reviewer's decision that the health plan never covers a certain type of benefit is clearly preempted. However, ERISA might not preempt a utilization reviewer's decision that the patient's medical circumstances do not warrant coverage for a particular type of treatment, because the decision concerns the quality, rather than the quantity, of care provided. *See, e.g.*, Long v. Great W. Life & Annuity Ins. Co., 957 P.2d 823, 832 (Wyo. 1998); *see also DOL Opposes Malpractice Preemption; Legislative Response Appears Unclear*, 6 Health L. Rep. (BNA) No. 14, at 503 (Apr. 3, 1997) (reporting that the U.S. Department of Labor supports this distinction).

107 A Wall Street Journal-NBC News poll conducted in July 1998 showed that 79% of Americans favored new laws to regulate managed care. *See* Robert Keatley, *A Special Weekly Report from the Wall Street Journal's Capital Bureau*, WALL ST. J., July 31, 1998, at A1. Meanwhile, a 1998 Washington Post-ABC News poll showed that 60% of Americans favored "tougher government regulation of managed care programs." Terry M. Neal & Caroline Daniel, *In Kenosha, Most Voters Have an HMO Story*, WASH. POST, July 19, 1998, at A7. A 1998 Henry J. Kaiser Foundation-Harvard University survey found that 78% of Americans favored a "patient protection law in general" to protect consumers of managed care, although that number declined to 40% if insurance premiums would rise by $200 per year or more as a result. *Clinton Calls for Patients' Rights Bill; Public Anxiety About Health Care Grows*, 7 Health L. Rep. (BNA) No. 38, at 1499 (Sept. 24, 1998).

108 ERISA does not preempt federal legislation, which would consequently affect all Americans enrolled in MCOs.

become ill.[109] In 1997, Congress followed the lead of most states and enacted a mandatory minimum postpartum hospital stay of forty-eight hours for natural births and ninety-six hours for Caesarean-section births.[110] In 1998 and 1999, Democrats and Republicans in both houses of Congress championed different versions of a patients' bill of rights.[111] If enacted into law, any of the competing proposals would mandate a host of new health care benefits for MCO customers. Such a bill of rights would likely include guaranteed coverage for visits to emergency rooms and the right to some level of reimbursement for visits to out-of-network physicians.[112] Separate proposals that Congress is currently considering include a mandatory minimum hospital stay following mastectomies[113] and mandatory coverage of prescription contraceptives.[114]

C. The Case for Freedom of Contract

Academic opposition to government regulation of MCOs is spearheaded by analysts who believe that private contracting between MCOs and customers, unimpeded by government regulation, provides the most promising avenue for rationalizing the amount of resources the United States devotes to medical care. In a recent article, Patricia Danzon succinctly stated the basic free-market argument:

> In the managed care marketplace, if plans compete on price, choice, and quality, they have incentives to cover services that yield expected health benefits that are worth their costs to consumers. Patients who want comprehensive coverage can choose high premium plans.
>
> . . . .
>
> . . . Consumers self-select to different types of health plan [sic], based on their preferences for cost, coverage, copayment, prompt access to new technologies, restrictions on choice, and so forth.

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109 *See* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, §§ 701, 703, 110 Stat. 1936, 1939-45, 1946.

110 *See* 26 U.S.C. § 9811 (Supp. III 1997).

111 *See supra* note 11.

112 For examples of bills discussing coverage of visits to emergency rooms, see S. 2330, § 721, H.R. 4250, § 1001; S. 1891, § 101; and S. 644, § 2771(B). For bills discussing some coverage for visits to out-of-network providers, see S. 2330, § 725; S. 1891, § 105; and S. 644, § 2772. For bills discussing access to specialty care, see H.R. 4250, § 1001 and S. 1891, § 104.

113 *See* Women's Health and Cancer Rights Act of 1997, S. 249, 105th Cong.; Breast Cancer Patient Protection Act of 1997, S. 143, 105th Cong. President Clinton actually called for the enactment of such a bill in his 1997 State of the Union Address. *See President Clinton's Message to Congress on the State of the Union*, N.Y. TIMES, Feb. 5, 1997, at A20.

114 *See* Equity in Prescription Insurance and Contraceptive Coverage Act of 1997, S. 766, 105th Cong.

> Thus consumers' choices among health plans reflect their preferences and willingness-to-pay . . . .[115]

From this perspective, the market for health care in the era of managed care allocates the appropriate amount of resources—more or less—to health care.[116] If MCOs systematically provide reduced benefits and services at relatively low cost, then consumers must prefer such a package.[117] The popularity of managed care means that "[c]onsumers have voted with their feet for cheaper (more restrictive) health care coverage, and their ex post complaints about the same do not change that fact."[118]

Mandating benefits, on the other hand, effectively forces consumers to pay for insurance that they do not want or to go without any coverage at all.[119] The alignment of consumer preferences and the features of their managed care plans is imperfect, of course, because there can never be a sufficiently diverse menu of plans to suit the tastes of every eccentric individual. Nevertheless, the variety of choices that the market provides to consumers allows each individual to select a plan that is approximately utility-maximizing.[120] If groups of consumers have preferences that are not served by the products offered by MCOs, entrepreneurial competitors can be counted on to introduce new products to the benefit of those consumers.[121] Accord-

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115 Danzon, *supra* note 14, at 509, 511.

116 *See id.* at 492 ("The growing market share of various types of managed care plans is compelling evidence that a significant fraction of consumers are willing to forgo some choice in return for the lower premium and lower out-of-pocket payments that managed care can offer."). Danzon also notes that "[t]he fact that consumers increasingly select plans that employ capitation and [utilization review] controls indicates that consumers are willing to accept such techniques for controlling overuse of insured services, in preference to either higher premiums or higher copayments." *Id.* at 511.

117 *See* EPSTEIN, MORTAL PERIL, *supra* note 39, at 429; *cf.* Frank H. Easterbrook, *Cyberspace and the Law of the Horse*, 1996 U. CHI. LEGAL F. 207, 215 ("'Better' terms (as buyers see things) support higher prices, and sellers have as much reason to offer the terms consumers prefer (that is, the terms that consumers find cost-justified) as to offer any other ingredient of their products."); Hyman, *supra* note 28, at 437 ("Policy sellers must weigh whether broadening coverage . . . [is] worth doing if [it] price[s] the policy out of the market—or result[s] in a shift in the nature of coverage from that which is most appealing to the covered pool as a whole.").

118 Hyman, *supra* note 28, at 447.

119 *See, e.g.*, HALL, *supra* note 39, at 22 (calling state law mandates an important source of inefficiency in the insurance system). Hall notes that "[e]conomists explain that it usually makes no sense to mandate or encourage insurance that many consumers are unwilling to buy." *Id.* at 24.

120 *Cf.* Don Bellante & Philip K. Porter, *A Subjectivist Economic Analysis of Government-Mandated Employee Benefits*, 13 HARV. J.L. & PUB. POL'Y 657, 661 (1990) (stating a similar argument for the approximate efficiency of employee-benefit packages that employers offer).

121 *See* Moran, *supra* note 45, at 14 ("Based on our experience in most other markets, we might expect competing health plans to view consumer dissatisfaction as a business opportunity to be exploited with new products and programs aimed directly at the concerns of disgruntled buyers."); *cf.* Rice, *supra* note 40, at 401 (explaining that economic

ing to free-market advocates, legislatively mandated benefits can only decrease social utility and are therefore unwarranted.[122]

One need not be so sanguine about the present efficiency of the market, however, to oppose regulation of the health care industry. Clark Havighurst has provided the most thorough and thoughtful argument in favor of unencumbered private contracting for medical care.[123] Havighurst believes that, notwithstanding the cost-containment strategies of MCOs, the United States continues to inefficiently overallocate resources to medical care.[124] The primary reason for this overallocation (other than the tax subsidy accompanying employer-provided health coverage[125]), Havighurst contends, is that the available selection of health care plans consists only of homogenous, high-cost, "Cadillac" options.[126]

Why do MCOs fail to offer low-cost, low-service health insurance packages when a significant portion of the population wishes to spend less of its income on medical care? According to Havighurst, they are hamstrung by (1) vague contracts with patients and (2) courts that prevent MCOs from denying very expensive and only marginally beneficial care by holding MCOs that do deny such care liable for breach of contract and their physicians liable for malpractice.[127] To this

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theory predicts supply will adjust in reaction to consumer demand). Two other authors make a similar argument:

> [I]t is the disequilibrium that prevails in markets that creates the discrepancies . . . that give rise to opportunities for gains from trade. . . . Competition is the process that brings forth the discovery of potential gains from trade, and the entrepreneur is the prime catalyst in this discovery process. The entrepreneur's alertness to previously unexploited opportunities is the essence of the process of value production.

Bellante & Porter, *supra* note 120, at 663.

122 *See* EPSTEIN, MORTAL PERIL, *supra* note 39, at 431.

123 *See* HAVIGHURST, *supra* note 46, *passim*; Clark C. Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. 47, *passim* (1994); Havighurst, *supra* note 39, *passim*; Clark C. Havighurst, *"Putting Patients First": Promise or Smoke Screen?*, HEALTH AFF., Nov.-Dec. 1997, at 123.

124 *See* HAVIGHURST, *supra* note 46, at 1, 147.

125 *See* HALL, *supra* note 39, at 20 ("Economists convincingly point to the tax laws as the main culprit for excessive levels of health insurance."); HAVIGHURST, *supra* note 46, at 100-03 (explaining that the preferential tax treatment of employer-sponsored health plans provides employees with the incentive to overconsume medical care relative to other goods).

126 *See* HAVIGHURST, *supra* note 46, at 104. He notes:

> There is at least some factual support, however, for the hypothesis that the U.S. health care system offers only a kind of Hobson's choice, requiring consumers either to purchase some version of a health care Cadillac or to take their chances with the safety net that more or less exists for those without health insurance.

Id.

127 *See id.* at 145, 321-22. Havighurst explains that "payers do not yet have clear contractual authority from consumers to withhold financing . . . where beneficial care must be forgone if consumers' resources are to be saved for more advantageous uses." *Id.* at 145. He adds that "providers [in MCOs] face possible legal liability if they depart from the costly practice standards customary in the insured-fee-for-service sector." *Id.* at 148. Additionally,

point, it might be added that MCOs are increasingly hamstrung by the new benefit mandates, which effectively prohibit MCOs from offering more restricted insurance plans at lower prices.[128] Havighurst would rationalize the provision of health care services by encouraging competing health plans to offer substantively different types and levels of medical care, and by permitting consumers to choose the level at which the expected marginal benefit of the care they receive most closely approximates the marginal cost of the plan.[129]

Several critical assumptions undergird the claim that the unregulated market can produce an efficient amount of health care. First, the claim assumes that MCOs engage in some meaningful form of competition for patients. The validity of this assumption undoubtedly varies across different regions of the country, but the assumption probably holds true in many locations,[130] so I will accept it *arguendo* for the purpose of this Article.

Second, the claim assumes away possible market distortions arising out of the principal-agent relationship between health care consumers and the employers that make many of the purchasing decisions for them. Most privately-insured Americans receive health care coverage through their employers.[131] For virtually all of these consumers, choice is limited to the plans the employers choose to offer. Nearly half of these consumers have only one plan offered by

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Havighurst asserts that "without better, enforceable contracts expressly authorizing aggressive economizing in pursuit of efficiency in the no man's land of benefit-cost trade-offs, health plans could undertake such economizing only at their (and their providers') legal peril." *Id.* at 152.

128 *See id.* at 32 (describing the limiting impact mandated benefits have on private contracting choices).

129 *See id.* at 2 ("[C]onsumer choices must be consequential, not inconsequential, and . . . freedom of contract is necessary to make them so."); *see also* HALL, *supra* note 39, at 24 (describing consumer contracts for medical care that would be provided "only where both need and potential benefit are compelling or demonstrably clear" as a "measured way" to limit insurance).

130 A recent report found that in California, for example, most areas of the state were home to between five and ten HMOs in 1998. *See* John Bertko & Sandra Hunt, *Case Study: The Health Insurance Plan of California*, 35 INQUIRY 148, 148 (1998). The prevalence of mergers in the managed care industry, however, may make the assumption of significant competition less tenable in more locations in the future. *See* Trish Riley, *The Role of States in Accountability for Quality*, HEALTH AFF., May-June 1997, at 41, 42 (arguing that mergers restrict consumer choice). One study estimates that perhaps as many as 37% of Americans live in areas where fewer than three HMOs are likely to be efficient. *See* Richard Kronick et al., *The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition*, 328 NEW ENG. J. MED. 148, 150 (1993). A recent report finds that "frenetic merger and acquisition activity" has reduced the number of "dominant HMO competitors" in Boston and Minneapolis-St. Paul each to three. Michael H. Bailit, *Ominous Signs aud Portents: A Purchaser's View of Health Care Market Trends*, HEALTH AFF., Nov.-Dec. 1997, at 85, 86.

131 According to one study conducted in 1996, 90.3% of privately insured Americans received their health care coverage from their employer. *See* Melinda L. Schriver & Grace-Marie Arnett, *Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations*, HERITAGE FOUND. BACKGROUNDER, Aug. 11, 1998, at 1, 7 tbl.2.

their employers,[132] effectively leaving them with no choice at all. For the market to operate efficiently, employers must select health care plans that their employees would select on their own, at least most of the time. If employers select less-expensive, more limited health plans than employees would choose themselves if they had complete purchasing autonomy but had to pay the full cost of the coverage, the market might currently provide an inefficiently low level of coverage—one that benefits mandates could remedy.

Employers that act as health insurance purchasers most likely are not perfect agents for their employees, acting without any taint of self interest.[133] But the extent to which the interests of employers affect the scope of health care benefits that the market provides is far from clear. Approximately half of the employees who receive health care coverage through their employers do have a choice between two or more plans,[134] and 85% of workers in firms of 200 or more employees have such a choice.[135] Consequently, in most cases health plans must design benefits packages to appeal to consumers, not just to purchasing intermediaries.[136]

In addition, even employers who make health insurance purchase decisions for their employees have a strong incentive to select products employees themselves would choose. Employers compete with one another to hire and retain employees. Presumably, after determining how many dollars they are willing to expend on an employee, employers maximize their interests by providing the combination of salary and benefits (including health insurance) that maximizes the

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132 *See* Etheredge et al., *supra* note 24, at 94 (asserting that 48% of employees who receive health insurance through their employers have only a single plan available).

133 Substantial survey evidence exists which suggests that employers are extremely sensitive to price when choosing among health plans. *See, e.g.*, ZELMAN & BERENSON, *supra* note 14, at 139-40 (reviewing several surveys). This evidence alone, of course, does not prove that employers universally fail to make the trade-offs between price and quality that their employees would desire.

134 *See* Etheredge et al., *supra* note 24, at 94 (noting that only 48% of employees have a single option); Stephen L. Isaacs, *Consumers' Information Needs: Results of a National Survey*, HEALTH AFF., Winter 1996, at 31, 40 n.2 (citing a survey that showed that 45% of employees had at least two health plan options in 1994); Jensen et al., *supra* note 20, at 127 (finding that in 1995, 62% of insured employees had at least two health plan options).

135 *See* Kelly A. Hunt et al., *Paying More Twice: When Employers Subsidize Higher-Cost Health Plans*, HEALTH AFF., Nov.-Dec. 1997, at 150, 153 (reporting that only 15% of employees in large firms had only one health care plan option).

136 Among small employers—those most likely to offer only a single health plan to their employees—the trend appears to be toward participation in larger insurance purchasing cooperatives that offer participating employees a variety of health insurance options from which to choose. *See, e.g.*, Elizabeth W. Hoy et al., *A Guide to Facilitating Consumer Choice*, HEALTH AFF., Winter 1996, at 9, 17 (describing the operation of the Health Insurance Plan of California (HIPC), a government-organized purchasing cooperative that offers 25 managed care plans to its participants, although not all are available state-wide).

employee's utility.[137] If an employer provides a health plan with more coverage than is optimal for its employees, it will suffer a competitive disadvantage relative to competitors that offer less (and presumably cheaper) health care coverage and a consequently greater salary.[138] In contrast, if an employer provides a health plan with suboptimal coverage, it could improve its competitive position by providing more extensive (and presumably more expensive) coverage and a correspondingly lower salary.[139]

Because of the uncertainty regarding the extent to which employers seek to satisfy their own interests—rather than those of the employees they represent—when making health insurance purchasing decisions, I will accept *arguendo* as well, for purposes of this Article, the assumption of free-market advocates that employers attempt to purchase the same level of insurance benefits for their employees that the employees would choose to purchase on their own.

Third, the free-market claim implicitly assumes that (a) consumers possess perfect information about their consumption choices and (b) are able to process that information flawlessly and costlessly.[140] Parts II and III of this Article will contest these assumptions, and thus challenge the conventional economic wisdom that an unregulated health insurance market will lead to an efficient allocation of resources between health care and competing goods. These Parts explain not only the fundamental flaws in these assumptions regarding the market for health insurance, but also the consequence of the failure of these assumptions: the allocation of too few resources to health care. Part IV then considers the likely efficacy of possible efficiency-enhancing interventions in the market.

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137 *See* Lawrence H. Summers, *Some Simple Economics of Mandated Benefits*, 79 AM. ECON. REV. 177, 178 (1989) (noting that, in a competitive equilibrium, employers will provide health care benefits by reducing an employee's salary if the value of the benefit to the employee exceeds the cost of the benefit to the employer).

138 For example, one small employer explained that he stopped providing health insurance for his employees because, although the employer paid 50% of the cost of coverage, employees complained that they would rather go without care than have half the cost deducted from their paychecks. *See* Robert Pear, *Government Lags in Steps to Widen Health Coverage*, N.Y. TIMES, Aug. 9, 1998, at A1. Moreover, a recent study has shown that over the last decade, more employees are declining employer-provided health insurance. *See* Philip F. Cooper & Barbara Steinberg Schone, *More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996*, HEALTH AFF., Nov.-Dec. 1997, at 142, 144 (suggesting that some employers are offering more coverage than what their employees want).

139 *Cf.* Etheredge et al., *supra* note 24, at 94 (noting that while the desire to control costs has led employers away from traditional fee-for-service insurance, the desire to please workers is driving employers away from closed-panel HMOs and toward MCOs with more provider flexibility).

140 *See* Claude S. Colantoni et al., *Imperfect Consumers and Welfare Comparisons of Policies Concerning Information and Regulation*, 7 BELL J. ECON. 602, 602-03 (1976).

II
INCOMPLETE CONTRACTS AND STRATEGIC INCENTIVES

A. Health Benefits as Search, Experience, or Credence Goods

It is possible to classify all health care benefits as "search," "experience," or "credence" goods[141]—a distinction that will bear on the analysis of the conditions under which the free market can reliably provide an efficient level of benefits. Search goods are those which consumers can evaluate at a reasonable cost prior to purchase; experience goods require purchase and use before consumers can assess their characteristics; and credence goods are those whose quality cannot be assessed by the ordinary consumer even after use.[142] For example, articles of clothing tend to be search goods; customers inspect and try them on before purchasing them. Canned tuna fish, on the other hand, is an experience good; consumers normally compare brands of tuna fish by purchasing and consuming them.[143] Legal representation is a credence good for all but the most sophisticated consumers; even after trial, a client usually has a difficult time assessing the quality of his representation.

Health care benefits can be described as search goods only if consumers can learn precisely whether a given MCO does or does not provide benefits in question before making their enrollment decisions. Most benefits mandates concern such benefits. For example, before selecting a health care plan, a consumer can investigate and learn with certainty whether a particular MCO permits women to see an OB-GYN without prior referral from a primary care physician.

Many health care benefits, however, are experience goods, because it is quite difficult or even impossible for an MCO to specify at the time of enrollment what benefits it will or will not provide in the case of innumerable contingencies. The treatment that an MCO will provide to treat a certain type of cancer, for example, is an experience good because the precise treatment any patient receives will almost certainly depend on a variety of factors. These factors might include the presentation of the disease in the particular patient and the state of research on cancer treatments at the time of diagnosis. Consider, for example, the story of one woman who was told by five of the six HMOs she contacted that they could not predict in advance whether she would be able to continue her current breast cancer treatment if

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141 *See* Phillip Nelson, *Information and Consumer Behavior*, 78 J. POL. ECON. 311 *passim* (1970) (describing and contrasting search and experience goods); Alan Schwartz & Louis L. Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630, 658 & n.69, 659 (1979) (describing search, experience, and credence goods).

142 *See* Schwartz & Wilde, *supra* note 141, at 658 & n.69, 659.

143 *See* Nelson, *supra* note 141, at 312 (providing this example).

she enrolled in their plans.[144] It would be unduly costly, and perhaps impossible, for an MCO to specify ex ante what treatment it will provide in every possible set of circumstances that a cancer patient might face. Consequently, regardless of how diligently a health care consumer might investigate and compare health plan options before enrolling, she most likely could not learn whether, given a particular contingency, an MCO would provide her with a specific treatment benefit until she experienced that condition while under the MCO's care.

This analysis is further complicated by the fact that most patients who would like to know the circumstances under which an MCO would provide a certain benefit are not interested in the specific benefit as such. Presumably, the information customers really desire is the extent to which the MCO provides its patients with the most beneficial care regardless of cost, and, conversely, the extent to which the MCO limits costly, but only marginally beneficial, care. To the extent a consumer wishes to learn the MCO's algorithm for making these cost-quality trade offs, an MCO's treatment for, say, cancer might be a credence rather than an experience good. Even after receiving the treatment, the patient might have no way to assess adequately its quality.

The distinction among search, experience, and credence benefits impacts any analysis of the efficiency of mandated benefits legislation. This Part argues that MCOs have a strategic incentive to provide an inefficiently low level of experience and credence benefits, because consumers must select an MCO prior to learning the true quality of the benefits provided and because MCOs are not likely to be concerned with losing customers who later learn that they provide low-quality benefits. Thus, this Part, standing alone, suggests that mandates might be appropriate for benefits that are experience or credence goods. It does not, however, demonstrate any failure by the free market to provide the efficient level of search benefits—benefits about which consumers can receive full information before enrolling in an MCO.

Part III expands the scope of the analysis. It contends that consumers are likely to behave in a "boundedly rational" manner when making health care purchasing decisions. If this characterization of consumer behavior is true, MCOs might provide an inefficiently low level of all benefits—even benefits that are search goods—suggesting that mandates for all types of benefits might be efficient under some conditions.

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144 *See* Susan C. Rosenfeld, *So You Want to Join an H.M.O.? Good Luck*, N.Y. TIMES, Aug. 9, 1994, at A23.

B. The Problem of Incomplete Contracts

All but the simplest contracts are "obligationally incomplete": the terms of the contract do not specify the obligations of each party under every set of contingent facts.[145] This malady, endemic to private contracting, is especially severe in the context of consumer medical insurance contracts. When a consumer selects a plan, she enters into a contract that fully enumerates her obligations (usually consisting of the payment of a premium, either individually, or through her employer), but that fails to fully specify the plan's obligations. The complexity of health care dictates this situation.

With the exception of preventive care measures, virtually all services that the health plan might promise to provide the customer are contingent on future events, most of which are unlikely to occur for any given customer. A given course of medical treatment is necessarily specific to the particular illness or injury in question, and the precise type of treatment is also contingent on the patient's specific symptoms and condition. Consequently, the MCO can specify in a contract with a consumer which broad categories of treatment it is promising to provide (or to pay a physician to provide)—i.e., whether dental benefits or prescription drugs are covered—but it is both physically impractical and theoretically impossible for the MCO to specify fully what treatments it will provide. It is physically impractical because the MCO could not reasonably print the number of permutations in a contract.[146] It is theoretically impossible because the fast pace of change in medical technology and knowledge can mean that treatments considered appropriate for a set of symptoms on the date the customer enrolls with the MCO might not be appropriate when the customer later develops those symptoms.

Consider, for example, a patient who wishes to know whether her MCO will pay for an expensive magnetic-resonance-imaging (MRI) scan to rule out the presence of a brain tumor if she complains to her physician of headaches. Because the answer would most likely depend on the type, severity, and frequency of pain, as well as the age, medical, and family history of the patient, it would be impractical for the

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145 *See, e.g.*, Ian Ayres & Robert Gertner, *Strategic Contractual Inefficiency and the Optimal Choice of Legal Rules*, 101 YALE L.J. 729, 730 (1992) ("Legal scholars use the term 'incomplete contracting' to refer to contracts in which the obligations are not fully specified. . . . A contract that failed to specify the seller's obligations in the event of a flood . . . would thus be obligationally incomplete.").

146 *Cf.* Susan D. Goold, *Allocating Health Care: Cost-Utility Analysis, Informed Democratic Decision Making, or the Veil of Ignoranee?*, 21 J. HEALTH POL., POL'Y & L. 69, 74-75 (1996) ("The arguments against relying solely on prior consent to actual rationing policies are primarily practical. The amount of information needed by consumers would be extremely large if we were to claim that they are truly informed about all potential situations when care might be withheld.").

MCO to specify ex ante, by contract, the circumstances under which it would authorize the procedure. Alternatively, consider the actual case of a patient whose colon cancer was not discovered in a timely fashion because, when she complained to her doctor of abdominal and pelvic pain and rectal bleeding, the doctor ordered an ultrasound exam, which failed to detect the cancer, but failed to order a barium-enema x-ray, which would have detected the cancer.[147] Because the propriety of a particular diagnostic test depends on an intense factual inquiry into the patient's precise condition, it would be unrealistic for the patient to hope that she would be able to determine whether her MCO would approve the test by referring to her insurance contract or enrollment materials. Consider also a woman whose MCO agreed to pay for part-time home-nursing care, but not hospitalization during her high-risk pregnancy.[148] Her fetus went into distress and died while the nurse was absent.[149] No MCO could have possibly specified ex ante whether it would or would not approve hospitalization in that precise factual situation.

As a result, rather than attempting the impossible task of specifying ex ante what treatments they will provide under what conditions, MCOs rely on vague promises that they will provide all "medically necessary" or "reasonable and necessary" treatments.[150] Such overbroad terms can perhaps provide guidance in divining contractual obligations in extreme circumstances. For example, they might support an MCO's denial of a particular treatment when the treatment would not provide any medical benefit or would provide no more benefit than a less expensive treatment. But they provide virtually no guidance as to the MCO's obligations in the more common cases in which a particular treatment offers some marginal benefit but at a high marginal cost.[151] Has an MCO that contracts to provide all "medically necessary" treatment promised to pay for an MRI scan that will be instrumental in detecting a brain tumor one time in a million? What if the scan would detect a tumor one time in ten thousand? The problem

147 *See* Greely, *supra* note 19, at 75-76 (describing the story of this patient, Joyce Ching); David R. Olmos, *Cutting Medical Costs—or Corners?*, L.A. TIMES, May 5, 1995, at A1 (same); Michael Parrish, *It Could Happen to You*, HEALTH, May-June 1996, at 115 (same).

148 *See* Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1322-24 (5th Cir. 1992).

149 *See id.*

150 *See* Hirshfeld & Thomason, *supra* note 23, at 4 (describing how coverage decisions often influence medical decisions).

151 In the real world, few situations exist in which medical science is precise enough to determine exactly which treatments will provide no benefit whatsoever to the patient. When an MCO determines that a treatment is unnecessary, it is usually making an implicit cost-benefit determination. *See id.* at 22-23 ("[M]edical decisions involve a substantial amount of uncertainty about what will help and what may actually harm a patient. When health plans make or influence necessity determinations, they are engaged in making value judgments that weigh the interests of the individual against the group.").

for consumers is that they do not and will not know the answers to these questions until they seek treatment for a specific set of symptoms.[152]

Just as MCOs usually promise to provide care that is medically necessary, they typically exclude coverage for treatments that are "experimental."[153] Like medically necessary treatments, the definition of experimental treatment is subject to differing interpretations and is difficult to define ex ante.[154] A study of insurance company responses to patient requests between 1989 and 1992 for coverage for autologous bone marrow transplants to treat breast cancer illustrates the wide variance in health insurance plans' understanding of the term "experimental."[155] The plans approved approximately three quarters of the 533 requests studied and denied the other one quarter, usually on the basis of the plan's determination that the treatment was experimental.[156] Notably, the requested and denied claims did not appear to differ in terms of the patients' clinical characteristics or the contractual language at issue.[157]

The problem of severe and asymmetrical contractual incompleteness in contracts between MCOs and consumers—no doubt an unavoidable result of the enterprise's complexity—creates a powerful incentive for profit-maximizing MCOs to provide an inefficiently low amount and quality of care. An analytical framework borrowed from game theory—what I will call the "managed care game"—can help illustrate why this is true.

C. The Managed Care Game

1. *Two Players, One Decision*

Assume, for the first step of the analysis, a game with two players, each of whom must make a single decision. The players are a consumer who wishes to purchase insurance that will cover the costs of treatment of a possible future ailment or condition ("Condition X"), and an MCO that markets a health plan that provides care for this condition. The consumer has two choices: he may (1) choose

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152 *Cf. id.* at 25 ("Each plan has substantial latitude for how it defines necessity, and different plans proceed in varying ways.").

153 *See* Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055, 1056 (1996).

154 *See* Havighurst, *supra* note 39, at 1769 ("Almost by definition, an experimental procedure cannot be precisely identified in advance for the purpose of unambiguously excluding it from the contract.").

155 *See* William P. Peters & Mark C. Rogers, *Variation in Approval by Insurance Companies of Coverage for Autologous Bone Marrow Transplantation for Breast Cancer*, 330 NEW ENG. J. MED. 473, 473 (1994).

156 *See id.* at 474.

157 *See id.* at 475.

"MCO"—enroll in the MCO's health plan—for which he must pay a fixed monthly premium, or (2) choose "not-MCO"—take his business to a competing plan. The MCO likewise faces two choices: it may (1) choose to provide "expensive" care for Condition X or (2) provide "cheap" care for the same condition. For example, if Condition X is pregnancy, "expensive" care might involve providing a new mother with a forty-eight hour postpartum hospital stay, and "cheap" care might require the mother's discharge from the hospital within twenty-four hours after delivery. If Condition X is instead a form of cancer, "expensive" care might include coverage for an autologous bone marrow transplant when other treatments have proven unsuccessful, whereas "cheap" care might exclude this benefit.

Each player in the managed care game—customer and MCO—receives a payoff, representing its gains or losses from the relationship. This payoff depends on both players' strategy choices. If the customer selects "not-MCO," each player receives a neutral payoff of zero dollars; each player neither gains nor loses from the relationship because no relationship is consummated. If the customer chooses "MCO" and the MCO chooses "expensive" care, both parties enjoy a gain from the transaction. The MCO incurs a relatively high expected cost—it may or may not ever have to provide the service to this patient—by promising the expensive benefit, but it still earns a net expected profit from the customer's enrollment. If the customer ever develops the necessary condition, he receives the expensive benefit he desires. If the customer chooses "MCO" and the MCO chooses "cheap" care, the customer loses from the transaction because the MCO provides a lower level of care. Although "cheap" care is likely to be better for the customer than no care, the payoff is negative because of the opportunity cost: the customer who joins an MCO that provides cheap care loses the opportunity to join another MCO. The MCO, however, receives a large windfall in this situation. It captures the customer's monthly premium without having to bear the cost of providing the expensive care and is therefore better off than it would have been had it chosen to provide expensive care.

Figure 1 shows the various choices and payoffs of the game in what is known in the language of game theory as the "normal form" depiction of the game.[158] The customer's strategy choices are displayed along the left side of the matrix, the MCO's strategy choices are displayed along the top of the matrix, and the payoffs of the customer and the MCO are displayed for each of the four possible combinations of strategies. To summarize the payoffs of the game, the MCO maximizes its income if the customer chooses "MCO" while it chooses

158 For an introduction to the concept of a normal-form game, see generally DOUGLAS G. BAIRD ET AL., GAME THEORY AND THE LAW 6-49 (1994).

to provide "cheap" benefits; the customer maximizes his utility if he chooses "MCO" and the MCO chooses "expensive" benefits.

FIGURE 1

		MCO: Expensive Care	MCO: Cheap Care
CUSTOMER	MCO	+, +	–, ++
	not-MCO	0, 0	0, 0

Payoffs: Customer, MCO

If the players in the managed care game select their strategies simultaneously or without knowledge of each other's strategy choice, and both players behave rationally (that is, maximize their payoffs), we can predict that the MCO would choose to provide "cheap" care and that the customer would choose "not-MCO." This result occurs because the customer should realize that if he selects "MCO," the MCO is better off selecting "cheap" coverage (++ vs. +), and that if he selects "not-MCO," the MCO is indifferent between its two choices (0 vs. 0). Given these possible payoffs, the MCO should select "cheap" coverage.[159] Knowing that the MCO will best serve its interests by providing "cheap" coverage, the customer will best serve her interests by selecting "not-MCO," because her resulting payoff of zero is preferable to the negative payoff that she would receive if she were to select "MCO."

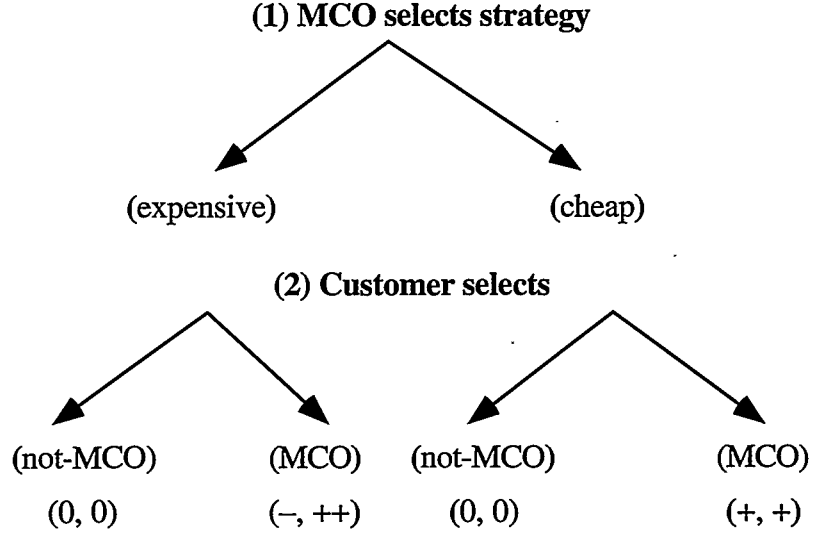
2. *Sequential Choice*

Replacing the assumption that the players make their choices simultaneously with the assumption that they make their choices sequentially makes the game more realistic. In the real world, either the MCO or the customer must reveal a strategy first, and that party cannot alter its strategy based on the other party's choice. There are two

159 In game-theory terms, selecting cheap coverage is a weakly dominant strategy for the MCO, meaning that its payoff from selecting cheap coverage will be equal to or greater than its payoff from selecting expensive coverage, no matter which strategy the customer chooses.

possible sequences of events. In the first, the MCO communicates to potential customers the level of care that it will provide customers who contract Condition X. If the customer then chooses to enroll in the plan, the MCO's representation becomes part of the contract between the two parties. If the customer contracts Condition X and the MCO does not provide at least the represented level of care, the customer has an enforceable claim against the MCO for breach of contract. Figure 2 depicts this version of the managed care game, along with the two players' payoffs, in its "extensive form."

FIGURE 2



Payoffs: (Customer, MCO)

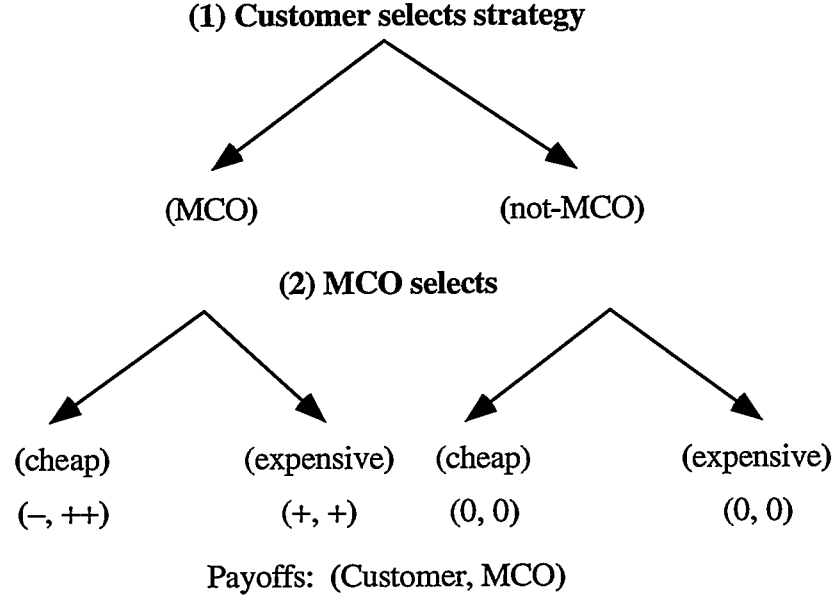
This depiction of the game in its extensive form allows us to predict the results through a process known as "backwards induction," by which we determine the two parties' incentives by examining the diagram from the bottom up.[160] If the MCO were to select "cheap" care, the customer would select "not-MCO" because her resulting zero payoff would be higher than the negative payoff she would receive by selecting "MCO." If the MCO were to select "expensive" care, the customer would be better off selecting "MCO" than "not-MCO." Knowing that the customer's incentive is contingent upon its strategy choice, the MCO has the incentive to choose "expensive" care. By doing so, the MCO would receive a positive payoff (because the cus-

160 For a more extensive game-theory discussion of the extensive form of games and the solution concept of backwards induction, see generally BAIRD ET AL., *supra* note 158, at 50-57.

tomer would then choose "MCO") rather than the zero payoff it would receive by selecting "cheap" care (because the customer would choose "not-MCO"). Even a greedy MCO would lack the incentive to select "cheap" care.

In the alternative version of the sequential game, the MCO does not make an enforceable commitment to provide "cheap" or "expensive" care prior to the customer making his strategy choice. Instead, the customer must first decide whether to enroll in the MCO, and the MCO subsequently chooses its strategy. Figure 3 depicts this version of the game.

FIGURE 3



The use of backwards induction demonstrates that changing the order of play changes the players' incentives considerably. If the customer were to choose "not-MCO," both parties would receive a zero payoff regardless of which strategy the MCO were to choose. If the customer were to select "MCO," the MCO could then maximize its payoff by choosing "cheap" care. Appreciating this result, the customer's incentive is to choose "not-MCO," because he is better off with a zero payoff than the negative payoff he would receive if he were to choose "MCO."

An important conclusion that can be drawn by examining both versions of the managed care game is that both parties are better off if the MCO chooses first; that is, if the MCO commits to provide a specified level of care before the customer decides whether to enroll in the MCO's plan. If the MCO selects first, both parties will receive a posi-

tive payoff; if the customer must select first, both players will receive a zero payoff. This, in turn, leads to the prediction that the MCO will legally commit to providing expensive care if it is able to do so. If the choices of "expensive" and "cheap" care represent search goods, the MCO can specify its choice before the customer decides whether to enroll with the MCO. However, if "expensive" care and "cheap" care represent benefits that are experience or credence goods, the MCO will be unable to make a legally enforceable choice of "cheap" or "expensive" care for Condition X prior to the time when the customer must decide whether to enroll in the MCO's health plan.

Consider the two possibilities. Dental care is a search good; prior to enrollment, the consumer can learn whether the MCO's health plan includes it. Consequently, customers will demand that, prior to enrollment, MCOs reveal whether dental care is or is not a covered benefit. An MCO that refuses to reveal this information would find very few takers for its services. In contrast, the precise benefit the MCO will provide in the case of a severe headache is an experience good; fully specifying such a benefit ex ante is impractical because the benefit depends upon a number of variables including, but not limited to, the location of the pain, the associated symptoms, and the patient's age and prior medical history. The MCO may recommend an aspirin to treat the headache, or it may conduct an expensive MRI scan to search for a tumor. But before the consumer enrolls in the MCO's health plan and contracts symptoms, the MCO will promise vaguely to provide "medically necessary" care. Because in this situation it would be impractical, if not outright impossible, for the MCO to commit credibly to provide either "cheap" or "expensive" care before the customer chooses "MCO" or "not-MCO," both parties are locked into a suboptimal, zero-zero payoff structure.

3. *Competing MCOs*

Thus far, we have assumed that the managed care game consists of two players, each making one strategy choice. In the real world, a customer who chooses "not-MCO" must then play the same game with another MCO, and then another, until she finally selects an MCO. This pattern illustrates a problem: the customer's optimal strategy is to select "not-MCO" for every health plan in her array of options because each MCO will have the incentive to choose "cheap" care if the customer first commits to enrolling in its plan. If we add the assumption that the customer prefers "cheap" coverage to no coverage at all—a plausible assumption for most consumers—then the customer finds herself in a no-win situation. She must select *some* MCO, although she knows that the plan she selects will choose to provide "cheap" coverage for Condition X. In other words, although selecting

"not-MCO" in a single play of the game results in a neutral zero-dollar payoff to the customer, selecting "not-MCO" in every play of the game results in a payoff that is more negative than the payoff she receives if she chooses "MCO," and the MCO subsequently chooses "cheap" care.

When the benefit in question is an experience or credence good, then, the customer's unavoidable fate is to receive "cheap" care. The cloud, however, does have a silver lining: because customers know that they are destined to receive "cheap" care, the insurance premium the MCO charges will reflect the cost of that cheap care. Recall that although the game assumes competition among MCOs and the customer must ultimately select an MCO that will provide "cheap" care, she can choose any of the competitors. Thus, each MCO will have to price the "cheap" benefits package at the marginal cost of providing the package. The bad news for customers is that they will be able to purchase only "cheap" care. The good news for customers is that they will be able to purchase it at a relatively low price.

4. *Assessing the Outcome of the Managed Care Game*

Is the inevitable outcome of the managed care game more efficient than if the MCO were to provide "expensive" care at a price that reflected the additional cost of such care? The answer hinges upon whether the marginal benefit to customers of "expensive" care, discounted by the probability that they will develop Condition X, exceeds the marginal cost of the MCO's provision of coverage for that condition. In other words, the question is whether customers would be willing to pay the marginal cost of "expensive" coverage or would instead prefer to accept lesser coverage in exchange for having the marginal premium dollars not spent on "expensive" care available for other goods and services.

Clearly, in a first-best world, customers could satisfy their individual preferences by choosing between paying a higher insurance premium for "expensive" care or a lower premium for "cheap" care. If customers have heterogeneous preferences, the existence of more options ensures that more customers will have a choice that comes close to maximizing utility.[161] But, as the managed care game suggests, if individually rational customers and MCOs operate in an unregulated market under the assumptions provided, the result will not be a menu of options for consumers. In the free market, all customers will be forced to accept "cheap" care for Condition X at a "cheap"-care price.

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161 *Cf.* Bellante & Porter, *supra* note 120, at 661 ("An approximation of the ideal, utility-maximizing package [of wage and job characteristics] is obtained for each worker . . . when he chooses among the variety of packages supplied by employers.").

The government can alter this result by mandating that MCOs provide "expensive" care for Condition X. Although specifying highly contingent benefits ex ante will create the same problems for legislative bodies that MCOs face, courts can conceivably enforce "expensive" care mandates ex post.[162] Mandates will enhance efficiency if the majority of customers value the "expensive" benefit more than its marginal cost. Of course, if the majority of customers prefer the "cheap" benefit at the lower price, mandating the "expensive" benefit would force customers to pay for something they would rather not have, and thus would be inefficient.

D. Customary Constraints on Strategic Underperformance

The preceding description of the managed care game can be generalized to any contracting situation in which the buyer of goods or services has no way of judging the quality of the seller's product before purchasing it, and the seller has no method of credibly guaranteeing the product's quality. This situation can be described alternatively as a "lemons" problem:[163] in the market for goods in which consumers cannot tell high from low quality prior to purchasing, the presence of low-quality goods will tend to drive high-quality goods out of the market, regardless of whether or not there are customers willing to pay a high price for high quality.[164]

Circumstances in which sellers provide experience goods are relatively common, and common experience suggests that these scenarios do not always cause all sellers to offer low-quality products at low prices. This leads to the question: what critical aspect or aspects of the "real world" has the managed care game, as this Article has described it, failed to capture? The answer is that the description of the game assumes only a single period of play.

When a seller or a buyer are repeat players in a given market, it is possible that different incentives will hold sway and the parties will not behave in the way that the single-iteration model predicts. Specifically, in many interactions with payoff structures similar to those of the managed care game, sellers have two countervailing incentives not to provide low-quality service at a low price if customers are willing to pay the marginal cost of higher quality service. First, in many markets, customers are repeat purchasers. In these situations, sellers can improve their future income stream by satisfying customers so that they will return. Second, even if customers are not likely to be repeat purchasers, the seller can build a reputation for quality by demonstrating

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162 This Article discusses this approach in greater detail *infra* Part V.A.

163 *See* George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970).

164 *See id.* at 495.

high quality to customers who value it. This reputation can pass from current customers to future customers. Once the seller establishes such a reputation it can serve as a bonding mechanism that permits the seller to credibly commit to providing a high-quality product or service. This bonding may occur even if customers cannot judge the quality of the product or service prior to purchase, and even if the seller cannot credibly warrant a specific level of quality.[165]

Either together or separately, these incentives can outweigh a seller's incentive to provide low quality in the current transaction and can lead to the provision of high-quality goods and services if customers value high quality at its marginal cost. When these incentives operate effectively, the unregulated market can provide buyers with a choice between high-quality/high-price sellers on the one hand, and low-quality/low-price sellers on the other. This choice permits each individual buyer to allocate the efficient amount of resources to the product. From an efficiency standpoint, such a menu of options is superior to a government mandate of high quality. Mandating high quality permits those buyers who would prefer to pay for high quality to allocate their resources more efficiently, but it forces buyers who would prefer to save money and purchase a low-quality product to inefficiently allocate too many resources to the product.[166]

Consequently, the defensibility of this Article's thesis that mandated health care benefits can enhance efficiency relative to the free market turns on the complete or near absence of incentives to cultivate repeat business and build a reputation for quality in the managed care market. The remainder of this Part argues that these incentives do not exist for two reasons. First, the unusual nature of the product which MCOs sell distorts sellers' usual incentive to cultivate repeat business. Second, the complexity of the product substantially reduces the incentive to expend resources to cultivate a reputation for high quality in the managed care field.

1. *Relational Contracting and Repeat Business*

In the typical contract between a buyer and a seller, the seller seeks to develop a reputation with the buyer that will lead to repeat patronage. Soliciting new customers is difficult and expensive work; generally, businesses with superior performance records are those that are able to rely on repeat business for a large percentage of their

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165 *Cf. id.* at 499-500 (explaining that firms can counteract the lemons problem by developing brand names that both indicate quality and give consumers a means of retaliation if purchases do not meet their expectations).

166 Mandated benefits can also lead to an underallocation of resources by buyers who prefer a low-quality, low-price option if those buyers prefer not to purchase the product at all, rather than pay the marginal cost for the mandated high-quality option.

sales.[167] Put another way, a long-term view of relationships with customers often prevents sellers from maximizing the profits they could garner from a single transaction.

MCOs, like most sellers, rely on repeat customers. In the current competitive health care market, MCOs spend large amounts of money to recruit new customers, who are usually committed to the MCO for only one year at a time. In most instances, the customer has the option of re-enrolling with her MCO or switching to a competitor every year.[168] An MCO can hope to be profitable only if it is able to retain most of its customers beyond their initial enrollment term.

But MCOs differ from most sellers in two important respects. First, in many cases, even consumers who experience the treatment quality their MCOs provide will not be able to adequately assess its quality; in other words, medical treatment is often a credence good rather than an experience good.[169] For a consumer to determine whether a treatment received was "expensive" or "cheap," she must be able to compare that treatment to an alternative.[170] Few consumers are knowledgeable and sophisticated enough to know, on their own, what treatment they could have received, but did not.[171] Some consumers will obtain information about the quality of care they received; perhaps their physician or a different physician will inform them ex ante that a better quality treatment is available but that the MCO will not approve it, or perhaps an attorney will inform them ex post that better options were available. These situations, however, are almost certainly exceptions that prove the rule. When medical care is a credence good, the MCO's risk of losing consumers by providing "cheap" care is minimal.

Second, and more importantly, even if every customer could assess the quality of any treatment received, MCOs still would lack an incentive to provide more expensive care. Although most sellers of goods and services desire repeat patronage from all of their customers, MCOs would prefer not to retain a portion of their customers

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167 *See generally* FREDERICK F. REICHHELD, THE LOYALTY EFFECT (1996) (analyzing the success of companies that focus on customer loyalty and describing their business strategies).

168 *See* HALL, *supra* note 39, at 247 (noting that "the convention of annual open enrollment" gives customers the opportunity to switch from one MCO to another if they decide their enrollment decision was a mistake).

169 *See* Rice, *supra* note 40, at 413-15 (reviewing evidence of consumer behavior in the health insurance context and concluding that "consumers do not seem to be able to evaluate the usefulness of medical services").

170 *Cf. id.* at 407 (noting the difficulty that health care consumers have in predicting the results of choices alternative to the one they actually made).

171 *See id.*

from one year to the next.[172] In any given year, the sickest approximately two percent of Americans consume approximately forty-one percent of the nation's health care resources,[173] and just ten percent of the population uses seventy percent of all health care provided.[174] Because of this reality, an MCO that is able to avoid enrolling the sickest portion of the population stands to be extremely profitable. There is widespread belief that MCO marketing practices are consciously designed to attract the healthier members of the population and to discourage the less healthy from enrolling.[175] Because customers who are sick and consume a large amount of resources in one year are more likely than average to be heavy consumers in future years, a profit-maximizing MCO will want to retain its healthy customers and convince its unhealthy customers to go elsewhere.[176]

Consequently, MCOs lack an incentive to provide expensive care for Condition X in order to retain customers, because the customers whom the MCO will impress with its devotion to quality are precisely the customers the MCO does not want. Conversely, customers who experience low-quality care from an MCO are likely to look elsewhere for care in the future, to the extent that they are so able. In most markets, defections would be bad for business; but in the peculiar market for health insurance, defections by customers most likely to defect are usually good for business.

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172 *See* ZELMAN & BERENSON, *supra* note 14, at 109-10 ("[R]ather than giving its highest user the red-carpet treatment, a health plan may have no problem when its highest user walks out the exit door and enrolls somewhere else. When plan ethics are borderline and economic pressures severe, they may even help them find that door.").

173 *See* Berk & Monheit, *supra* note 51, at 147 (reporting that the sickest 2% of the population in 1987 accounted for 41% of health care expenditures); Etheredge et al., *supra* note 24, at 96 (asserting, in 1996, that "10% of the population uses 70% of health care").

174 *See* Etheredge et al., *supra* note 24, at 96.

175 *See* ZELMAN & BERENSON, *supra* note 14, at 157 ("[M]any marketing strategists will advise most plans to project a reputation for good quality—but not too good."). For example, one author has noted that Medicare managed care plans that promote exercise programs are probably more interested in attracting customers who are in good health (and thus find exercise programs attractive) than in fostering fitness. *See* Kuttner, *supra* note 63, at 1559. Another set of experts states matter-of-factly that MCO "[m]arketing strategies are usually designed primarily to attract good risks and to avoid patients on whom a plan would lose money" and rhetorically asks "[w]hy do health plan ads show happy, healthy babies[.]" Etheredge et al., *supra* note 24, at 96; *see also* Joseph P. Newhouse, *Risk Adjustment: Where Are We Now?*, 35 INQUIRY 122, 122-23 (1998) (describing the incentives of health plans to "market their services so as not to appeal to bad risks").

176 If the customer is an individual insurance purchaser, the MCO might mitigate some of the costs associated with a heavy user of resources by charging that customers a higher-than-average, experience-rated premium; if the customer is a member of an insurance group, the MCO may be able to charge the group an experience-rated premium to compensate for the customer's heavy use of services. Even so, it is usually impossible for health insurers to make a profit on their sickest customers simply because charging rates high enough to cover the tens of thousands of dollars of care that these customers consume is impractical.

It is not always true, of course, that an MCO would wish customers who actually experience the quality of care it provides to choose not to renew their coverage. Depending on the nature of Condition X, its development might not be correlated with a patient consuming a higher-than-average amount of medical care in future years. For example, MCOs have no incentive to skimp on treatment for common ear infections or stomach viruses because the customers who seek treatment for these maladies are probably no more likely than average to be high resource users overall. In some cases, the opposite might be true: the need for certain treatments might be correlated with low overall resource use. For example, sports-related injuries might be correlated with low future resource use because they are generally suffered by young people in good health.[177] The need for infant care might be correlated with low future resource use because, on average, young families tend to be fairly healthy. It follows that an MCO might have a strong desire to retain customers that require these services and might even have an incentive to choose expensive care for those conditions. Therefore, MCOs might find it advantageous to provide expensive sports medicine and infant care, but these examples are almost certainly the exceptions that prove the general rule.

2. *Reputational Effects*

To summarize, there are two unique features of the market for health insurance that are highly relevant to this discussion: (1) the seller does not wish to retain some of its customers, and (2) in most cases, these unwanted customers are the only ones who will have become iuformed about the quality of the MCO's services after contracting. Consequently, sellers' usual desire for repeat business will not motivate an MCO to provide high-quality care, even if most of its customers would prefer high quality and would be willing to back up that preference with premiuin dollars. But even though an MCO may not wish to retain its sickest customers, it will want to retain healthy customers and recruit new ones. Thus, the MCO should be concerned with building a reputation for providing services that customers value. If, in fact, customers want high-quality care, reputational concerns should cause MCOs to provide high-quality services.

Clearly, MCOs do care about their reputation among their customers at some level. In recent years, many MCOs have polled customers about their satisfaction with MCO service for the purposes of publicizing favorable results and upgrading service if results are unfa-

177 *Cf.* Hyman, *supra* note 39, at 7 (noting that "individuals in their 20s and 30s require more sports medicine than those in their 50s").

vorable.[178] But it is telling to look at the methods with which MCOs that have taken such steps seek to measure their reputation for quality. The indicia of quality are usually limited to items that the ordinary customer, rather than the high-cost customer alone, is likely to have experienced[179]—for example, time waiting for an appointment and ease of processing claim forms.[180] Why do MCOs fail to exhibit as much concern with their reputation among their customers for providing high-quality care to the very sick as with their reputation for quality in more pedestrian areas of service?

There is no clear answer to this question, but the following three hypotheses, all of which are based on imperfect information in the market for MCO services, are the most convincing. First, because most customers who receive care for any Condition X are medically unsophisticated and unlikely to be competent to evaluate the quality of the care they receive, the reputational costs of providing low-quality service likely will be less severe for MCOs than for other sellers of goods and services.

Second, only the small percentage of MCO customers that suffer a serious illness or injury learn about the level of care the MCO provides. Therefore, even if members of this limited cohort are able to recognize the quality of care, any reputational costs associated with providing low-quality service will be more limited than if most or all customers discovered the MCO's level of quality. If this cohort communicates its knowledge of the MCO's low quality primarily to others who are likely to be heavy resource consumers and thus undesirable to the MCO, the limited development of a reputation for providing low-quality service could, perversely, inure to the benefit of the MCO.[181] In other words, if the seriously ill communicate their grievances primarily to others who are undesirable health insurance risks—a plausible, though not obviously correct, assumption—an MCO's reputation for low quality among its heaviest service users will not damage its bottom line.

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178 *See, e.g.*, U.S. News and World Report, *The HMO Roll* (Oct. 5, 1998) <http://www.usnews.com/usnews/nycu/health/hehmohon.htm>.

179 *See, e.g.*, Avery Comarow, U.S. News and World Report, *Behind the HMO Rankings* (Oct. 5, 1998) <http://www.usnews.com/usnews/nycu/health/hohmobeh.htm> (measuring prevention, access to care for adults and children, member satisfaction, and physician credentials).

180 *Cf.* ZELMAN & BERENSON, *supra* note 14, at 112 (noting that consumers may be suspicious of satisfaction surveys, which MCOs frequently cite, because only the small percentage of consumers who become seriously ill in a given year "have had a chance to see their plan really put to the test").

181 *See* Thomas L. Greaney, *How Many Libertarians Does It Take to Fix the Health Care System?*, 96 MICH. L. REV. 1825, 1833 (1998) (book review) (noting that in the world of health care, "perversely, having a good reputation for quality can lead to unfavorable selection").

Finally, even if an MCO were to develop a reputation for low quality in the broader community, that reputation would be damaging only to the extent that consumers are able to differentiate the reputations of competing MCOs. If consumers believe, correctly or incorrectly, that little quality differentiation exists among MCOs, a reputation for low quality likely will lead to general complaints among the public about managed care.[182] These complaints perhaps could lead to the increase in mandated-benefits legislation that we have witnessed this decade, but they would not leave the particular MCO at a competitive disadvantage.

III
BOUNDED RATIONALITY AND COMPLEX CHOICES

A. The Optimization Model

The previous Part demonstrates how, under a set of plausible assumptions, MCOs operating in an unregulated market will provide an inefficiently low quality of benefits that can be classified as experience or credence goods. The managed care game, however, has a different equilibrium for benefits that are search goods. Recall that the experience good-credence good problem results from the inability of an MCO to specify what level of benefit it will provide a consumer before the consumer chooses whether to enroll with the MCO. For search goods, the sequence of moves in the managed care game is reversed, and the likely outcome changes.

Assuming again that consumers prefer "expensive" to "cheap" care for Condition X, backwards induction suggests that if the MCO chooses "cheap" care, the consumer will choose "not-MCO" in order to achieve the neutral payoff of zero rather than a negative payoff. If the MCO chooses "expensive" care, the consumer will select "MCO" in order to receive a positive payoff. Knowing this, the MCO will realize it cannot achieve the outcome of "++" it would receive if it were to select "cheap" care while the consumer chooses "MCO." Consequently, the MCO should select "expensive" care to salvage a positive outcome rather than a zero payoff. In this version of the managed care game, the sole equilibrium is "expensive" care with "MCO."

The managed care game, then, suggests that the market will provide the efficient level of benefits that can be adequately specified prior to contracting. When consumers are willing to pay the marginal cost of broader or more costly services, MCOs will have an incentive to

182 *See* ZELMAN & BERENSON, *supra* note 14, at 127 (observing that in the current world of managed care, "[t]he anecdote about one HMO denying a patient access to an appropriate but expensive procedure becomes an indictment of managed care in general, not an indictment of *one* managed care plan").

provide them; conversely, when consumers prefer to spend their dollars elsewhere, MCOs will have an incentive not to provide marginally more expensive care.

This efficient outcome depends, like the predictions of most economic models, on the assumption that consumers are ruthless optimizers—that they carefully compare the detailed descriptions and fine print of health insurance plans, that they make complicated trade offs between price and services,[183] and that they reward (with enrollment) the MCO that tailors its offerings to their preferences and punish (by selecting a competing plan) those that fail to do so.[184] As an example of how this assumption is necessary to guarantee the efficient allocation of resources to medical care, consider the following examples:

> (1) Consumers prefer that their health plan provide coverage for Condition X, and they are willing to pay the marginal actuarial cost of this coverage. Local MCOs, *A*, *B*, and *C*, offer identical coverage except that *A* and *B* provide coverage for Condition X (and charge a marginally higher price) while *C* does not. Consumers who optimally allocate their resources will avoid *C*, forcing it to add coverage of Condition X to its plan to attract customers. If consumers make suboptimal resource allocation decisions, however, it is possible that *C* can prosper without adding the efficient coverage.
>
> (2) As in the first example, consumers are willing to pay the cost of coverage for Condition X. A variety of differences exists, however, in the services (and prices) *A*, *B*, and *C* offer, one of which is that *C* does not offer coverage for Condition X. Many consumers who optimally allocate their resources might select *C*, despite the fact that it inefficiently fails to cover Condition X, because they much prefer the rest of *C*'s benefits package to *A*'s and *B*'s packages. On the other hand, some marginal consumers, who just barely prefer the remainder of *C*'s benefits package to *A*'s and *B*'s packages, will choose *A* or *B* because the benefit of coverage for Condition X is more valuable to them than the other marginal differences among *A*, *B*, and *C*. Although *C* might attract some consumers when it does not provide coverage for Condition X, it will be more successful if it adds this coverage (and its marginal price) to its benefits package. If consumers are unable to perfectly compare *A*'s and *B*'s benefits to *C*'s benefits, however, *C* might not need to provide coverage for Condition X to maximize its profits.

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183 For a detailed example of how consumers make complicated trade offs between price and services, see David M. Eddy, *Connecting Value and Costs*, 264 JAMA 1737, 1737-38 (1990) (calculating the value to an individual, healthy consumer of a drug that would reduce the risk of death from myocardial infarction).

184 Consumers' market choices accurately reflect their preferences. *See generally* P.A. Samuelson, *A Note on the Pure Theory of Consumer's Behaviour*, ECONOMICA, Feb. 1938, at 61 (describing the theory of consumer behavior in decision making).

The "consumer-as-optimizer" model assumes, most importantly, that consumers adopt strategies for choosing among several options, each with multiple attributes, that are both nonselective and compensatory.[185] A strategy is nonselective when consumers evaluate the information available for all attributes of each alternative before making a choice among alternatives;[186] a strategy is compensatory when the decision maker trades off desirable attributes of one option against desirable attributes of other options, taking into account the marginal benefit of each attribute.[187]

If MCO *A* offers coverages *X* and *Z*, but not *Y*, and MCO *B* offers coverage *Y*, but not coverages *X* and *Z*, a compensatory strategy would require the consumer to determine whether the value of coverage *Y* is more or less than the value of coverages *X* and *Z* combined. Notice that compensatory decision making requires the consumer to do more than ordinally rank the various coverages in terms of relative value; it requires her to convert different attributes into a common currency for comparison. If a consumer knows only that she prefers coverage *Y* to coverage *X* and coverage *X* to coverage *Z*, she cannot use a compensatory strategy for choosing among MCOs because she cannot evaluate whether *X* and *Z* combined are preferable to *Y* alone. To be certain that she makes the optimal decision, she must place all three coverages on the same value scale. If she values *Y* at $100 (or 100 utils), *X* at $75 (or 75 utils), and *Z* at $50 (or 50 utils), MCO *A* would be her optimal choice because $X + Z > Y$. If she values *X* at only $25 and *Z* at only $10, however, MCO *B* would be her optimal choice because $Y > X + Z$.

The classic example of compensatory and nonselective choice strategies found in the decision-theory literature is called "weighted adding."[188] Using this strategy, an actor assigns an "importance

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185 *See* ROBERT COOTER & THOMAS ULEN, LAW AND ECONOMICS 17 (2d ed. 1997) (explaining that rational-choice theory underlying the economic analysis of law assumes that an individual's preferences can be completely ordered, meaning that the individual "is *not* allowed to say, 'I can't compare them'").

186 *See* James R. Bettman et al., *Constructive Consumer Choice Processes*, 25 J. CONSUMER RES. 187, 189 (1998) (describing selective strategies and, by implication, nonselective strategies).

187 *See* JOHN W. PAYNE ET AL., THE ADAPTIVE DECISION MAKER 29 (1993) (distinguishing between compensatory and noncompensatory strategies); David M. Grether et al., *The Irrelevance of Information Overload: An Analysis of Search and Disclosure*, 59 S. CAL. L. REV. 277, 282 (1986) ("[A] choice strategy is called compensatory because it permits good scores on some attributes to compensate for bad scores on others."); Barbara E. Kahn & Jonathan Baron, *An Exploratory Study of Choice Rules Favored for High-Stakes Decisions*, 4 J. CONSUMER PSYCHOL. 305, 306 (1995) (describing compensatory models); Peter Wright, *Consumer Choice Strategies: Simplifying vs. Optimizing*, 12 J. MARKETING RES. 60, 60-61 (1975) (defining compensatory and noncompensatory decision strategies).

188 *See* Bettman et al., *supra* note 186, at 190. This general approach is known by a number of different names. *See, e.g.*, RALPH L. KEENEY & HOWARD RAIFFA, DECISIONS WITH MULTIPLE OBJECTIVES: PREFERENCES AND VALUE TRADEOFFS 282-353 (1976) (discussing

weight" to each attribute on which he evaluates alternatives and a subjective value for how each alternative fares on each attribute. He then gives each alternative an overall score by multiplying each attribute's importance weight by its subjective-value score and summing the results.[189] The weighted-adding approach, when executed precisely, permits the actor to choose the decision option that maximizes his utility—sometimes referred to as maximizing the accuracy of the choice.[190] For this reason, weighted adding is often assumed to be a normative method of analyzing choices.[191]

The consumer-as-optimizer model, along with its implicit assumption that consumers make purchasing decisions using a weighted-adding strategy or an approach that leads to the same result, is firmly established dogma in the law-and-economics literature because it (1) is simple, (2) tends to approximate reality in many instances, and (3) provides a better general model of human behavior than any other single theory. But these virtues, while significant, do not demonstrate that the assumption is true or even useful in every legal application. In the market for health care, the assumption seems highly implausible. Common experience suggests that consumers select their health insurance plan in a less rigorous way; they do not conduct a thorough compensatory analysis that takes into account and values every attribute of each available plan.[192] Unfortunately, little hard data exist on how, analytically, consumers make decisions about purchasing health insurance. There is, however, extensive research on the subject of how consumers choose among alternatives with multiple attributes in other contexts. This evidence, coupled with some basic assumptions about the context of health insurance decision making, permits the development of a theory of consumer choice among managed care plans.

I will argue that the consumer-as-optimizer model of decision making is implausible in the context of health insurance and that a

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"multi-attribute utility analysis"); PAYNE ET AL., *supra* note 187, at 24 (discussing the "weighted additive rule").

189 *See* Bettman et al., *supra* note 186, at 190.

190 *See id.* at 195 ("The accuracy of a decision strategy can be defined by using the weighted adding model . . . .").

191 *See* PAYNE ET AL., *supra* note 187, at 24.

192 A recent article puts the basic intuition this way:

> Even with the optimal price and performance information, consumers find it difficult to weigh the relative costs and benefits of a large number of plans. If this comparison also involves many differences in service coverage and cost sharing, consumers are much less likely to make rational choices. The number of variables may simply be too great to be manageable.

Hoy et al., *supra* note 136, at 10; *see also, e.g.*, John K. Iglehart, *Role of the Consumer*, HEALTH AFF., Winter 1996, at 7, 7 ("[B]ecause most people are healthy most of the time, very few of us are prepared to invest the time necessary to become highly knowledgeable consumers.").

model of "boundedly rational" consumer choice is descriptively far more realistic. The important implication of this model, I then argue, is that if health care consumers are less-than-perfect optimizers, the dynamics of an unregulated market for medical insurance are likely to result in the inefficient underprovision of benefits by MCOs. If the assumptions and reasoning are correct, government mandates of benefits—even of benefits that are search goods—have the potential to enhance the efficiency of society's allocation of resources to medical care.

B. Models of Boundedly Rational Decision Making

1. *Theoretical Alternatives to the Optimization Model*

In the 1950s, Herbert Simon argued that the optimization model based on the "global rationality of man" was an implausible descriptive model of most human decision-making contexts, especially those that require individuals to compare many options or options with many features.[193] Rather than optimizing, Simon argued, individuals "satisfice"[194] in many situations: they develop aspirations and select decision options that meet them, without regard to whether another "better" decision choice might theoretically exist.[195] Simon believed that limitations on individuals' cognitive ability to process large and complicated data sets bound their capacity to make so-called "rational" decisions, such that boundedly rational behavior is an unavoidable aspect of the human condition.[196]

Others have built on Simon's descriptive insight by arguing that satisficing results not from immutable coguitive limitations, but from costs associated with information acquisition or processing that outweigh the benefits of making an optimal decision.[197] From this perspective, satisficing can be globally rational (and thus desirable) behavior, even if it leads to suboptimal decisions in individual circumstances. For the purposes of our examination of mandated health care benefits, the important questions are whether consumers satisfice rather than optimize when purchasing health insurance, and, if they

193 Herbert A. Simon, *A Behavioral Model of Rational Choice*, 69 Q.J. ECON. 99, 99 (1955).

194 The term "satisfice" has two somewhat different meanings. This Article uses the term in its more general sense to mean that decision makers discontinue their analysis short of identifying the optimal choice when they have identified a choice that is "good enough," rather than as the label of a very specific decision-making strategy. *See* Bettman et al., *supra* note 186, at 190 (describing how a decision maker processes a problem using a satisficing heuristic).

195 *See* Simon, *supra* note 193, at 103-04; Herbert A. Simon, *Rational Choice and the Structure of the Environment*, 63 PSYCHOL. REV. 129 (1956); *see also* James G. March, *Bounded Rationality, Ambiguity, and the Engineering of Choice*, 9 BELL J. ECON. 587, 590 (1978) (describing the pioneering work of Simon in establishing the concept of bounded rationality).

196 *See* Simon, *supra* note 193, at 99-101.

197 *See, e.g.*, Grether et al., *supra* note 187, at 279.

satisfice, what consequences ensue for the efficient provision of health care by the market. Why consumers satisfice, and whether it is desirable for them as individuals to do so, is unimportant.

If the weighted-adding model of decision making is nonselective and compensatory, and thus consistent with the optimization hypothesis, lexicographic decision making is weighted adding's polar opposite. A lexicographic strategy calls for the consumer to select the option with the highest ranking on the most important attribute.[198] For example, a consumer who believes that the number of participating physicians is the most important MCO attribute would employ lexicographic decision making by selecting the MCO with the largest number of participating physicians, regardless of its other attributes. This decision-making strategy is highly selective in that it requires the consumer to consider only information concerning the most important attribute, allowing her to ignore all other information.[199] This strategy is also noncompensatory in that it does not require the consumer to trade off the number of participating physicians against other desirable attributes, such as price, maternity benefits, or mental health coverage.

One can view the weighted-adding and lexicographic approaches as opposing endpoints on a spectrum of decision-making strategies.[200] The weighted-adding approach, which leads to optimal, utility-maximizing decisions, requires large amounts of information about options and complex processing of that information, but it maximizes the accuracy of decisions. In contrast, the lexicographic approach requires minimal information about options and allows for simple processing,[201] thereby minimizing cognitive effort. Between these endpoints lie a large number of decision-making strategies that require less information and cognitive effort than weighted adding, but that offer greater accuracy than a strict lexicographic approach.

For example,[202] the strict lexicographic approach might be relaxed somewhat. Under one variation of the approach, sometimes re-

198 *See* PAYNE ET AL., *supra* note 187, at 26; Bettman, et al., *supra* note 186, at 190; Wright, *supra* note 187, at 61. If two or more choices have the same score or value for the most important attribute, the lexicographic strategy requires the decision maker to choose the one with the highest score on the second most important attribute. *See* PAYNE ET AL., *supra* note 187, at 26; Amos Tversky, *Elimination by Aspects: A Theory of Choice*, 79 PSYCHOL. REV. 281, 285 (1972).

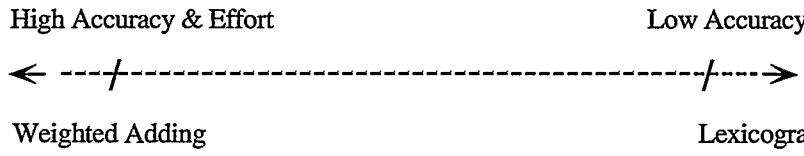
199 *See* Tversky, *supra* note 198, at 285.

200 *See infra* Figure 4.

201 *Cf.* Bettman et al., *supra* note 186, at 190 (suggesting that attribute-based processing is easier than alternative-based processing).

202 For a more complete list of decision approaches that fall between weighted adding and lexicographic choice on the scale presented in Figure 4, see PAYNE ET AL., *supra* note 187, at 22-29.

FIGURE 4



ferred to as "elimination by aspects" (EBA),[203] the decision maker ranks potential attributes in order of importance. She then determines how all alternatives score on the most important attribute, but rather than choosing the alternative with the highest score, she eliminates from consideration those alternatives that fall below a minimum, satisfactory value. If only one alternative remains under consideration, she selects that alternative. In this case, the strategy has the same result as the strict lexicographic approach. If multiple alternatives remain, she repeats the process by considering the second most important alternative, and so on until she makes a selection.[204] Notice that this approach is less selective than the lexicographic approach (although it is still relatively selective) because it often requires the decision maker to analyze alternatives on the basis of multiple attributes. Like the lexicographic approach, EBA is noncompensatory; the decision maker need not attempt to balance the virtues of a choice that is desirable on an important attribute against the virtues of a choice that is desirable on two or more less important attributes.

Alternatively, health care purchasers could incorporate from the weighted-adding approach some elements of compensatory decision making while remaining selective in the amount of data they process.[205] Such an approach can be called "modified weighted adding." For example, consumers might make trade offs among desirable features of health insurance plans, rather than relying on a strict hierarchy of plan attributes, but limit their compensatory decision making to attributes that rank relatively high in importance or salience. This approach is consistent with empirical data that suggest that even ex-

203 *See* Bettman et al., *supra* note 186, at 190. This conception of EBA is slightly different than Amos Tversky's original conception of the strategy, which posited that decision makers randomly selected based on probabilities dependent on the relative importance of the attributes the order in which they considered the aspects under the theory. *See* Tversky, *supra* note 198, at 285.

204 *See generally* PAYNE ET AL., *supra* note 187, at 27; Bettman et al., *supra* note 186, at 190.

205 *Cf.* PAYNE ET AL., *supra* note 187, at 28-29 (observing that individuals often use combinations of decision-making strategies rather than a single pure strategy).

pert decision makers have difficulty using more than half a dozen or so pieces of information when evaluating alternatives.[206]

Consider a consumer who determines that the most important attribute of an MCO is that the MCO's group of participating providers includes her current physician, but that the price of premiums, the location of participating hospitals close to her home, and the extent of maternity benefits also are very important. She might consider a plan that does not include her current physician if it offered a significantly lower price and significantly better maternity benefits than all of the plans that included her physician. Other benefits competing plans offer, however, would not enter into her calculus under this decision-making model.

2. *Decision Making and Health Care Choices*

It is difficult to predict exactly which of a nearly infinite number of strategies consumers will adopt in a particular situation; decision-making approaches are highly dependent on the structure of the problem at hand.[207] Some evidence suggests that, as a general rule, most nonexpert decision makers are not likely to use compensatory and nonselective decision-making strategies.[208] A number of features of the choice between competing managed care options suggests that health care consumers are particularly unlikely to adopt decision-making strategies that are fully compensatory and nonselective. The context suggests it is highly likely that consumers will use decision-making strategies that will provide (to varying degrees) MCOs with the incentive to underprovide some benefits relative to the efficient level.

a. *Complexity*

As Figure 4 suggests, decision-making approaches that are most accurate require a great deal of cognitive effort. Conversely, decision

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206 *See* Ruth H. Phelps & James Shanteau, *Livestock Judges: How Much Information Can an Expert Use?*, 21 ORGANIZATIONAL BEHAV. & HUM. PERFORMANCE 209, 209-10 (1978) (citing studies). *But see id.* at 211-13 (presenting evidence that livestock judges were able to balance more attributes when evaluating the quality of hogs).

207 *See* PAYNE ET AL., *supra* note 187, at 6; Bettman et al., *supra* note 186, at 187-88.

208 In one interesting study, Barbara E. Kahn and Jonathan Baron asked subjects a series of questions about how they would choose a cancer treatment. *See* Kahn & Baron, *supra* note 187, at 308. The experimenters asked subjects to state the most important factor and to answer whether they should base their decision on that factor alone; the experimenters then provided them with a list of factors to rank in order of importance. *See id.* at 311. Approximately one third of the subjects said they likely would make their decision based only on the most important factor—effectively adopting a strict lexicographic approach. *See id.* at 312. In a sister study, only about one-fourth of the subjects identified a compensatory strategy as the way they would approach the problem. *See id.* at 313; *cf.* PAYNE ET AL., *supra* note 187, at 25 (asserting that "while people sometimes make decisions in ways consistent with procedures like [weighted adding], more often people appear to make decisions using simpler choice processes").

makers can minimize this effort by adopting simpler approaches that are not as accurate. From one perspective, then, selecting a decision-making strategy can be seen as choosing a balance between maximizing accuracy and minimizing effort.[209] Actors often use strategies approximating weighted-adding when they face simple decisions.[210] When choices become more complex, however, decision makers often place relatively more emphasis on the goal of reducing cognitive effort[211] and relatively less emphasis on the goal of achieving accuracy, thus becoming more likely to employ selective or noncompensatory decision-making strategies.[212]

Evidence from social science research suggests that consumers facing choices, each of which have a large number of attributes, tend to adopt selective decision-making approaches.[213] The literature on the problem of information overload suggests that the ability of consumers to make choices that are utility maximizing given the options actually decreases as the amount of information available increases beyond a certain point—probably somewhere between five and ten attributes per alternative.[214]

In one study, for example, the ability of subjects to select a house that was closest to their ideal house (judged on the basis of information previously provided by each subject) from among five alternatives was constant when the number of attributes used to describe each

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209 *See, e.g.*, PAYNE ET AL., *supra* note 187, at 11 ("[W]e believe that accuracy and effort are the *primary* determinants of contingent strategy use."); Bettman et al., *supra* note 186, at 192-93 (observing that decision makers must compromise between the desire to achieve accuracy and the desire to minimize cognitive effort); Wright, *supra* note 187, at 62 ("Consumers may often have to compromise between optimizing eventual consumption benefits and reducing the strains of decision making.").

210 *See* Kahn & Baron, *supra* note 187, at 306, 314 (citing sources).

211 In one set of experiments, in which experimenters asked subjects to evaluate a range of decision problems of varying complexity in terms of the number of alternatives or attributes that they had to consider, greater complexity led to increased response times in evaluating options and increased subjective judgments of the amount of effort involved in the task. *See* PAYNE ET AL., *supra* note 187, at 85-86.

212 *See, e.g.*, *id.* at 34 ("In general, as decisions become more complex, people will tend to use simplifying heuristics."); Ellen C. Garbarino & Julie A. Edell, *Cognitive Effort, Affect, and Choice*, 24 J. CONSUMER RES. 147, 148 (1997) ("As environments require more cognitive effort to process information fully, decision makers often switch to decision strategies or heuristics that are easier to implement[,] but these heuristics frequently result in less accurate decisions, biased responses, and preference reversals. . . . [P]eople are willing to forgo some benefits to conserve cognitive effort."); *cf.* Wright, *supra* note 187, at 65 (finding in one survey that decision makers found that the strain associated with compensatory decision-making strategies increased as the amount of information facing the decision maker increased).

213 *See* Bettman et al., *supra* note 186, at 200 ("Increases in the number of attributes generally lead[ ] to increased selectivity, but not strategy changes."); *see also* PAYNE ET AL., *supra* note 187, at 36-37 (noting that the evidence is mixed, with studies contradicting each other).

214 *See* Naresh K. Malhotra, *Information Load and Consumer Decision Making*, 8 J. CONSUMER RES. 419, 427-28 (1982) (citing empirical studies).

house increased from five to ten, but decreased significantly as the number of attributes per alternative increased to fifteen or more.[215] Presumably, the reason for this counterintuitive finding is that, as complexity increases, actors respond to the increasing demands on their cognitive capacity by shifting away from compensatory and nonselective decision-making strategies to selective and noncompensatory approaches.[216]

Choices can be complex because of the number of alternatives or the number of attributes that each alternative possesses.[217] For most insured Americans, selecting a health plan is not made particularly difficult by the number of alternatives, because most consumers purchase coverage through an employer that limits the choice set. But the decision is made extremely complex by the number of attributes associated with each alternative. The difficulty that nonexpert decision makers are likely to have in understanding and evaluating information concerning these attributes further exacerbates the complexity that the sheer number of attributes at issue in health insurance choices creates.[218]

The number of attributes associated with managed care plans likely causes consumers to simplify the decision task[219] by either (1) selectively analyzing a limited number of important or highly salient attributes in a compensatory, cost-benefit framework[220] or (2) adopting cognitively simpler, noncompensatory decision-making strategies.[221] Even those who are experts at comparing health insurance plans appear prone to such simplification. In a survey of health insur-

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215 *See id.* at 421, 422 & tbl.1, 423; *see also* Stanley F. Biggs et al., *The Effects of Task Size and Similarity on the Decision Behavior of Bank Loan Officers*, 31 MGMT. SCI. 970, 970 (1985) (noting that bank loan officers adopt noncompensatory strategies as the number of loan application attributes increases).

216 *See, e.g.*, JAMES R. BETTMAN, AN INFORMATION PROCESSING THEORY OF CONSUMER CHOICE 221 (1979); Malhotra, *supra* note 214, at 427; Wright, *supra* note 187, at 62.

217 *See* Bettman et al., *supra* note 186, at 189.

218 *See* Kahn & Baron, *supra* note 187, at 306 n.1 (noting that complexity increases not only with the increase in the number of attributes or alternatives, but also with the difficulty of processing the relevant information). If the complexity of the problem exceeds the cognitive capacity of the decision maker, the adoption of a decision strategy that requires less effort than the weighted-adding approach becomes a matter of necessity rather than a matter of choice.

219 In a series of computer simulations, Payne, Bettman, and Johnson tried to evaluate how close various low-effort decision-making approaches approximated the accuracy of a weighted-adding approach. *See* PAYNE ET AL., *supra* note 187, at 123-44. Although the experimenters found that simpler approaches approximated the more cognitively difficult weighted-adding method in some situations, those simpler approaches did not fare well as the number of attributes per alternative in choice problem increased. *See id.* at 137.

220 *See* Bettman et al., *supra* note 186, at 199 (noting that increases in number of attributes increase consumer selectivity in processing).

221 *Cf.* Susan Edgman-Levitan & Paul D. Cleary, *What Information Do Consumers Want and Need?*, HEALTH AFF., Winter 1996, at 42, 53 ("It is not clear, however, how much information consumers want or can interpret. . . . The task of integrating and synthesizing . . .

ance purchasers for large corporations, fifty percent said that considering all the relevant variables when making purchasing decisions was difficult, and twelve percent reported that they made purchasing decisions based on only a single variable![222] Only twenty percent of the survey respondents reported making cost-quality trade offs in a systematic way that might approach weighted-adding.[223]

The problem of complexity is closely related to—and perhaps even subsumes—the problem of time pressure. Research indicates that when actors must make choices under time constraints, they are more likely to adopt selective or noncompensatory decision-making strategies, or both, which, of course, require less cognitive effort to process.[224] In one set of experiments, researchers concluded that decision makers responded to time pressure first by trying to work faster, then by focusing on a more selective subset of relevant information, and finally by switching from more complicated to simpler decision-making strategies.[225] While the choice among managed care plans is not formally time constrained, the time-consuming nature of attempting to understand and digest the detailed information that competing plans provide may cause consumers to react as if formal time limits appeared inadequate for processing a given amount of information. That is, they are likely to process information more selectively and to adopt simpler, though less accurate, decision-making strategies in an effort to reduce the time needed to complete the analysis.

b. *Emotion-Laden Trade Offs*

Decision theorists refer to choices as "emotion laden" when they force actors to choose among conflicting values or goals.[226] For example, a choice between an inexpensive car without airbags and antilock brakes and an expensive car with these devices is emotion laden because it forces the consumer to choose between cost and safety. Because it is impossible to have both, this decision is likely to give rise to negative emotions. A choice between a car with a sun roof and another with a stereo, in contrast, might not be emotion laden. Although the trade off might be difficult to make, it is unlikely to

information across multiple health plans[ ] would be onerous, even for a sophisticated health services researcher.").

222 *See* Judith H. Hibbard et al., *Choosing a Health Plan: Do Large Employers Use the Data?*, HEALTH AFF., Nov.-Dec. 1997, at 172, 177.

223 *See id.*

224 *See* PAYNE ET AL., *supra* note 187, at 39; Bettman et al., *supra* note 186, at 200; Kahn & Baron, *supra* note 187, at 326 (citing studies finding that people under stress tend to use simpler decision rules and are more likely to exclude less important attributes from consideration).

225 *See* PAYNE ET AL., *supra* note 187, at 166.

226 *See* Bettman et al., *supra* note 186, at 196.

invoke a conflict of values.[227] When decisions are emotion laden, consumers have an incentive not only to maximize accuracy and to minimize cognitive effort, but also to avoid or to minimize the negative emotional consequences of making the decision.[228]

Research indicates that a primary way in which consumers attempt to avoid such negative affect is to adopt selective or noncompensatory decision-making strategies, which enable them to avoid the explicit trade offs that a compensatory, nonselective approach requires.[229] Adopting a "choose-the-cheapest-car" strategy can help a consumer to avoid the emotional consequences associated with determining whether to pay an additional $500 for a car with an airbag. The desire to avoid explicit trade offs can be heightened when a strong social norm militates against commodifying one or more of the features at issue.[230] For example, if individuals believe that sacrificing environmental quality for money or comfort is wrong, they will be less likely to use a compensatory strategy to determine whether to purchase a car that is cheap and luxurious or one that is expensive and uncomfortable but emits less carbon monoxide.

Against this backdrop, choices concerning health care are likely to be particularly emotion laden for many consumers. Selecting health care coverage often requires trading off cost against safety and protection (i.e., the the extent of coverage) and cost against convenience (i.e., the quantity and location of participating physicians and hospitals). The sense among consumers that good health for themselves and their family is not something that they should barter is likely to exacerbate the negative affect associated with these trade offs. Consequently, it is likely that consumers will tend toward selective and non-compensatory decision-making strategies to minimize or to avoid the emotional consequences of such choices.

c. *Ease of Processing Information*

When actors face complex problems, their need to adopt boundedly rational decision-making strategies depends in part on whether the relevant information is presented in a way that lends itself to compensatory and nonselective evaluation. In such situations, the

227 *Cf.* Jane Beattie & Jonathan Baron, *Investigating the Effect of Stimulus Range on Attribute Weight*, 17 J. EXPERIMENTAL PSYCHOL.: HUM. PERCEPTION & PERFORMANCE 571, 571 (1991) (observing that trading lives saved for dollars otherwise spent on highway maintenance may seem more difficult than trading a bigger apartment for a correspondingly lower rent).

228 *See* Bettman et al., *supra* note 186, at 205-06.

229 *See id.*; *cf.* PAYNE ET AL., *supra* note 187, at 30 (noting that "compensatory rules confront conflict, whereas noncompensatory rules avoid it").

230 *See* Mark Kelman, *Consumption Theory, Production Theory, and Ideology in the Coase Theorem*, 52 S. CAL. L. REV. 669, 692 (1979) (noting that individuals seek to withdraw "spheres of activity from the realm of marginalism and calculation").

choice of a decision-making approach might depend highly upon which comparisons the presentation renders salient.[231]

A simple experiment using consumer goods far less complex than health care—canned dog food, facial tissues, and dishwashing liquid—nicely illustrates the impact that problem display can have on choices. When experimenters posted signs in grocery stores listing the unit price of each brand option for each of the three items, a higher percentage of customers purchased the cheapest (per-unit) brands than when no posted sign appeared and shoppers had to go to more trouble to make the price comparison.[232] When price comparisons were easy to make, many shoppers' decisions turned on price; when price comparisons were difficult, more shoppers based their decisions on other product attributes—presumably ones that were relatively easier to compare.[233] In situations in which consumer choices depend on information presentation, it follows that many (if not most) consumers do *not* employ decision-making techniques that are compensatory and that make use of all relevant information.

When consumers encounter information describing competing MCOs, it is unlikely that the information presentation lends itself to relatively easy compensatory analysis. No industry-recognized standard method of information presentation exists. Even when they attempt to present their employees with charts comparing competing MCO packages, employers have difficulty depicting subtle variations in benefit and service levels in a way that facilitates easy comparisons. The area in which information comparisons are most likely to be tractable is price; that is, monthly payments, copayments, and deductibles are probably the most readily comparable attributes for most health care consumers. If the hypothesis that price attributes are easier to compare than nonprice attributes is correct, then consumers are likely to adopt noncompensatory choice strategies based on price, to the exclusion of benefits and services.

C. Bounded Rationality and the Efficiency of Markets

The failure of health care consumers to optimize when they choose among available MCO options greatly undermines the ability of the unregulated market to provide the efficient level of medical care. Boundedly rational consumer choice, like the inability of MCOs to fully specify contractual obligations, can cause the free market to provide less than the optimally efficient amount of care. If consumers who make purchasing decisions fail to reward an MCO for providing

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231 *See* PAYNE ET AL., *supra* note 187, at 50; Bettman et al., *supra* note 186, at 193.

232 *See* J. Edward Russo, *The Value of Unit Price Information*, 14 J. MARKETING RES. 193, 196-97 (1977).

233 *See id.*

marginally higher quality of care than its rivals, the MCO might lack a market-driven incentive to expend resources to provide that higher quality.

To understand the problem, consider the impact on an MCO's market incentives if consumers use any of the variants of selective or noncompensatory decision-making approaches described above. If consumers adopt a strict lexicographic approach to selecting a health plan, MCOs will have an incentive to be concerned with quality only with regard to plan attributes that a significant number of consumers rank as the most important. If coverage for chiropractic care, for example, were cheap to provide and highly desired by consumers, yet no consumers ranked it as the most important attribute of a managed care plan, the market would not punish MCOs that failed to provide this coverage.

In fact, the opposite is likely to be true if we make one additional assumption: that price attributes probably are very important to many consumers. A body of empirical evidence establishing that consumers are very price sensitive in health insurance purchasing decisions,[234] along with widespread anecdotal evidence that consumer choices among competing health care plans turn largely on price[235] and that plans rarely choose to compete on the basis of nonprice variables,[236] makes this assumption highly plausible.[237] If an employer pays the

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234 *See, e.g.*, Etheredge et al., *supra* note 24, at 98 ("The evidence shows that individuals tend to select lower-price plans from employers' multiple-choice offerings and that even small premium differences can drive enrollment shifts among health plans."); Jensen et al., *supra* note 20, at 130 ("Workers have been shown to be highly price-sensitive in their decisions regarding plan choice. Where required contributions differ greatly across plans, workers tend to choose lower-cost plans—that is, those that require them to contribute less."); *see also* Michael Chernew & Dennis P. Scanlon, *Health Plan Report Cards and Insurance Choice*, 35 INQUIRY 9, 10 (1998) (concluding that "nearly all existing studies have found 'price' to have a statistically significant negative effect on the probability of enrolling in a health plan").

235 *See, e.g.*, Bailit, *supra* note 130, at 86 ("[P]urchasers and consumers seldom buy because of quality of care. Instead, purchasing decisions are based on cost, network size, and administrative convenience."); Hirshfeld & Thomason, *supra* note 23, at 32 ("During recent years, increasing costs have made premium levels a very important factor in patient selection of health plans."); Iglehart, *supra* note 192, at 7 ("Most [consumers] seem to base their decisions on cost, regardless of the benefit package offered . . . .").

236 *See, e.g.*, HALL, *supra* note 39, at 252 ("Very little differentiation exists [among insurance offerings] in the particulars of coverage beyond how much the patient must pay out of pocket."); Greaney, *supra* note 181, at 1833 ("[T]hough there has been vigorous competition among plans based on price and nonprice variables (for example, choice of physician, style of care, and breadth of network), there is very little evidence of rivalry based on outcomes or quality of care indicators."). *But see* Robert H. Miller, *Competition in the Health System: Good News and Bad News*, HEALTH AFF., Summer 1996, at 107, 117 (reporting that "purchasers have begun to pay greater attention to quality of care").

237 When employers offer employees a choice of health plans and pay the full premium cost for their chosen plan, the price of the plan is far less likely to concern the end consumers. An increasing number of employers that offer multiple plans, however, is either paying only a fixed percentage of the premium cost or requiring that the employee

full cost of an employee's health insurance or requires the same employee contribution regardless of which plan the employee selects, the employee will, of course, have little incentive to consider price when making the enrollment decision. Very few employees, however, find themselves in this position.[238] For the vast majority, selecting a more expensive plan from a set of employer-provided options means making a larger contribution to their coverage each month.[239] Assuming that price is the most important MCO attribute to a sizeable number of consumers, MCOs that offered a desirable coverage and consequently, increased the price of their plan by even a small amount, would find themselves at a competitive disadvantage in a world of lexicographic choice.

Consumers' use of EBA, or a similar decision-making strategy, could create incentives for MCOs to provide an inefficiently low level of coverage for two reasons. First, the EBA approach suggests that MCOs would have an incentive to provide benefits that consumers value so long as those benefits are among the most important or salient health plan attributes to many consumers. Nonetheless, MCOs are likely to underprovide any benefits that are not among the most important plan attributes, and are thus unlikely to be considered in an EBA analysis, as long as many consumers consider price among the most important attributes.[240]

Second, even for benefits that are very important or highly salient to consumers, MCOs would have an incentive to provide only the minimal benefit level necessary to prevent its plan from being eliminated when consumers evaluate that attribute. For example, suppose that many consumers rank mental health care benefits high on their list of health plan attributes but believe that a plan's provision of such benefits is minimally satisfactory if it provides at least some coverage for outpatient counseling services. Market incentives would cause MCOs to provide only that minimal level of coverage, even if more expanded coverage would be efficient. Consumers using EBA do not reward

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pay the full marginal cost of plans that cost more than the basic offering. *See, e.g.*, Hoy et al., *supra* note 136, at 13-14 (describing Xerox's health benefits plan, which provides employees with an incentive to choose efficient HMOs by forcing them to pay any difference in cost between the plan they choose and the "low-cost plan").

238 *See* Jensen et al., *supra* note 20, at 131 (finding that only 7.7% of employers pay employees' full premium cost and only 3.7% require the same employee contribution regardless of plan selection).

239 *See id.* at 130-31. The most common practice for employers is to provide the same monthly contribution to an employee's health insurance regardless of plan selection, meaning that the employee pays the full marginal cost of a more expensive plan; the second most common practice for employers is to provide the same percentage subsidy, meaning that employees pay more when they select a more expensive plan, but less than the full marginal cost of their decision. *See id.*

240 The reasoning I use here is the same as in the example of lexicographic choice.

MCOs for providing more than the minimum satisfactory benefit level, and MCOs can use their resources to provide other benefits (one of which could be "low price") in an effort to keep consumers from eliminating their plans from consideration because they fall short in another area.

If consumers follow a modified weighted-adding approach rather than EBA, MCOs would have a market incentive to provide the efficient level—rather than just the minimum acceptable level—of benefits that are important or salient enough to make their way into consumers' analysis. Even under this approach, however, MCOs would have an incentive to provide an inefficiently low level of benefits that are not highly salient to many consumers.

In a world in which consumers are relentless optimizers rather than boundedly rational decision makers, the failure of buyers to reward with their patronage sellers that provide high quality service is evidence that buyers do not value the marginal quality at its marginal cost. In such a world, sellers must provide lower-quality, lower-price services to compete for buyers in the market. In so doing, sellers also provide the efficient level of quality. In the market for managed care, however, the failure of buyers to select only the sellers of high-quality service is not necessarily evidence of a lack of willingness to pay for quality. Even customers who would be willing to pay the marginal cost of higher-cost services if asked to evaluate individually the value of each feature of an MCO's benefit package might not reward that high quality when an MCO offers it as part of a large and complex bundle of services.

D. Mitigating the Bounded-Rationality Problem

1. *The Sophisticated-Purchaser Constraint*

This is not the end of the story. As economists rightly point out, observing that consumers as a class are not relentless, rational maximizers does not alone undermine the free market's claim to efficiency. Defenders of the rational-maximizer assumption respond to the inevitable charge that the assumption is too optimistic to capture the nuances of actual behavior with the claim that the market will operate as if the assumption were true even when evidence demonstrates that it is false.[241]

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241 *See, e.g.*, GEORGE J. STIGLER, THE THEORY OF PRICE 6 (3d ed. 1966). Stigler suggests:

> When we assume that consumers, acting with mathematical consistency, maximize utility, . . . it is not proper to complain that men are much more complicated and diverse than that. So they are, but if this assumption yields a theory of behavior which agrees tolerably well with the facts, it must be used until a better theory comes along.

Demonstrating that if even a sizable minority of consumers are rational maximizers with a sophisticated understanding of their purchase options, market competition will cause all sellers to behave as if every consumer is an informed, rational maximizer may substantiate this claim.[242] To compete for the business of sophisticated, optimizing consumers, sellers will have to offer the combination of price and service that these consumers prefer. MCOs generally do not negotiate benefits packages with individual consumers—at least not in the group insurance market; instead MCOs offer the same package at the same price to all members of a group. A desire to compete for the business of sophisticated consumers thus requires MCOs to offer the same benefits package to all consumers. Under this set of assumptions, the fact that some or even many consumers are not rational maximizers should not affect the product that MCOs offer.

2. *Adverse Selection*

The problem with the sophisticated-purchaser claim lies in its reliance on the assumption that the minority of sophisticated consumers are as desirable to sellers as the boundedly rational majority or, more specifically, that an MCO has the same incentive to seek the business of the sophisticated consumer as it has to seek the business of the unsophisticated consumer. In the market for managed care, this assumption is likely to be false. Consumers who search the fine print of MCO statements of benefits and devote significant amounts of time to a close and careful comparison of competing plans are likely to share, on average, two characteristics that differentiate them from the broader pool of managed care consumers. First, they are likely to be sicker than the average consumer, or more likely than the average consumer to become sick. Second, they are therefore more likely than the average consumer to be willing to pay the marginal cost of higher-quality care.

The risk of adverse selection is a common problem in insurance markets.[243] The insurer must determine the actuarially sound price of insurance, which depends on the risk that the insured will suffer a covered event and the likely severity of that event. But the consumer often possesses private information about the level of risk he poses. Insurance companies must always fear that if they determine a price for insurance based on the risk characteristics of a group, the higher-

242 *See, e.g.*, Steven Salop & Joseph Stiglitz, *Bargains and Ripoffs: A Model of Monopolistically Competitive Price Dispersion*, 44 REV. ECON. STUD. 493, 494, 501 (1977).

243 Adverse selection characterizes the problem that the highest-risk people create in a given pool choosing to purchase insurance; their presence leads to higher claims activity than the pool, as a whole and on average, would produce. *See* ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW 14-15 (1988) (describing generally the concept of adverse selection in insurance).

risk individuals in the group will purchase coverage while the lower-risk members of the group will not.[244]

In theory, the adverse selection problem can lead to extreme consequences. If only consumers who face a higher-than-average risk of loss purchase insurance, the cost of providing that insurance will increase, forcing insurers to increase premiums to cover these costs. This price increase, in turn, could cause the healthiest consumers in the market to drop out, raising average costs even higher. The logical endpoint of what is commonly called the insurance "death spiral" is the exit from the insurance market of all but the highest-risk consumers. For all other consumers, the ever-increasing price of insurance will exceed their probable health care costs.

The problem of adverse selection is particularly troubling in the health insurance market because consumers are more likely to have private information about their risk level—i.e., their family history or diet—than consumers in, for example, the market for fire insurance. The notoriously high cost of health care insurance in the individual market illustrates the problem. Individuals at low risk of suffering large medical costs forgo coverage to avoid paying premiums set at the average cost of insuring individual insurance purchasers. This absence by relatively healthy consumers drives up the average cost of coverage and, in turn, causes more consumers of below-average risk to exit the market.

The provision of medical insurance as a fringe benefit of employment, common since World War II, has limited this problem somewhat in the group insurance market. Even young, healthy individuals who work for employers that provide health care insurance rarely opt out of coverage, keeping the average health of managed care consumers relatively constant and preventing the onset of the death spiral.[245] But the problem remains, albeit in a less severe form, when different MCOs offer a group of employees different benefits packages. Sicker consumers are likely to differentially prefer more substantial and higher-priced benefits packages, driving prices for the more substantial packages even higher, and thereby driving an ever larger number of healthy customers away from the plan.[246]

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244 *See, e.g.*, Esther B. Fein, *Calling Infertility a Disease, Couples Battle with Insurers*, N.Y. TIMES, Feb. 22, 1998, at A1 (reporting that one large insurance company had discontinued benefits for infertility because infertile women were disproportionately choosing the company's plan, thereby driving up costs).

245 A rational basis exists for the tax breaks provided only for employer-sponsored health insurance—a tax policy that policy analysts routinely criticize. *See, e.g.*, Carrie J. Gavora, *Congress's Wrong Prescription for the HMO Headache*, HERITAGE FOUND. BACKGROUNDER, July 21, 1998, at 1.

246 *See, e.g.*, Hoy et al., *supra* note 136, at 25-26 (claiming that Wisconsin's Employee Trust Fund moved to offering its state employee members standardized benefits packages

The adverse-selection problem is likely to emerge in a slightly different guise within the context of consumers' approaches to selecting among managed care plans. Consider a simple classification of all managed care consumers into two categories: (1) "healthy" consumers, who reasonably believe that their chances of suffering expensive illnesses are below average and (2) "unhealthy" consumers, who reasonably believe that their chances of suffering the same illnesses are higher than average. Unhealthy consumers have a higher than average incentive to purchase health insurance; they also have a stronger incentive to incur the search and analysis costs involved in making the optimal choice among competing managed care plans. Viewed from the opposite perspective, healthy consumers have a weaker incentive to bear the costs of studying the full array of benefits that MCOs offer because they have a lower probability of finding themselves in a situation in which they would need these benefits. Similar to the adverse selection problem, the least-healthy purchasers of managed care are most likely to spend the time and effort to ensure that their purchase decisions maximize their utility.[247]

As a result, MCOs lack the incentive that sellers usually have to compete for the business of the more sophisticated, thorough consumers most likely to equate the marginal cost of coverage with its marginal benefit. MCOs generally cannot charge their most unhealthy consumers the full marginal cost of their coverage even when, as is not always the case, MCOs can charge them a somewhat higher price. Consequently, all other things being equal, MCOs would prefer to enroll consumers who are less thoroughly informed about the full range of benefits offered. This circumstance would lead them to pursue the strategy they would follow if all consumers were boundedly rational, rather than the strategy that they would follow if all consumers were ruthless optimizers of utility.

IV
AVENUES OF COLLECTIVE ACTION

When an MCO cannot credibly commit to providing certain benefits prior to a consumer's decision to enroll, it will have an incentive to provide less extensive or lower-quality care than is efficient unless the reputational costs it will suffer outweigh the savings it can reap by following such a strategy. In short, even if consumers would both pre-

from competing MCOs to avoid adverse selection against plans offering better benefits packages).

247 One focus-group study of what information health care consumers wanted from managed care plans revealed that the chronically ill and retired participants were more concerned about access to information concerning benefits packages than other participants. *See* Edgman-Levitan & Cleary, *supra* note 221, at 49.

fer and be willing to pay higher monthly premiums for the promise of more extensive or higher-quality service if they become ill, the market will not respond to these preferences because individual consumers lack the necessary information to back them up through their purchasing decisions. Furthermore, if those consumers whom MCOs desire are boundedly rational decision makers, attuned to price but not to benefit subtleties, MCOs will have a market incentive to provide an inefficiently low level of all benefits—even those they can commit to provide prior to contracting. For these two reasons, an unregulated market for managed care is likely to provide less than the efficient amount of care.

To solve, or more likely reduce, the problem of MCOs inefficiently underproviding services, consumers must take collective action to improve the collection and processing of information. There are two potentially fruitful avenues by which they may accomplish this goal. First, consumers can use government to mandate benefits that consumers with complete information and unbounded rationality would purchase in a perfect market. Second, consumers can use sophisticated agents—be they government entities or private organizations—to provide more complete and digestible information about benefits options, thereby supplying MCOs with an incentive to offer the efficient balance of price and service.

Students of law and economics will recognize that these approaches reflect the common dichotomy of legal solutions to market imperfections: the former approach requires that government act to mimic efficient market outcomes, while the latter approach requires government (or private entities) to facilitate efficient private ordering.[248] This Part considers each possibility's potential.

A. Mimicking the Market with Mandated Benefits

As highlighted above, one way to reduce the inefficient underprovision of managed care is for government to act on behalf of consumers collectively, identifying particular benefits or types of care that MCOs are likely to underprovide, relative to their efficient level, and then mandating their provision. This approach has two obvious drawbacks: (1) the risk of error in the government's analysis is high, and (2) the solution is necessarily a second-best one, even if the analysis is error free.

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248 *See, e.g.*, MARK KELMAN, A GUIDE TO CRITICAL LEGAL STUDIES 123-24 (1987) (identifying market mimicking and market facilitation as the twin policy prescriptions of law and economics, but noting that no consensus exists within the law and economics community as to which approach is preferred); Russell B. Korobkin & Thomas S. Ulen, *Efficiency and Equity: What Can Be Gained by Combining Coase and Rawls?*, 73 WASH. L. REV. 329, 336-37 (1998) (summarizing the traditional law-and-economics dichotomy).

With respect to the first point, benefits mandates in the pursuit of the efficient allocation of resources require the government to engage in the tricky business of identifying those services that are not provided by the market, but for which consumers would be willing to pay the marginal cost.[249] Objective evidence is notoriously difficult to collect on these types of questions. Government actors could identify managed care benefits that an unregulated market might underprovide, such as (1) experience or credence goods that MCOs cannot realistically promise by contract prior to consumer selection of an MCO, or (2) benefits of relatively low importance or salience to boundedly rational consumers that they are likely to ignore when making purchasing decisions. But the mere fact that a benefit fits either description does not prove that the unregulated market provides an inefficiently low amount of the benefit. On any given issue of quality, consumers might well prefer to pay less and consequently receive less.[250] Managed care arose precisely because of the widespread belief that fee-for-service medicine was providing gold-plated service to a society that did not wish to pay its marginal cost.[251] Government mandates of all benefits that the market might underprovide would trade the problem of inefficient underprovision of care with the old problem of its inefficient overprovision.

Second, even when the government correctly identifies high-cost services for which most consumers would be willing to pay the cost of insurance, mandated benefits can never result in the provision of the optimally efficient level of medical care. By limiting choice, mandates violate the principle of welfare economics that more options can lead to increased utility for a group of individuals with heterogeneous preferences.[252] Consider the following hypothetical example: eighty percent of consumers would be willing to pay the marginal cost of providing autologous bone marrow transplants for those who might benefit from them or of providing longer postpartum hospital stays, while twenty percent of consumers would prefer not to pay for these

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249 *See* Epstein, *Why?*, *supra* note 39, at 312 (noting that the problem of imperfect information which plagues the private market for health care will also plague public actors); *cf.* Fred S. McChesney, *Economics, Law, and Science in the Corporate Field: A Critique of Eisenberg*, 89 COLUM. L. REV. 1530, 1548 (1989) (noting, in the corporate law context, that lawyers must compare the disadvantages of "real-world markets" with the disadvantages of "real-world government" action rather than with an unrealistic utopian view thereof).

250 Proving the inefficiently low amount of a consumer good provided in the real world is nearly impossible because tastes are impossible to measure. *Cf.* Thomas Russell & Richard Thaler, *The Relevance of Quasi Rationality in Competitive Markets*, 75 AM. ECON. REV. 1071, 1073 (1985) ("[I]t is virtually impossible to classify an act as nonrational *in practice* because of the difficulty in controlling for differences in tastes . . . or in information . . . .").

251 *See supra* Part I.A.

252 *See* Bellante & Porter, *supra* note 120, at 665 (noting that the "potential for . . . social welfare optimization is greatest when the range of options open to workers and the flexibility of employers to adjust is greatest").

benefits. In these scenarios, universally mandating the benefits would be more efficient than permitting the market to underprovide them, but mandates would be inefficient for fully twenty percent of consumers. In a system of mandated benefits, one size must fit all.[253] The twenty percent who would not prefer the mandates are faced with two consumption choices, both of which are inefficient. They can overconsume the benefit in question, or they can opt out of the health insurance system entirely.[254]

The latter possibility, which illustrates the counterintuitive point that the costs of mandated benefits will not necessarily be borne in the form of overconsumption of health care, is particularly noteworthy. Benefits mandates will cause the cost of health care coverage to increase. This increase will inevitably cause some consumers who would prefer low-cost, low-quality care over the gold-plated, mandated version, to drop out of the private insurance system entirely,[255] either because their employer decides not to provide health insurance or they decide not to accept the insurance their employer does offer.[256] This effect has the consequence of either burdening the public health care safety net or causing the consumers who opt out to underconsume medical care, relative to a world in which they could purchase any level of insurance.[257] These are the precise problems that mandates seek to solve. Opponents of mandated benefits are quick to

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253 *Cf.* Colantoni et al., *supra* note 140, at 611 ("The requirement that all cars be equipped with seatbelts entails the nonavailability of cars without seatbelts, and those consumers for whom the optimal choice would not include seatbelts are penalized.").

254 See *supra* notes 119-20 and accompanying text (discussing the argument that mandated benefits will force marginal consumers out of the managed care system, resulting in less care for this group rather than more).

255 Although the rate of increase in health insurance costs has diminished in the 1990s, benefits mandates undoubtedly make current costs higher than they otherwise would be. This could explain, at least in part, the fact that the percentage of Americans with private insurance is decreasing despite high rates of employment. *See* U.S. GEN. ACCOUNTING OFFICE, EMPLOYMENT-BASED HEALTH INSURANCE: COSTS INCREASE AND FAMILY COVERAGE DECREASES (1997) (providing statistics on decreasing rates of private insurance); *see also* Barbara Markham Smith, *Trends in Health Care Coverage and Financing and Their Implications for Policy*, 337 NEW ENG. J. MED. 1000, 1000 (1997) (noting the irony of decreasing rates of employer-provided insurance in a healthy economy of increasing employment).

256 Between 1987 and 1996, the percentage of employees who accepted employment-based health insurance decreased. *See* Cooper & Schone, *supra* note 138, at 144. In other words, employees eligible for coverage are choosing to go without, presumably because they have decided that coverage is not worth the employee contribution to the premium which the insurance policy requires.

257 *See, e.g.*, Frank A. Sloan & Christopher J. Conover, *Effects of State Reforms on Health Insurance Coverage of Adults*, 35 INQUIRY 280, 288 (1998) (reporting the results of a national study showing that the addition of each mandated benefit decreases the likelihood of an individual having private health insurance by .004%).

point out the irony in the fact that legislation designed to guarantee more care can actually result in less care for some.[258]

To concede that mandated benefits are not a panacea for failures of the private health insurance market, however, is merely to recognize that mandated benefits are a second-best solution to the inefficiency of the unregulated market. This concession is far from fatal to the argument for mandates. As long as the efficiency gains of guaranteeing a majority of consumers an efficient level of care exceed the attendant costs of forcing a minority of consumers to overconsume or underconsume health care, government mandates can be efficiency-enhancing overall. The critical question from a policy perspective is not whether mandated benefits can have some net positive benefit—they can under the plausible assumptions made in this Article—but whether other forms of collective action are likely to be even more desirable.

B. Facilitating Efficient Private Ordering

Of course, the second-best solution of government mandates could be avoided altogether if consumers had accurate information about MCO features ex ante and the ability to decide optimally among their choices, considering all features of each offering. Armed with this information, market incentives would force MCOs to provide the benefits for which consumers were willing to pay and would prevent MCOs from providing benefits that consumers did not value at their marginal cost. The one-size-fits-all problem of government mandates would be avoided, because different MCOs could offer different benefits packages, allowing consumers with varying preferences to gravitate to the plans that provided the balance of cost and service that they preferred (as long as healthy and unhealthy consumers did not have divergent preferences).

An obvious way to encourage such an ideal, market-driven system would be for government to provide (or mandate that MCOs disclose) more detailed information to consumers about the level of service and range of benefits that MCOs provide. Many commentators favor this

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258 *See, e.g.*, JOHN C. GOODMAN & GERALD L. MUSGRAVE, FREEDOM OF CHOICE IN HEALTH INSURANCE 20 (National Ctr. for Policy Analysis Policy Report No. 134, 1988) (arguing that state regulation of health insurance prices millions out of the health insurance market in the United States); JOHN C. GOODMAN & GERALD L. MUSGRAVE, PATIENT POWER 47 (1992) (asserting that state health-benefits mandates price 25% of the uninsured population out of the market for health insurance); Beth Mandel Rosenthal, Note, *Drive-Through Deliveries, and the Newborns' and Mothers' Health Protection Act of 1996*, 28 RUTGERS L.J. 753, 773 (1997) ("[F]ederal meddling in the private health care market will ultimately limit access to affordable, quality care."). This problem is particularly salient in an era in which the American economy is strong, but the number of Americans without health insurance continues to increase—to more than 43 million, by recent estimates. *See* Robert Pear, *Americans Lacking Insurance Put at 16 Percent*, N.Y. TIMES, Sept. 26, 1998, at A1.

approach,[259] and some states have enacted legislation designed to implement it.[260] But because managed care contracts cannot be fully specified, and because consumers are unlikely to maximize their utility when choosing between complicated options with multiple attributes, merely providing more detailed information to consumers is unlikely to lead to the efficient provision of health care coverage.[261] The limited available evidence suggests that consumers make surprisingly little use of the currently available information concerning quality of health care.[262] For a market-facilitating approach to have any hope of leading to an efficient allocation of resources to health care, information must be organized in a way that permits consumers to behave as if they could make optimal cost-benefit trade offs among fully specified managed care contracts.

In theory, there are two ways the market might accomplish this. Under what can be called the ex post approach, the MCO may provide consumers with information about its reputation for quality, which could then enable those consumers to select a preferred cost-quality balance. Under what can be called the ex ante approach, the MCO might contract to follow a predetermined set of medical practice guidelines when providing care, thus binding itself to a level of quality without having to fully specify a precise list of coverages or treatments it will offer. Both approaches have significant shortcom-

259 *See, e.g.*, ZELMAN & BERENSON, *supra* note 14, at 14-15 (advocating government policies that encourage competition and ensure that those making the purchasing decisions have the necessary information to facilitate that competition); *id.* at 165-66 (arguing for disclosure of information about plans and delivery systems that is essential to consumer protection); Lynn Etheredge, *Promarket Regulation: An SEC-FASB Model*, HEALTH AFF., Nov.-Dec. 1997, at 22, 22-24 (proposing mandated information disclosure similar to what the Securities and Exchange Commission requires of publicly traded corporations); Greely, *supra* note 19, at 81-82 (supporting legislation mandating disclosure, but noting that detailed disclosures may have little value); John K. Iglehart, *State Regulation of Managed Care: NAIC President Josephine Musser*, HEALTH AFF., Nov.-Dec. 1997, at 36, 36 (interviewing the National Association of Insurance Commissioners president, who notes that her organization's "primary concern is one of information disclosure for consumers").

260 For example, New York has enacted a complex disclosure law that requires managed care plans to inform prospective customers of, among other things, the drugs that are included in and excluded from the plan's formulary, the utilization review policies for specific diseases and treatments, performance measures of the plan's grievance procedures, and rules concerning how the plan will evaluate requests for experimental and investigational treatments. *See* N.Y. INS. LAW § 3217 (McKinney, WESTLAW through L. 1999, chs. 5-24, 26-30, 32-39, 41-49, 56-59, and 61-63); *see also* N.Y. COMP. CODES R. & REGS. tit. 11, § 52.65 (WESTLAW through May 31, 1999) (providing an example); FAMILIES USA FOUND., *supra* note 1, at 25.

261 Apparently recognizing the latter problem, one notable pair of proponents of increased disclosure as an alternative to government mandates concedes that "[s]ome standardization of benefits, so that consumers can more easily compare plan offerings, would also be valuable." ZELMAN & BERENSON, *supra* note 14, at 199.

262 *See, e.g.*, Bailit, *supra* note 130, at 87 (citing an unpublished Pennsylvania study showing that cardiac patients rarely consulted available data on bypass mortality rates before undergoing bypass surgery).

ings that render them inferior to the market-mimicking approach of mandated benefits, at least in the current environment.

1. *Enhancing Reputational Effects*

The most likely way to reduce the difficulty and cost to individual consumers of information collection and processing would be to increase the reputational effect of the benefits packages MCOs actually offer. Easy consumer access to information about an MCO's reputation that accurately reflects the quality level of offered benefits packages could serve as an ex post check on an MCO's ex ante incentive to offer an inefficiently low level of care. The evolving movement to develop "report cards" for managed care provides a notion of how this might work.

To date, efforts to develop report cards as a means of informing consumers' managed care purchasing decisions have primarily focused on measuring the quality of care MCOs provide.[263] This is usually accomplished by comparing the incidence of procedures provided by an MCO, such as coronary artery bypass operations per member or childhood immunizations per member, or by comparing patient's health outcomes, rather than by analyzing the range and extent of benefits that competing plans offer.[264] A number of implementation problems have stalled these efforts.

First, comparative quality ratings require that MCOs share proprietary health care records and report this information in a uniform way. Not surprisingly, MCOs are often reticent to share the necessary information with rivals or the public, and even when they are willing to do so, it is difficult for them to reach an agreement on standards for the type of information reported and the form in which it is reported.[265]

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263 *See supra* notes 178-80 and accompanying text.

264 The most notable attempt to devise a type of quality report card is the Health Plan Employer Data and Information Set (HEDIS), which the independent National Committee for Quality Assurance (NCQA) developed. The goal of the HEDIS is to provide comparative statistics on how well MCOs provide care along a number of different dimensions. *See generally* Alain C. Enthoven & Carol B. Vorhaus, *A Vision of Quality in Health Care Delivery*, HEALTH AFF., May-June 1997, at 44, 49-50 (describing HEDIS and other attempts to compare quality of care).

265 Paul Starr has analyzed in detail the slow development in the health care industry of the type of computer systems that would allow for the efficient compilation of outcomes data. *See* Paul Starr, *Smart Technology, Stunted Policy: Developing Health Information Networks*, HEALTH AFF., May-June 1997, at 91. When health plans report information that can be used to measure quality, they have an obvious incentive to manipulate the data to their advantage. As one author explains, "plans will turn themselves inside out to be able to report 'good' HEDIS data." Alice G. Gosfield, *Who Is Holding Whom Accountable for Quality?*, HEALTH AFF., May-June 1997, at 26, 36. The federal government is attempting to ameliorate this problem by requiring MCOs that provide service to Medicare patients to submit HEDIS data. *See* John K. Iglehart, *Changing with the Times: The Views of Bruce C. Vladeck,*

Second, outcome comparisons require that MCOs adjust data for differences in the ex ante condition of patients across MCOs. Because a multitude of factors concerning a patient's initial conditions, many of which are unknown, influence how she will respond to treatment, adequate adjustment methods have proven elusive.[266] Without adequate risk adjustment, report cards not only might be misleading, but they might also discourage providers from treating the more severely ill patients in any given illness category.[267]

Third, the quality comparisons that have emerged are often so complicated for consumers to understand and evaluate that they fail to solve the bounded-rationality problem. As one analyst recently described the problem, "[w]e could . . . bury consumers in a pile of descriptive information about health plans, their provider networks, and their performance[,] . . . [but] [e]ven if consumers were willing to wade through the pile, . . . the vast majority would find the information ambiguous at best."[268] In recent years, a group of large employers and health care providers has developed a standardized data collection system, known as the Health Plan Employer Data and Information Set (HEDIS), in an effort to provide health care consumers with a standardized set of quality measures by which they can compare providers.[269] Currently, HEDIS tracks fourteen measures of clinical quality, from the prevalence of colorectal cancer screening to the number of flu shots given to high-risk adults.[270] It would seem unlikely, however, that the average consumer could translate an MCO's performance on such measures into an informed opinion about the MCO's quality of care, even if she could understand the data.[271]

HEALTH AFF., May-June 1997, at 58, 60 (interviewing the administrator of the federal Health Care Financing Administration (HCFA)).

266 *See, e.g.*, Enthoven & Vorhaus, *supra* note 264, at 45 (noting that the ability to compare quality across MCOs "is seriously impaired by the regrettable absence of broadly based, valid, reliable, and risk-adjusted outcomes data"); Newhouse, *supra* note 175, at 123 (concluding that "there is almost universal agreement that we do not know how to do [risk adjustment] well").

267 For example, after Pennsylvania began to issue report cards on the performance of coronary artery bypass grafts by hospitals and individual surgeons, cardiac surgeons reported they were less likely to operate on severely ill patients for fear that doing so might harm their performance rating. *See* Arnold M. Epstein, *Rolling Down the Runway: The Challenges Ahead for Quality Report Cards*, 279 JAMA 1691, 1694 (1998).

268 Moran, *supra* note 45, at 20.

269 *See generally* Chernew & Scanlon, *supra* note 234, at 9-10 (evaluating the impact of report cards such as HEDIS); Enthoven & Vorhaus, *supra* note 264, at 49-50 (describing HEDIS and other attempts to compare quality of care); Epstein, *supra* note 267, at 1691-92 (documenting the expansious to the indicators used in HEDIS).

270 *See* Epstein, *supra* note 267, at 1692 & tbl.1.

271 *See id.* at 1696 (noting that detailed comparison data can confuse patients and concluding that "we need to find better ways to use quality reporting to empower purchasers and improve quality of care").

A recent survey of some of the most sophisticated consumers—health insurance purchasing agents for thirty-three large corporations—revealed that only about half of them used HEDIS data when choosing from among competing health plans.[272] Given this woefully low number, it is hardly surprising to learn, as more than one recent study has reported, that most consumers who have comparative plan performance information do not use that information in making their enrollment decisions, although most say that plan quality is very important to them.[273]

At least the first two of the aforementioned problems could be largely avoided if MCO report cards measured the range of benefits the MCO provides rather than the quality of care it delivers.[274] Public or private intermediaries between health plans and consumers could compare benefits packages offered by competing MCOs and provide each with a single "grade," or perhaps several grades. In theory, this grading could effectively condense complicated information in a way that even boundedly rational consumers could digest and balance against salient plan attributes such as price and physician availability. Experimental findings support the prediction that consumers would welcome such predigested information. These findings indicate that even when actors use simple, noncompensatory decision-making approaches, they are likely to favor the use of compensatory approaches, which presumably underlie report cards, when an agent is making the same decision for them.[275]

Benefits report cards would be superior to benefits mandates in an important respect: unlike mandates, the report card approach would allow MCOs to offer various combinations of price and benefits that would appeal to different consumers. Two drawbacks, however, suggest that report cards are not a viable alternative to benefits mandates. The first and more pedestrian problem is that private entities have yet to provide consumers with report cards measuring MCO benefits packages, rendering report cards an insufficient alternative to mandates at the present time. Report cards could become more prev-

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272 *See* Hibbard et al., *supra* note 222, at 174 & exhibit 1. The health-insurance purchasing agents who were surveyed were only half as likely to use hospital outcomes data than HEDIS data. *See id.* at 175 & exhibit 2.

273 *See* Chernew & Scanlon, *supra* note 234, at 19 (finding that "employees do not appear to respond strongly to plan performance measures"); *see also* S. Robinson & M. Brodie, *Understanding the Quality Challenge for Health Consumers: The Kaiser AHCPR Survey*, 23 J. QUALITY IMPROVEMENT 239 (1997) (finding that only 34% of consumers with comparative plan performance information reported using it in making plan enrollment decisions).

274 This assertion does not mean to suggest that reliable comparisons of the quality of care MCOs provide would not significantly enhance the ability of consumers to demand an efficient level of health care from the market.

275 *See* Kahn & Baron, *supra* note 187, at 318-22 (reporting experimental data on the role of compensatory rules in a rational actor's decision-making process).

alent, however, as the market for managed care matures, or alternatively, if the government produced the report cards.[276] For example, Vermont state government has pledged to issue report cards on managed care plans beginning in 1999, although its approach, which will rate plans on their compliance with state regulations, is offered as a complement to, rather than as a substitute for, mandates.[277]

The second and more significant problem is that the extent to which consumers would find ratings of benefits packages, even in a condensed report-card format, salient enough to factor into purchasing decisions is unclear. It is highly probable that sicker consumers would be systematically more likely than healthier consumers to factor benefits ratings into their purchasing decisions, thereby creating a perverse incentive for MCOs to attempt to earn bad grades. In this case, report cards might mitigate against the problem of consumers' bounded rationality to some extent, but they would be unlikely to stop MCOs from offering an inefficiently narrow range of benefits.

2. *Creating Less Complex Managed Care Contracts*

If report cards are viewed as efforts to motivate MCOs to provide an efficient level of care through ex post evaluation, the concept of contracting into medical practice guidelines attempts to constrain MCOs ex ante to provide the efficient level of care. Rather than threatening to punish MCOs reputationally for providing an inefficiently low level of care after the fact, this approach attempts to simplify the amount and complexity of information consumers must assimilate in order to contract with MCOs for the efficient level of care before they require health care services.

Recognizing the impossibility of specifying all the contractual obligations of an MCO ex ante and the difficulty consumers have in evaluating a plethora of benefits, Clark Havighurst suggests that consumers should enter into simpler contracts with MCOs that merely specify a general level of care.[278] Consumers who prefer "Cadillac"-quality care and are willing to pay for it may purchase high-benefit, high-quality plans; those who prefer to pay a lower price and receive "Chevrolet"-quality care—a group Havighurst predicts is the majority—can contract for a level of care at which they acknowledge that the MCO may not take every scientifically possible step to fight all illnesses that could develop.[279] But how does an MCO fully specify the

276 Alternatively, the government could promulgate data-reporting requirements for all MCOs, which would hopefully make the production of report cards easier and more cost effective for private entities.

277 *See* Pfeiffer, *supra* note 4, at 1.

278 *See* HAVIGHURST, *supra* note 46, at 162. Havighurst also provided models of what these contract clauses might look like. *See id.* at 187-93.

279 *See id.* at 104.

benefits provided in a Chevrolet-quality plan? Without this specification, MCOs will have the incentive to charge a Chevrolet premium, but provide consumers with a "Yugo" level of treatment.[280] Without specific quality-of-care guarantees, it would be exceedingly difficult for a Chevrolet consumer to prove that an MCO that refuses to provide a desired service or treatment has breached its contract. The MCO would certainly argue that the consumer knew she was only purchasing a cost-effective level of care and that the desired benefit is not cost effective.

Havighurst proposes that the specificity problem be solved by the MCO pledging to provide care in accordance with a set of clinical practice guidelines created by a third party.[281] The third party—a government entity or consumer organization—could design various practice guidelines for physicians who desire to treat each potential condition either (1) as aggressively as possible or (2) in accordance with various levels of cost-quality trade offs. By contracting to follow one set of guidelines, the MCO could effectively fully specify its obligations ex ante.[282] Mark Hall and Gerard Anderson have offered a similar recommendation.[283] They suggest that MCOs describe the level of medical effectiveness that they promise to supply to a consumer in the same terms used by medical researchers who report on the effectiveness of treatments, thus making the promise to provide a certain level of medically effective treatment enforceable.[284]

These proposals are commendable for several reasons. By requiring MCOs to commit to following a complex set of practice guidelines or specific research findings prior to consumers' enrollment, the approach would counteract the incentives for MCOs to provide a low level of care created by obligationally incomplete contracts. By collapsing a multitude of benefits and services into a single package that can be identified as, for example, "high-level benefits," "medium-level benefits," or "low-level benefits," this approach could both reduce the complexity of the decision consumers face and mitigate the problem of boundedly rational choice. If MCOs offer a potentially different benefit level for chiropractic care, dental care, mental health care, or maternity care, for example, most consumers likely will not find any individual type of benefit salient enough to play a role in their choice process. In contrast, if all of these benefits are grouped, consumers might find it easier to adopt a compensatory decision-making approach, trading off the value of high-level benefits against other sali-

280 *See supra* Part II.

281 *See* HAVIGHURST, *supra* note 46, at 227-29; Havighurst, *supra* note 39, at 1795-98.

282 *See* HAVIGHURST, *supra* note 46, at 230.

283 *See* Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992).

284 *See id.* at 1686-87, 1691-94.

ent product attributes, such as price or the participation of a favorite physician.

That said, this approach does have serious drawbacks. First, whether it would ever be possible, in practice, to develop a set of practice guidelines detailed enough so that an MCO could even come close to fully specifying its contractual obligations by pledging to follow those guidelines is unclear. According to one team of experts, a set of guidelines that would provide a treatment protocol for every disease, while taking account of even a modest array of clinical differences, complications, and combinations of conditions, would require ten billion entries.[285]

Second, consumer choice would only be simplified if a third party, either private or governmental, rated the set of practice guidelines an MCO pledged to follow as Cadillac or Chevrolet quality. The fewer the number of categories or levels that the rating sources recognized, the less likely that plans would provide the efficient level of all types of benefits. For example, if a set of guidelines could achieve a Cadillac rating by providing a certain level of mental health benefits, MCOs would have an incentive to contract for guidelines that specified just that amount of coverage and no more, even if many consumers would value expanded coverage. This would allow a plan to maximize its quality ranking (in this example, its Cadillac rating), while minimizing its price. In other words, health plans would tend to follow practice guidelines that required the lowest level of benefits within each quality classification. The more categories of quality that a rating system recognized, the less of a problem it would be if health plans gravitated to the bottom of each category. Unfortunately, the more categories that are recoguized, the less the Havighurst approach would mitigate the bounded-rationality problem that the complexity of health care choices causes.

Finally, neither the Havighurst nor the Hall-Anderson approach would solve the adverse-selection problem that creates an incentive for MCOs to offer an inefficiently low quality of care. Plans that promised to follow Cadillac-level practice guidelines would likely find themselves with patients who are sicker than average, forcing those MCOs to raise their prices, consequently causing their healthier patients to choose Chevrolet-quality plans, and so on.[286] Cadillac plans could well enter into death spirals that leave only Chevrolet plans viable in the market. If only Chevrolet options were available, or if Cadillac

285 *See* Robert W. Dubois & Robert H. Brook, *Assessing Clinical Decision Making: Is the Ideal System Feasible?*, 25 INQUIRY 59, 63 (1988).

286 *Cf.* HALL, *supra* note 39, at 52-53 (pointing out the same destabilization effect of offering medical savings accounts in combination with catastropbic insurance in a market in which comprehensive coverage is also offered).

options were available but at a price that only the wealthiest could afford, consumers would find themselves in much the same situation that they are in today: facing a market that offers a single level of benefits likely to be inefficiently low in many areas. This fear is not entirely theoretical. Several large insurance pools have had trouble maintaining a range of high-quality insurance options for members. For example, insurers in the Federal Employee Health Benefits Program, which covers federal employees, found that offering "high option" and "low option" versions of their plans resulted in extreme adverse selection against the "high option" versions, and a number of insurers left the program altogether after attracting too high a percentage of unattractive risks.[287]

V

GOVERNMENT INSTITUTIONS AS SOURCES OF MANDATED BENEFITS

By mandating that MCOs provide certain coverages and treatments as part of their benefits packages, government can potentially improve, in terms of efficiency, the allocation of resources to the provision of health care. At the present time, this market-mimicking approach offers more promise than competing market-facilitating approaches. This Part considers which government institutions—judicial, legislative, or administrative—are best suited to the task of mandating benefits.

When one fears that benefit levels will be inefficiently low because MCOs are unable to credibly commit to providing high benefit levels prior to contracting with consumers, courts, with their ex post perspective, are the only institution able to enforce market-mimicking mandates. But because courts must view cost-quality decisions in the context of a single patient who has already become ill, they are poorly positioned to evaluate those instances when high benefit levels would be efficient, and when they would be inefficient. When benefits at issue are search goods—MCOs can specify their level to consumers prior to contracting—but it is feared that MCOs provide these benefits at an inefficiently low level because of consumers' bounded rationality, legislatures are preferable to courts as decision-making bodies because they can view difficult allocation decisions from the more appropriate ex ante perspective.

Legislative decision making, however, is troubling for a different reason: public choice theory suggests that benefits with enough political support to win a legislative mandate are likely to be precisely those benefits that are salient to consumers and, consequently, do not re-

287 *See id.* at 53.

quire government mandates. Independent decision-making bodies that can view benefit mandate decisions from an ex ante perspective while remaining at least partially insulated from the political process are those most likely to impose an efficient level of mandated benefits. Consequently, rather than mandating specific benefits, legislatures should establish expert commissions with the power to mandate benefits when they believe that the market for managed care provides an inefficiently low level of those benefits.

A. The Trouble with Courts: Ex Post Decision Making

Although the 1990s have witnessed an explosion of mandates emanating from state legislatures and occasionally from the federal government, court adjudication of suits filed by consumers against their MCOs for refusal to provide desired benefits can be seen as implicitly having the same effect. By interpreting contract language strictly and harshly against MCOs that refuse to provide benefits that their customers desire, judicial decisions can have an effect on the provision of managed care that is nearly identical to that of a legislative mandate.

Courts impose mandates in the context of a single patient after that patient has become ill. This ex post perspective has a distinct benefit: it makes it possible for a court to enforce a mandate that cannot be adequately specified ex ante. As Part II explained, MCOs have a strategic incentive to provide "cheap" benefits at a "cheap"-benefit price when the precise contours of a benefit are so highly contingent upon a patient's specific situation that an MCO cannot describe it with specificity prior to the consumer's enrollment in the MCO's health plan.[288] In such situations, the ex post perspective of courts is necessary to even begin to evaluate the level of the benefit provided. It is impossible, for example, to specify ex ante what an "expensive" benefit for a severe headache would be.[289] Consequently, only after the patient has suffered a headache and receives treatment is it possible to determine whether the MCO provided an "expensive" benefit.

The unique perspective of courts, however, makes it profoundly difficult for judges to evaluate whether a benefit provided by an MCO is, in fact, inefficiently low. Courts must evaluate benefits provided by an MCO in the context of a single patient, whose preferences for a certain level of benefits may not reflect that of the majority of consumers. Furthermore, they must do so after the patient has become ill, at which time she has an incentive to exaggerate her preference for a

288 *See supra* Part II.A-C.

289 *See supra* Part II.C.2.

high-quality, high-priced benefits package.[290] As a result, courts are likely to establish inefficiently high benefit levels.

A wave of lawsuits in the early 1990s[291] over health plans' denials of coverage for certain treatments, which coincided with an explosion of legislative benefits mandates, aptly illustrates the problem. The plotline of adjudicated claims is often similar. The customer's doctor recommends a treatment for a life threatening illness that is either extremely costly, of disputed effectiveness, or both. The health plan denies coverage on the grounds that the treatment is excluded from the terms of the customer's coverage. The customer then files suit seeking coverage for the disputed treatment.

Because of the problem of incomplete managed care contracts, however, the terms of the insurance contract fail to address explicitly whether the MCO is obligated to provide the benefit sought. In general, the MCO usually promises to provide all "medically necessary" treatment, but includes in the contract a blanket exclusion for treatments that are "experimental."[292] The term "experimental," along with the standard by which plan administrators will determine whether the treatment is experimental, are rarely defined with any degree of specificity in the managed care contract.

This scenario presents the court with a Hobson's choice: either it must deny coverage that the customer claims she implicitly assumed she was paying for when she or her employer purchased her insurance policy, or it must force the plan to underwrite a service it claims it assumed it would not be liable for when it priced and marketed its plan. Most of the time (although not always) the courts rule for the customer.[293] Most typically, courts have resolved these disputes by invoking a basic principle of contract law that ambiguities in a contract are interpreted against the drafter.[294] In *Dahl-Eimers v. Mutual of Omaha Life Insurance Co.*,[295] for example, the Eleventh Circuit ruled that a blanket exclusion of treatments "'considered experimental'"

290 *See* David M. Eddy, *Rationing by Patient Choice*, 265 JAMA 105, 108 (noting that yielding to patient demands for treatment that the patient was not willing to pay for when she was healthy would "disconnect value and cost," and violate the maxim that "[y]ou can't change your bet after the wheel is spun" (internal quotation marks omitted)).

291 From 1960 to 1994, the number of insurance coverage lawsuits concerning issues of medical appropriateness that led to reported court opinions rose from only 5 in the 1960s, 36 in the 1970s, and 71 in the 1980s, to 200 within the first four years of the 1990s. *See* Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055, 1060 (1996).

292 *See id.* at 1055-56.

293 *See id.* at 1062 (reporting an overall patient success rate of 57% in private health insurance cases).

294 *See* Havighurst, *supra* note 39, at 1766.

295 986 F.2d 1379 (11th Cir. 1993).

was ambiguous as a matter of law and could not, without more evidence, support the insurer's denial of coverage.[296]

Although the opinion is a sound application of the standard black letter law of insurance contracts, the rule is problematic in the context of health insurance coverage, in which the vision of a completely specified contract is entirely unrealistic. The multitude of conditions a customer could develop, multiplied by the number of potential treatments for each condition, creates an enormous number of contingencies. Even the most conscientious health plan could not hope to explicitly include or exclude each treatment possibility prior to a customer's enrollment in the plan. If health insurance contracts are interpreted against the insurer on the grounds of ambiguity even when an insurer exercising the highest degree of care in drafting could not have avoided the ambiguity, the result is, as Havighurst has argued, a judicially imposed requirement that insurers provide Cadillac-quality coverage to all customers—even when this is inefficient because many customers would undoubtedly prefer to accept Chevrolet-quality coverage at lower price.[297]

As a case in point, consider the fallout from *Fox v. HealthNet of California*,[298] in which a jury awarded $89 million in compensatory and punitive damages to a plaintiff who was denied coverage for a bone marrow transplant to treat breast cancer on the grounds that it fell into the plan's exclusion of "investigational" treatments.[299] Commentators have claimed that, largely as a result of that verdict, nearly all MCOs now provide coverage for this treatment.[300] Presumably, their prices reflect the cost of this coverage. This outcome might be the most efficient second-best solution to the problem, but only if the Cadillac version of breast cancer treatment is the majoritarian option: most customers would have opted ex ante for broader coverage at an actuarially determined price had they been given the explicit choice between it and a smaller but cheaper bundle of coverages and services. If this description of consumer preferences is not accurate,

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296 *Id.* at 1381-83 (citing policy language); *see also* Pirozzi v. Blue Cross-Blue Shield, 741 F. Supp. 586, 589-90 (E.D. Va. 1990) (citing the Ninth Circuit and asserting that "[i]n the context of modern medicine, the term experimental seems clearly ambiguous on its face" (internal quotation marks omitted) (citation omitted)). *But see* Fuja v. Benefit Trust Life Ins. Co., 18 F.3d 1405, 1410 (7th Cir. 1994) (holding that the term "'in connection with medical research' is unambiguous" and refusing "to artificially create ambiguity where none exists" (internal quotation marks omitted) (citations omitted)).

297 *See* HAVIGHURST, *supra* note 46, at 181-82; *cf.* HALL, *supra* note 39, at 66 (concluding that insurers are reluctant to deny care "because, historically, courts have been unreceptive or outright hostile to insurers' attempts to interfere in clinical discretion for any reason").

298 No. 219692 (Cal. Super. Ct. Dec. 23, 1993) (LEXIS, Cal. File).

299 *See id.*

300 *See* David P. Maslen, *Employer Managed Care Liability: Defining and Managing the Risk*, J. COMPENSATION BENEFITS, July-Aug. 1995, at 5; *see also* Danzon, *supra* note 14, at 505 (same).

court-ordered bone marrow transplants to treat breast cancer, imposed on the managed care industry and its consumers via the interpretive device of *contra proferentem,* are suboptimal.

To efficiently resolve coverage litigation ex post, then, a court must determine not merely whether the health insurance contract is ambiguous as to whether the plan covers the claimed service, but also whether the majority of customers would have agreed to pay the marginal cost of such coverage ex ante if the choice was specified and the consumer was a thorough and careful optimizer of his managed care choices.[301] In the context of a general liability insurance policy, this is precisely what the Supreme Court of New Jersey sought to do in *Owens-Illinois, Inc. v. United Insurance Co.*[302] Explicitly seeking an "efficient"[303] resolution of the coverage dispute, the court assigned a Special Master to determine whether similarly situated policy holders would have purchased broad protection against asbestos-related liability at market prices if they could have foreseen the then-unknown risk of asbestos liability.[304] The case is notable because it is unusual for a court to undertake the task of attempting to determine ex post what litigants would have done ex ante in counterfactual situations in an effort to achieve an efficient outcome, rather than blindly applying the rule of *contra proferentem* without regard to the possible resulting inefficiencies.[305]

To suggest that this type of endeavor stretches the institutional competence of the judicial branch of government past the breaking point would be an understatement.[306] First, a court would have to make speculative predictions about the preferences of thousands of consumers who are not parties to the litigation and have no advocate in the process. In addition, judges would sometimes have to favor an unidentified, generalized mass of health insurance consumers, represented by a large insurance provider,[307] over an identifiable, ill, and

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301 *Cf.* Danzon, *supra* note 14, at 508 (noting that, "[v]iewing a coverage dispute as a contract issue, the relevant question is [whether] consumers [would] have been willing to pay for insurance coverage of this service, given their ex ante probability distributions of illness and expected outcomes from treatment, the cost of treatment, and iatrogenic risks," and concluding that, "[f]or private health plans, the relevant measure is the ex ante willingness-to-pay of plan enrollees").

302 650 A.2d 974 (N.J. 1994).

303 *Id.* at 993.

304 *See id.* at 988-96.

305 Insurance law scholar Kenneth Abraham notes that the "degree of candor" exhibited by the *Owens-Illinois* court "is unusual." Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation,* 95 MICH. L. REV. 531, 552 (1996).

306 *See* HALL, *supra* note 39, at 71 (concluding that "courts are institutionally ill-suited to apply this insurability perspective to coverage disputes").

307 *Cf.* Havighurst, *supra* note 39, at 1765 (observing that in litigation an insurance company "appears as a corporate deep pocket" that is "a powerful player in an unequal game").

sympathetic plaintiff,[308] often with his life hanging in the balance[309]—a difficult task even for the most coldly analytical legal mind.[310]

Applying standard contract interpretation principles to health insurance policies does not always expand coverage. It can, and sometimes does, have the opposite effect of limiting coverage, with equally questionable consequences from an efficiency perspective. When insurers explicitly list excluded services and treatments, or provide a specific definition of what falls under the exclusion for experimental treatments, courts often approve subsequent denials of coverage. In *Bechtold v. Physicians Health Plan*,[311] the Seventh Circuit ruled in favor of a health plan's denial of coverage for autologous bone marrow transplants as treatment for solid tumors, including breast cancer, because the plan had explicitly excluded such coverage.[312] In *Harris v. Mutual of Omaha Cos.*,[313] the same court found in favor of a health plan that excluded coverage for Phase I, II or III clinical trials as experimental, and subsequently refused to pay for a "phase II trial" treatment requested by its insured.[314] In *Fuja v. Benefit Trust Life Insurance Co.*,[315] the same court again allowed an insurer that excluded treatments administered "in connection with medical or other research" to refuse to provide a treatment currently being investigated in research studies.[316]

While these cases present competent judicial applications of the *contra proferentem* doctrine, which holds that unambiguous contracts will be enforced according to their terms, whether they promote the efficient allocation of resources to health care is far from clear. If the majority of policyholders would have preferred ex ante to pay the marginal cost of coverage for the experimental treatments that the insurer denied ex post, enforcing the plain language of the insurance

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308 *See* Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1464 (1994) (reflecting on the judicial resolution of health care claims and concluding that "human beings, forced to make actual decisions framed as health versus money, find themselves seeming and feeling inhumane" and "resort to just about any mechanism . . . to avoid or postpone facing the reality of scarcity").

309 Plaintiff success rate in health insurance coverage disputes is *lower* when the patient is highly likely to die without the requested treatment than if the patient faces only a small risk of death. This finding suggests insurers are reluctant to deny coverage to a dying patient without an extremely strong contractual basis for doing so, probably because they fear a court will treat them harshly. *See* Hall et al., *supra* note 291, at 1065.

310 *Cf.* David C. Hadorn, *Setting Health Care Priorities in Oregon*, 265 JAMA 2218, 2219 (1991) (describing how public policy is often based on the Rule of Rescue—rescuing identified individuals at all costs, but not expressing the same commitment when the individual is merely a statistic).

311 19 F.3d 322 (7th Cir. 1994).

312 *See id.* at 328-29.

313 992 F.2d 706 (7th Cir. 1993).

314 *Id.* at 712-13.

315 18 F.3d 1405 (7th Cir. 1994).

316 *Id.* at 1410 (internal quotation marks omitted).

contracts is inefficient. Because of the problems of adverse selection and consumers' bounded rationality, the fact that coverage for experimental treatments was not included and priced in the contracts litigated in those cases is hardly proof that the provision of such coverage would have been inefficient. The range of facts and the ex ante perspective necessary to determine whether the provision of a specific benefit is efficient make the legislature more institutionally competent than the judiciary to make such determinations, at least when an ex post perspective is not necessitated by the impracticality of fully specifying benefits ex ante.

B. The Trouble with Legislatures: Public Choice

Mandated benefits legislation can be viewed as the legislature deciding what benefits a majority of policy holders would have selected at the actuarially determined price, assuming complete information, unbounded rationality, and no market imperfections caused by adverse selection. Legislatures surely fall short of perfection when they attempt to make such assessments. But facts about the health insurance market and the preferences of a majority of consumers—facts about a broad population rather than about a specific litigant—are far more available to legislatures ex ante than to courts ex post.

That legislatures have an institutional advantage relative to courts in determining whether mandating benefits will enhance efficiency does not mean that delegating this task to legislatures is without problems. There are two primary drawbacks to legislative implementation of mandated benefits. The first problem stems from the observation that small but well-organized interest groups are likely to have too great an influence on the legislative process.[317] The consequence is that legislatures might enact benefits mandates, not because enactment promotes efficiency in the allocation of social resources, but because it benefits a particular group that wields a disproportionate amount of political power. Substantial danger exists that benefit mandates will be "simply concessions by state legislators to special interests to force consumers into buying insurance coverage for specific dis-

317 This problem, which the "public choice" literature thoroughly describes, is not unique to the mandated benefits context. *See* Einer R. Elhauge, *Does Interest Group Theory Justify More Intrusive Judicial Review?*, 101 YALE L.J. 31, 38-39 (1991) (explaining how interest group theory posits that collective action problems, which make it difficult for groups to assert their influence on the political process, are more pronounced for large groups with diffuse interests than for smaller groups with intense interests); *see also* Daniel A. Farber & Philip P. Frickey, *The Jurisprudence of Public Choice*, 65 TEX. L. REV. 873, 890-901 (1987) (describing the influence of special interests on legislation); Jonathan R. Macey, *Promoting Public-Regarding Legislation Through Statutory Interpretation: An Interest Group Model*, 86 COLUM. L. REV. 223, 229-33 (1986) (asserting that concentrated interest groups have a greater incentive than members of the general public to promote legislation).

eases or medical practices whether or not it is needed or wanted."[318] Proponents of the free market often criticize the regulation of MCOs on this ground.[319]

Every mandated benefit undoubtedly serves one or more interest groups with a financial or ideological stake in the provision of the benefit.[320] Groups of health care providers have a strong financial interest in the mandating of benefits that they provide. Psychiatrists and psychologists, for example, have an obvious interest in lobbying on behalf of mental health benefits mandates regardless of their cost. Women's rights advocates might see mandated maternity benefits as desirable from a gender-equality perspective, also without concern for costs involved. Consumers who believe such benefits are too costly are likely to be relatively diffuse, with less lobbying clout than their more organized counterparts[321]—if they realize at all that benefits mandates take money from their pockets.[322] This power imbalance might be offset if insurance companies oppose inefficient benefits mandates out of fear that marginal purchasers will exit the market, but there is no guarantee that this would have the effect of limiting enacted benefits mandates to those that are socially efficient. In any event, at the very least, legislative consideration of benefits mandates ensures that an untold amount of resources will be unnecessarily wasted in the lob-

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318 Henry N. Butler, *The Political Market for Mandated Health Care Benefits Under the Proposed National Health Security Act*, 3 KAN. J.L. & PUB. POL'Y 113, 115 (1994); *see also* HALL, *supra* note 39, at 22 (claiming that state mandates are often imposed "as the result of lobbying by special interest groups representing medical professionals"); Enthoven & Singer, *supra* note 2, at 30 (warning that "one should be sure that what is being proposed is consumer protection and not provider protection masquerading as consumer protection"); Hyman, *supra* note 28, at 425 ("[T]he drafting of consumer protection initiatives is readily hijacked by providers, who have their own interests at heart.").

319 *See, e.g.*, EPSTEIN, MORTAL PERIL, *supra* note 39, at 426 (claiming that the losers of "major institutional change" have led the legislative attack on managed care in an attempt to "recapture some of their gains through politics"); Hyman, *supra* note 28, at 451 ("[T]he government is not a neutral party when it comes to these matters—especially when it is enlisted by providers [of health care] to create or enforce a cartel, in which event most of the surplus is likely to be captured by those same providers.").

320 *See* Moran, *supra* note 45, at 18 (predicting that "[i]f we purport to regulate the terms of all salable health insurance in the United States, then all parties whose economic existence hinges on continued insurance coverage will fight savagely for inclusion").

321 *See* John F. Niblock, Comment, *Anti-Gay Initiatives: A Call for Heightened Judicial Scrutiny*, 41 UCLA L. REV. 153, 169 & n.91 (1993) ("[D]iscrete and insular groups possess certain political advantages, such as solidarity, organization and lobbying power, that more diffuse and anonymous groups, such as lesbians and gays, lack." (citing Bruce A. Ackerman, *Beyond* Carolene Products, 98 HARV. L. REV. 713, 745 (1985))).

322 *Cf.* Bellante & Porter, *supra* note 120, at 685 ("The politician realizes little opposition to proposed mandated benefits because the cost of the benefit is hidden . . . and these costs are spread . . . ."); Butler, *supra* note 318, at 116 (arguing that politicians like to spend money from sources other than tax revenue "because the adverse economic impacts are more difficult to trace back to [the legislature], making the political costs lower, yet the potential political benefits are just as great as they would have been had [the legislature] paid for the program on budget").

bying efforts of those with personal interests in which benefits are imposed.

Even if legislatures resist the pressure of concentrated interest groups and enact benefit mandates in response to consumer demands, the second, and extremely ironic, problem remains. Public-spirited legislatures are likely to mistakenly enact precisely the *wrong* benefit mandates. Vocal consumer support is a necessary precondition for a public-spirited legislature to mandate a particular benefit. But if a benefit is important and salient enough to consumers for them to petition their representatives for legislation, the unregulated market will most likely provide the benefit anyway, assuming that most consumers are willing to pay its marginal actuarial cost. Government action, in such cases, is either unnecessary or inefficient. The market is most likely to underprovide benefits of relatively lesser importance to consumers—ones that are little noticed by the public. By definition, less important benefits will not be the subject of significant consumer lobbying. Without public pressure, busy legislatures are unlikely to identify benefits that the market underprovides and thus should be mandated.

Postpartum maternity benefits may illustrate this irony. As stories of hospitals involuntarily discharging mothers and their newborn infants from the hospital within twelve hours of birth because their MCOs refused to pay for additional hospitalization proliferated and created a public outcry, two responses occurred roughly simultaneously. More than half of the states,[323] followed by the federal government,[324] mandated minimum postpartum hospitalization benefits. At approximately the same time, a substantial number of MCOs began to compete for customers on the basis of their generous maternity benefits.[325] Other health care providers began to see a market opportunity in postpartum maternity benefits as well; a number of hospitals attempted to lure customers by advertising free "extra" days of postpartum hospitalization.[326]

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323 *See* Kuper, *supra* note 77, at 667-68 (reporting that 28 states had passed mandated benefits bills, and legislation was pending in others when the federal government passed its version of the same law).

324 *See supra* note 7 and accompanying text.

325 *See* Moran, *supra* note 45, at 14 ("Within days after the [news became public], a substantial number of health plans had revised or clarified their policies regarding maternity length-of-stay and were actively advertising that fact. [The fruits of] the various legislative efforts . . . [thus] appeared well after the problem had disappeared from the market."); *see also* Stuart Auerbach, *Doctor's Alliance Has a Remedy for Managed Care Limits*, WASH. POST, Dec. 30, 1996, at F12 (reporting on an MCO advertisement that it did not provide "drive-through deliveries").

326 *See* Kuper, *supra* note 77, at 685-86 (reporting that hospitals in Washington, Michigan, New York, and Illinois have offered newborn infants and their mothers free postpartum stays of 48 hours, even if their insurance would not pay for the full stay).

These market responses suggest that a benefits mandate was probably not necessary to ensure the efficient provision of postpartum hospitalization coverage. Postpartum maternity benefits may not have always been of sufficient importance and salience to boundedly rational consumers to insure their efficient provision by the free market. But the publicity surrounding "drive-through deliveries" in the mid-1990s apparently made these benefits salient to a critical mass of attractive consumers and thus assured the market's efficient provision of them. The same publicity that led to a market response also led to a legislative response that was, by that time, rendered unnecessary.

C. Expert Commissions

Because courts must resolve the cases of individual litigants, they are in a poor position to make the type of cost-benefit trade offs that the provision of efficient benefits mandates requires. Legislatures can focus on the ex ante costs and benefits to broad populations of mandated benefits, rendering them better suited institutionally than courts to determine which mandates would be efficient. Unfortunately, benefits with enough political support to win a legislative mandate are likely to be either those that the unregulated market would provide or those that are inefficient but championed by unduly influential interest groups or irate consumers who do not, in fact, desire the benefit in question at its actuarial cost.

In light of the shortcomings of courts and legislatures as decision makers, states (or the federal government) should place the power of determining which benefits should be mandated and which should be left to the market in the hands of specially created, independent expert commissions. Legislation of specific benefit mandates (or "body part" bills, as they are sometimes called) should be replaced by legislation delegating to independent expert bodies the responsibility of evaluating such proposals.[327] These bodies should be explicitly charged with performing a market mimicking function, mandating only those benefits estimated to be inefficiently underprovided by the health insurance market.

There are reasons to believe that expert commissions would be superior to legislatures at the task of mandating the "right" (efficiency enhancing) benefits and avoiding mandating the "wrong" (efficiency decreasing) benefits. First, they should be composed of scientists and economists with the technical ability to determine which benefits not provided by the market would improve the efficient allocation of re-

327 At least one analyst, following a market-facilitating rather than a market-mimicking regulatory model, has recently proposed the formation of a federal agency, modeled after the Securities and Exchange Commission, that would mandate uniform information disclosure requirements for MCOs. *See* Etheredge, *supra* note 259, at 23.

sources to health care and should be mandated; few legislators are likely to possess these technical abilities.[328] Second, whereas busy legislators with wide-ranging responsibilities are not likely to independently attempt to mandate a benefit prior to a lobbying effort on its behalf, an independent commission can be charged with the task of proposing mandated benefits that have not yet spawned such lobbying efforts.

Perhaps most importantly, expert commissions are less likely than legislatures to mandate inefficient benefits as a result of pressure lodged by rent-seeking interest groups. To be sure, concentrated interest groups can sway commissions, as well as legislatures.[329] But by staffing such commissions with professionals who have specific technical expertise and who are not career politicians or bureaucrats, and by making the terms of commission members sufficiently lengthy to protect them from political retribution for their decisions, the commissions can be substantially insulated from the political process.[330] As one example, witness the notable success of the Presidential Base Closing Commission in neutralizing the power of interest groups that had succeeded for many years in blocking congressional attempts to close inefficient military bases.[331] As another example, consider the ability of independent central banks, such as the United States Federal Reserve, to conduct monetary policy largely free from political influences.[332]

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328 Even staunch opponents of legislative delegation of responsibility to administrative agencies believe that, once a legislature specifies the normative standards by which agencies are to make decisions, the technical application of those standards is a proper subject of delegation. *See* Peter H. Aranson et al., *A Theory of Legislative Delegation*, 68 CORNELL L. REV. 1, 24 (1982) ("No one who argues for requiring greater specificity in legislative delegations supposes that the members of Congress could or should specify within narrow limits . . . [the scope of technical legislation]. But one might imagine that legislators would at least address the basic framework . . . within which power levels would be set.").

329 *Cf. id.* at 26 (claiming that delegation of decision making to administrative agencies will not eliminate the influence of interest groups, but merely lead to the presence of interest groups in the agencies).

330 In addition, if the executive appoints expert committees, they may be more insulated from the political process than are legislators. The executive—be it a governor or the President—is accountable to a broader constituency than legislators, and thus might be more responsive to the general public interest. For an elaboration of this argument, see JERRY L. MASHAW, GREED, CHAOS, AND GOVERNANCE 152-53 (1997).

331 *See, e.g.*, Alan S. Blinder, *Americans Versus Their Government: Is Government Too Political?*, CURRENT, Mar.-Apr. 1998, at 16, 20 (noting that the base-closing commission is "now viewed as a noteworthy success"); Carolyn Lochhead, *Armey of the Right*, REASON, July 1997, at 30, 32 (calling the commission "one of the great political successes of modern government").

332 *See* Geoffrey P. Miller, *An Interest-Group Theory of Central Bank Independence*, 27 J. LEGAL STUD. 433, 446-47 (1998) (arguing that independent central banks are far more insulated from political forces than they would be if they were under the direction of the government's treasury department).

Although legislatures in the 1990s have tended to mandate health care benefits directly, a few have delegated some decision making authority to independent commissions. Although none of these efforts has maximized the efficiency of health care benefits provided by MCOs and other insurers, they can be seen as initial steps in the right direction. Pennsylvania has enacted legislation that created a health-care cost containment council responsible for evaluating the efficacy of proposed health care benefits mandates and providing recommendations to the legislature.[333] By statute, the council's twenty-one members consist of an assortment of public officials and competing interest-group representatives[334]—not exactly a recipe for insulating mandate decisions from the pressures of interest group politics. One of the council's charges, however, is to establish mandated benefits review panels to independently assess legislative proposals.[335] These panels are to consist of four researchers: one in health insurance, one in biostatistics, one in economics, and one physician with knowledge of the proposed mandate's subject matter.[336]

In theory, this type of expert commission could help depoliticize and rationalize the promulgation of benefits mandates. Problems with the structure of the Pennsylvania legislation, however, have prevented mandated benefits review panels in that state from serving this function. First, the panels are only advisory; they have no actual power to either mandate benefits or block legislative mandates.[337] Second, the Health Care Cost Containment Council convenes the panel only if the council decides that data submitted by parties who support and oppose a proposed mandate are sufficient for a full analysis of the issue.[338] Although the council has received a large number of requests from the legislature to present recommendations on proposed mandates (eleven in 1998 alone), it has convened review panels only rarely since the data sufficiency provision was enacted in 1993.[339]

In response to a model act created by the National Association of Insurance Commissioners in 1991,[340] a number of states have created administrative bodies charged with specifying a mimimum level of insurance benefits, which any MCO or insurance company doing busi-

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333 *See* PA. STAT. ANN. tit. 35, § 449.5 (West, WESTLAW through end of 1998 Reg. Sess.).

334 *See id.* § 449.4(b).

335 *See id.* § 449.9(1).

336 *See id.* § 449.9(2).

337 *See id.* § 449.9(3).

338 *See id.* § 449.9(1).

339 *See* Email correspondence between Tricia Fanone and Flossie Wolf, Director of Policy and Legislative Affairs, Pennsylvania Health Care Cost Containment Council (Nov. 2, 1998) (on file with author).

340 *See* 1 NATIONAL ASS'N OF INS. COMM'RS, OFFICIAL N.A.I.C. MODEL INSURANCE LAWS, REGULATIONS, AND GUIDELINES at 35-1 (1984 & Supp. 1996).

ness in that market[341] must offer to small employers. Maryland is a representative example. The Maryland Health Care Access and Cost Commission has statutory authority to promulgate, by regulation, the minimum benefit levels that any insurance carrier may provide to firms with two to fifty employees.[342] The enabling legislation permits the governor, with the advice and consent of the state senate, to appoint the nine commission members, with the only restriction being that six of the nine must not be connected to a health care provider or payer.[343] In 1994, with the input of a governor-appointed Standard Benefit Plan Task Force,[344] the commission mandated a set of minimum benefits for the small-employer insurance market, taking into account the efficacy of proposed benefits and the overall affordability of the package.[345]

The Maryland legislation, like the Pennsylvania legislation, is a step, albeit an incomplete one, in the direction of rationalizing the process of mandating health care benefits. On the positive side, Maryland's commission was partially insulated from the political process, attempted to balance the costs and benefits of mandates, and had authority to promulgate mandates. On the negative side, the commission's power extended only to the small-employer insurance market, and its enabling legislation did not specify the qualifications of its appointees sufficiently enough to insure that the commission was truly expert rather than political.

Mandates can improve the efficiency of society's allocation of resources between health care and other goods when used to require benefits that will otherwise be systematically underprovided by the

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341 *See, e.g.*, ALASKA STAT. § 21.56.060 (Michie, WESTLAW through end of 1998 2d Sp. Sess.); COLO. REV. STAT. ANN. § 10-8-606 (West, WESTLAW through end of 1998 2d Ex. Sess.); DEL. CODE ANN. tit. 18, § 7211 (WESTLAW through end of 1999 Reg. Sess.); MD. CODE ANN., HEALTH-GEN. I § 19-1502 (WESTLAW through end of 1999 Reg. Sess.); N.D. CENT. CODE § 26.1-36.3-08 (WESTLAW through end of 1999 Reg. Sess.); WYO. STAT. ANN. § 26-19-308 (Michie, WESTLAW through end of 1998 Reg. Sess.).

342 *See* MD. CODE ANN., INS. § 15-1203 (WESTLAW through end of 1998 Reg. Sess.).

343 *See* MD. CODE ANN., HEALTH-GEN. I § 19-1503 (WESTLAW through end of 1998 Reg. Sess.).

344 *See id.* § 19-1501. The Editor's Note states:

> Section 4, ch. 9, Acts 1993, provides that 'the Governor shall appoint the Maryland Standard Benefit Plan Task Force to advise the Medical Care Data Review Commission on the initial development of the standard comprehensive health benefit plan to be adopted in accordance with § 700 of Subtitle 55 of Article 48A . . . and Title 19, Subtitle 15 of the Health-General Article.'

Id. § 19-1501 note. The note goes on to say that "the Governor shall, to the extent practicable, ensure that the Task Force is comprised of an appropriate and balanced mix of representatives of practitioners, hospitals, carriers, employers, labor, and consumers." *Id.*

345 *See* MD. INS. REGS. § 09.31.05 (1998); Don S. Miller & Thomas P. Barbera, *Report of the Maryland Standard Benefits Plan Task Force to the Health Care Access and Cost Commission*, Nov. 4, 1993, at 24-25.

market. On the other hand, mandates can cause an inefficiently high level of resources to be devoted to health care when they require benefits that the majority of consumers would rather not purchase at the amount of money they cost to provide. Government is most likely to use mandates efficiently (and not inefficiently) in the following circumstances:

> (1) A commission is created to evaluate the efficacy of benefits mandates;
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> (2) The commission is made an expert rather than a political entity by specifying membership qualifications to insure that members are well-qualified to evaluate the efficiency consequences of mandates;
>
> (3) The enabling legislation specifies that the commission's goal is to mandate only efficiency-enhancing benefits;
>
> (4) The commission is given authority to promulgate mandates that it believes will be efficiency enhancing. At a minimum, the commission should have the authority to call for a vote of the legislature to approve or disapprove (without amendment) its proposed mandates;
>
> (5) The commission is given authority to block legislative mandates that it believes will increase inefficiency in the allocation of resources. At a minimum, the commission should be able to require a supermajority of the legislature to override its opposition to a proposed mandate;
>
> (6) The commission's authority extends to all MCOs and insurance companies doing business in the jurisdiction, except to the extent that ERISA or other federal legislation preempts the mandates of a state body.

CONCLUSION

The public backlash against the perceived excesses of managed care has made "patient protection" or "mandated benefits" legislation ubiquitous in the 1990s at the state level and an issue of emerging salience at the federal level. Opponents of the legislation contend that it is inefficient; it causes consumers to spend more money on health care than they wish to spend. Proponents generally contend that notions of economic efficiency do not belong in discussions of the provision of health care.

This Article has contended that policymakers need not naively believe that they can legislate away the problem of scarcity in order to support benefit mandates in some circumstances. For two primary reasons, market incentives are likely to encourage MCOs and other providers of health insurance to offer an inefficiently low level of benefits. First, a simple game theoretic model suggests that, because it is impossible to completely specify the terms of a health insurance con-

tract, MCOs have an incentive to provide a lower level of coverage than consumers might wish to purchase. Second, psychological research on consumer decision making suggests that purchasers of a product as complicated as health care coverage are likely to adopt selective, noncompensatory choice strategies. Such strategies will systematically reward suppliers that provide a low-priced rather than a high-quality insurance product. Because of these market imperfections, mandated benefits can be efficiency enhancing rather than efficiency reducing.

The economic argument for mandated benefits depends, of course, on the assumption that government actors can successfully identify which mandates will be efficiency enhancing and which will not. This determination would be difficult under the best of circumstances, but courts and legislatures face institutional impediments to successfully making such complicated determinations. Appropriate mandated benefits decisions are most likely to be made by expert commissions that can find shelter from the influence of interest-group politics that is likely to affect legislative determinations.

The bad news about health care mandates is that consumers must pay for them. Contrary to the promises of populist clamoring for increased regulation of managed care, the public cannot expect an increased number of benefits free of charge. The good news about mandates is that, in some circumstances, consumers might prefer to pay for benefits that the market for health insurance does not provide rather than enjoy a reduced level of benefits at a somewhat lower price. In order to rationalize the amount of money devoted to health care, the debate over patient protection laws must take seriously both of these points. We have to pay for all the benefits that we wish to receive. But we can use government mandates to insure that we receive all the benefits for which we are willing to pay.