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## ARTICLES

# REGULATING MANAGED CARE: WHAT’S WRONG WITH A PATIENT BILL OF RIGHTS

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The basic theory of consumer protection is that “the consumer is gullible; . . . the businessman is criminal; and . . . the government is infallible.”\*\*

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For stylistic reasons, this Article uses “patient bill of rights” and “consumer bill of rights” interchangeably. A discussion of the substantive differences between these terms, which implicate quite different visions of what is at stake, is beyond the scope of this article.

\*\* *Regulatory Reform: Highlights of a Conference on Government Regulation* (W.S. Moore ed., 1975), at 52 (statement of Rep. John Erlenborn) (citing Catherine May).

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## I. INTRODUCTION

In just a few short years, managed care has gone from the darling of health policy wonks to the moral equivalent of the tobacco companies. Complaints about avoidable death and disability, delay, inconvenience, micro-management, profiteering, declines in quality, and petty bureaucracy are legion. A flood of horror stories has solidly implanted the perception that life under managed care is nasty, brutish, and short. Managed care organizations (“MCOs”) may provide health care services to the majority of insured Americans, but in movies and on television they have become the villains of choice.

State and federal legislators have responded with a virtual deluge of laws, bills, and regulations. At first, these initiatives targeted particular “offensive” managed care practices such as “gag clauses” and “drive-through deliveries,” but reform advocates quickly developed more comprehensive aspirations—with legislative and regulatory frameworks to match. The preferred strategy now appears to be to propose a “patient bill of rights,” encompassing a wide range of provisions which are asserted to be absolutely necessary if high quality health care is to be provided.<sup>1</sup> In Congress, Republicans and Democrats have proposed a host of patient bills

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1. There is a long history of describing legislation as providing a “bill of rights” to someone or another. See William Safire, *On Language*, N.Y. TIMES, August 1, 1999, § 6 (Magazine), at 22. Recent beneficiaries include taxpayers, taxi passengers, supermarket customers, and clients of lawyers. See *id.* It is not clear why legislation specifying minimum contract terms for MCOs should be described as a bill of rights, even if one ignores the Hohfeldian distinction between rights, privileges, and immunities. See WESLEY N. HOHFELD, *FUNDAMENTAL LEGAL CONCEPTIONS: AS APPLIED IN JUDICIAL REASONING* 64 (W. Cook ed., 1963). Service providers have also been known to formulate their own “bills of rights” in an attempt to fend off more restrictive regulation.

of rights.<sup>2</sup> Variants of such legislation have been considered and adopted by virtually every state legislature in the past year.<sup>3</sup>

Using a patient bill of rights to combat the perceived excesses of managed care has great popular appeal, but it does not follow that this strategy is actually sound policy—or that the provisions which will be enacted are actually beneficial—let alone cost-justified. Unfortunately, these issues have been largely ignored; commentators either treat the need for a patient bill of rights as a self-evident truth, provide an anecdotal horror story or two to justify particular provisions, or offer arguments on the order of “managed care bad; patient bill of rights good.”

The desirability of a patient bill of rights can not be resolved on the basis of such claims. A better strategy is to conduct a detailed examination of the benefits and costs of the proposed provisions and their alternatives. This approach has the advantages of rigor and concreteness, but is complicated by the rate of legislative flux and the lack of available data on some of the provisions. However, such scrutiny makes it quite clear that many of the proposed provisions are unlikely to provide significant benefit to consumers.<sup>4</sup> Indeed, several popular provisions are more accurately characterized as provider protection.<sup>5</sup>

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2. 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); and Patients' Bill of Rights Act, S. 326/H.R. 240 106th Cong. (1999). Other competing legislation includes the 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); and Bipartisan Consensus Managed Care Improvement Act, H.R. 2723, 106th Cong. (1999).

3. See generally Families USA Foundation, *Hit and Miss: State Managed Care Laws* (visited Aug. 22, 1999) <<http://www.familiesusa.org/hit1.htm>> [hereinafter *Hit or Miss*].

4. See, e.g., David A. Hyman, *Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?*, 85 N.C. L. REV. 5 (1999) [hereinafter *Drive-Through Deliveries*]; David A. Hyman, *Assessing the Policies We Have: Scenes From a Maul*, 24 J. HEALTH POL. POL'Y & L. 1061 (1999) [hereinafter *Scenes From a Maul*]; David A. Hyman, *Accountable Managed Care: Should We Be Careful What We Wish For?*, 32 U. MICH. J.L. REFORM (forthcoming 1999) [hereinafter *Accountable Managed Care*]; David A. Hyman, *Consumer Protection and Managed Care: With Friends Like These . . .*, in 1998 HEALTH LAW HANDBOOK 283, 283 (1998) [hereinafter *With Friends Like These*]; David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 415-420 (1998) [hereinafter *Call 911*].

5. See Hyman, *Drive-Through Deliveries*, *supra* note 4, at 8; Alain C. Enthoven & Sara J. Singer, *Markets and Collective Action in Regulating Managed Care*, 16 HEALTH AFF. 26, 30 (1997) (“One should be sure that what is being proposed is consumer protection and not provider protection masquerading as consumer protection.”); Peter T. Kilborn, *Bills Regulating Managed Care Benefit Doctors*, N.Y. TIMES, Feb. 16, 1998, at A1 (“The quip going around is that this is physician protection, not consumer protection.”).

An alternative strategy is to step back from the scrutiny of individual provisions, and consider the appropriateness of a bill of rights model as such to the regulation of managed care. Little effort has been made to evaluate whether legislators have the appropriate information, preferences, and incentives to arrive at the correct rights and associated institutional arrangements—let alone whether a set of universal non-waivable positive rights is actually a beneficial strategy for consumers. This Article systematically evaluates these considerations and concludes that a patient bill of rights is unlikely to deliver any real benefits to consumers, although it will create significant costs and distortions.

Part II outlines the economics of health insurance, the development of managed care, the rise of patient bills of rights, and market/regulatory failure. Part III explores the information on which legislators have relied in their campaign to regulate managed care. Part IV outlines legislative preferences and incentives and assesses whether the government can function as an honest broker when it regulates in this area. Part V evaluates the problem of regulatory fit and analyzes whether imperfections in the markets for health insurance and health care might justify some form of regulatory intervention, even if it does not take the form of a patient bill of rights. Part VI considers whether expert commissions offer an answer to the problems identified in Parts III-V. Part VII offers a narrative perspective on these issues. Part VIII provides a brief conclusion.

## II. HEALTH INSURANCE, MANAGED CARE, AND THE PATIENT BILL OF RIGHTS

In order to understand the causes of the campaign to enact a patient bill of rights, and the potential consequences of doing so, it is necessary to review the system through which health care and health insurance is delivered and regulated, and the advantages and disadvantages of these arrangements.

### A. A PRIMER ON HEALTH INSURANCE

Insurance is a contractual mechanism to shift, spread, and distribute risk. Health insurance allows an individual to pre-pay some portion of his anticipated medical expenditures for the coming year, and socialize some of the associated (but more unpredictable) health-related risks. The scope of the risks which are shifted and spread is dictated by a contract—the health insurance policy.

Health insurance policies are issued to groups and individuals. Group insurance lowers the administrative and marketing costs of insurance, and can decrease the significance of adverse selection.<sup>6</sup> When the group insurance is provided in connection with employment, it also qualifies for favorable tax treatment.<sup>7</sup> Coverage in both group and individual markets is based on the aggregation of consumer preferences, balanced against actuarial principles.

Most employed individuals who are insured secure their insurance through their employer.<sup>8</sup> Companies vary greatly in the coverage and out-of-pocket costs associated with the provision of such insurance to employees. Those risks which are not transferred are self-insured. Coverage which is more generous is more expensive. Copayments and deductibles help fine-tune the coverage (and deal with the problem of moral hazard) by allowing for a mix of self-insurance and third-party coverage.<sup>9</sup> Not surprisingly, a policy with a substantial copayment, deductible, and exclusions on preexisting conditions is substantially cheaper than one which provides first-dollar coverage for all medically necessary expenses.

Willingness to purchase health insurance is heterogeneous, and greatly affected by the premium.<sup>10</sup> As the premium increases, the policy becomes

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6. Because many individuals can predict their health needs better than insurers, those who voluntarily select insurance coverage are more likely to incur greater medical expenses than the general population. This phenomenon is commonly described as adverse selection. If coverage is written for a group that exists for reasons independent of the desire to secure insurance coverage, the effects of adverse selection are significantly mitigated. The substantive content of a policy can also induce adverse selection; if most insurers do not cover in-vitro fertilization ("IVF") an insurer offering such coverage will predictably attract many infertile couples.

7. See I.R.C. § 106 (1986) ("Gross income does not include contributions by the employer to accident or health plans for compensation (through insurance or otherwise) to his employees for personal injuries or sickness."). The value of this subsidy is estimated at \$76.2 billion per year in FY 1999. See Hyman, *Drive-Through Deliveries*, *supra* note 4, at 11 n.28.

8. See Judith R. Lave, Pamela B. Peele, Jeanne T. Black, John H. Evans III & Gabrielle Amersbach, *Changing the Employer-Sponsored Health Plan System: The Views of Employees in Large Firms*, 18 HEALTH AFF. 112, 112 (1999) ("In fact, 90 percent of nonelderly persons who have private health insurance are covered by employer-sponsored policies."). Of course, many employers do not provide health insurance to their employees, including many small businesses, and most businesses in the retail and agricultural sectors of the economy.

9. Moral hazard refers to the fact that an individual who is covered by insurance behaves differently than would be the case absent the insurance. Because insurance protects the insured from the full financial consequences of an adverse event, the individual is more likely to consume more health care services when illness strikes. See Mark Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 535 (1965) ("[T]he response of seeking more medical care with insurance than in its absence is a result not of moral perfidy, but of rational economic behavior."). This fact explains why, from an economic perspective, comprehensive coverage is not socially optimal.

10. See Hyman, *Call 911*, *supra* note 4, at 437.

less affordable for people at the margin. Those who are buying the policy must decide whether “better” coverage, however defined, is worth purchasing—and those who would willingly have bought a more limited policy must self-insure (that is, become one of the approximately forty-three million uninsured Americans) once the cost of the minimum available insurance product exceeds their willingness to pay.

Because insurance only shifts and spreads risk for which the policy provides coverage, the specification of such coverage necessarily implies a series of trade-offs within the common pool, with significant distributional implications within and across identifiable groups. For example, at any given level of premium, coverage of routine mammograms for women in their forties may preclude coverage of bone marrow transplants for advanced breast cancer patients. Similarly, coverage of family planning services may preclude coverage of more aggressive screening for prostate cancer. Legislative mandates can reallocate resources within the common pool, but new or enhanced services are covered at the expense of something else or increased premiums—or both.

Because most employed individuals secure their health insurance through their place of employment, employers play a significant role in the coverage and health care delivery markets. By selecting particular insurance plans to offer their employees, and excluding others, employers necessarily influence what services are covered, and the circumstances under which those services can be delivered. In like fashion, by selecting particular insurance products, employers effectively dictate the scope and nature of the cost-quality-access trade-offs their employees can make.<sup>11</sup> Although some employers offer their employees a choice of multiple health insurance arrangements, a sizeable minority offer only one plan, or offer multiple plans from only one insurer.<sup>12</sup> Even when multiple plans are offered, there is little ability to tailor coverage to particular needs and tastes.

The employer thus performs useful search and aggregation functions for its employees, but does so at the cost of some predictable disjunction between the choices of individual employees and those which are appealing to the risk pool at any given employer taken as a whole—even if the employer acts in the utmost good faith with regard to the selection of

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11. See Lave et al., *supra* note 8, at 112 (“[B]ecause employers sponsor only a limited number of health plans, some employees may be forced to ‘buy’ more or less health insurance than they want.”).

12. See Karen Davis, *Assuring Quality, Information, and Choice in Managed Care: Percentage of Adults Ages 18-64 in Working Families Who Have a Choice of Health Plans* (visited Aug. 23, 1999) <[http://www.cmwf.org/programs/health\\_care/hccahtml/dt109701.asp](http://www.cmwf.org/programs/health_care/hccahtml/dt109701.asp)>.

coverage terms. For example, some employees might prefer that their insurance cover more extensive postpartum hospitalization, while others might prefer better coverage of AIDS, and some employees might simply prefer less generous coverage in exchange for a higher take-home salary. The distribution of these preferences will also vary from employer to employer. The employees of a start-up software company are likely to want a quite different package of benefits than the employees of IBM, who in turn are likely to want a different package of benefits than the employees of General Motors.<sup>13</sup> In balancing these interests, the employer must choose a limited number of insurance products (because offering too many increases administrative costs and can dilute the bargaining power associated with volume purchasing) and must also ensure that the resulting offerings are appealing and affordable (because employees will complain and may even find other employment if they believe the offered coverage is inadequate).<sup>14</sup>

The significance of employers in the coverage market is demonstrated by the rise of managed care. Employers embraced managed care as the solution to spiraling health insurance costs, and employees found their choices accordingly constrained.<sup>15</sup> Employees were understandably displeased that their health insurance, which had previously provided free choice of providers and first-dollar coverage of anything and everything was being cut back—but when employees faced even a portion of the cost

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13. See Catherine C. McLaughlin, *Health Care Consumers: Choices and Constraints*, 56 MED. CARE RES. & REV. 24, 25 (1999):

While health insurance is but one factor in firm choice, it is not difficult to believe that young, single males may deliberately choose to supply their labor to a small, high-tech firm that offers no health insurance in exchange for higher wages, and that a young male with similar skills but two small children and a wife who does not want to enter the labor market may instead supply his labor to IBM, earning a lower salary, but receiving a rich family health insurance package at a large group rate.

*Id.*

14. To be sure, the ability of employees to find alternative employment that provides the desired benefits is likely to vary tremendously, which complicates the use of exit as a feedback mechanism. See George Annas, *Patients' Rights in Managed Care—Exit, Voice, and Choice*, 337 NEW. ENG. J. MED. 210 (1997). In addition, by the time employees discover a “gap” in their coverage, it may be too late for them to find another employer willing to hire them and provide insurance that covers the condition in question.

15. See Lave et al., *supra* note 8, at 122 (“In response to rising health care costs, employers are increasingly offering managed care products that restrict the set of providers available to workers and the way that workers get access to health care.”); Robert H. Brook, Caren J. Kamberg & Elizabeth A. McClynn, *Health System Reform and Quality*, 276 JAMA 476, 476 (1996) (“The transition to managed care in the United States has been largely driven by a desire by employers, insurance companies, and the public to control soaring health care costs.”).

of their decisions, they rapidly enrolled in less-expensive managed care plans.<sup>16</sup>

At present, roughly eighty-five percent of the employed population is in some form of managed care.<sup>17</sup> The federal and state governments have also embraced managed care for Medicare and Medicaid,<sup>18</sup> although the percentage of these populations in managed care currently lags behind the general population.<sup>19</sup>

#### B. WHAT IS MANAGED CARE?

Managed care encompasses a wide array of institutional arrangements for the financing and delivery of health care services.<sup>20</sup> Managed care developed in response to a health care system based on fee-for-service reimbursement, which insulated patients from the costs of their decisions. Under the fee-for-service system, individuals had free choice of providers, and insurers reimbursed those providers for whatever treatments they had

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16. See Lynn Etheridge, *What Is Driving Health System Change?*, 15 HEALTH AFF. 93, 98 (1997) ("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."); Roger S. Taylor, *Commentary*, 56 MED. CARE RES. & REV. 60, 62 (1999) ("[T]he majority of consumers were willing to trade the ability to choose providers for a reduction in out-of-pocket costs. . . . This helps explain why, when offered both a fee-for-service plan and a managed care plan, the majority chose managed care.").

17. See Bureau of Lab. Stat., U.S. Dep't of Lab., *Employee Benefits in Medium and Large Private Establishments, 1995* (1997) (noting that 86% of participants are covered by some form of managed care).

18. The Balanced Budget Act of 1997, Pub. L. No. 105-33, 1997 U.S.C.C.A.N. (111 Stat.) 251 (to be codified at 42 U.S.C. § 1395), created substantial incentives to move Medicare beneficiaries into managed care. See Jennifer E. Gladieux, *Medicare + Choice Appeals Procedures: Reconciling Due Process Rights and Cost Containment*, 25 AM. J.L. & MED. 61, 66-68 (1999). The Balanced Budget Act of 1997 also accelerated a preexisting trend toward mandatory managed care for the Medicaid beneficiary population. See Lisa Axelrod, *The Trend Toward Medicaid Managed Care: Is The Government Selling Out The Medicaid Poor?*, 7 B.U. PUB. INT'L L.J. 251, 256 (1998).

19. Of the approximately thirty-one million Americans in Medicaid, 53.64% or sixteen and one-half million are in managed care plans. See Health Care Fin. Admin., *National Summary of Medicaid Managed Care Programs and Enrollment* (visited Aug. 23, 1999) <<http://www.hcfa.gov/medicaid/trends98.htm>>. However, the penetration of managed care varies from 0% to 100%, depending on the state. See Health Care Fin. Admin., *Medicaid Managed Care State Enrollment* (visited Aug. 23, 1999) <<http://www.hcfa.gov/medicaid/mcsten98.htm>>. In Medicare, approximately 30% of the beneficiary population is in managed care, and the number has been growing rapidly, although the rate of growth has slowed in the last year. See Gladieux, *supra* note 18, at 63.

20. See Hyman, *Accountable Managed Care*, *supra* note 4, at 12:

[T]he financing and delivery of care can be integrated to a greater or lesser extent; the corporate structure can be non-profit or for-profit; providers can be employees of the managed care organization or independent contractors; providers can be selected and compensated and the risks shared in a wide variety of ways.

*Id.*

performed. The consequences of this arrangement were both predictable and extraordinarily expensive.

In response, MCOs developed supply- and demand-side strategies to force patients and providers to consider marginal costs in making health care consumption decisions. The “tools” of managed care include required pre-authorization, restricted access to specialists, restricted panels of providers, higher copayments (and sometimes denial of coverage) for out-of-network care, capitation, bonuses, practice guidelines, retrospective denials of coverage, “real-time” utilization review, restricted coverage of prescription drugs, and limitations on benefits. In global terms, MCOs offer a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles, and copayments than traditional indemnity insurance.

Patients who were used to relying on free choice of providers and open-ended reimbursement as guarantors of quality were understandably concerned about these changes, especially when the range of coverage choices and service delivery arrangements were, for many, effectively dictated by employers. Concern about the incentives created by managed care was heightened by the regulatory vacuum around certain aspects of employment-based health coverage—a subject addressed in Part II.C.

### C. REGULATORY MISMATCH: AN INTRODUCTION TO ERISA

In general, the regulation of health insurance has been left to the states, which have taken full advantage of this authority, and aggressively regulated the terms of insurance contracts. In addition, state courts have employed common law causes of action to encourage insurers to deliver on their promises. However, the Employee Retirement Income Security Act of 1974 (“ERISA”) creates a large loophole in this structure, by preempting most state-level regulation of health insurance if it is provided in connection with employment.<sup>21</sup> Because ERISA contains no substantive regulation of its own, and provides only an exceedingly limited set of remedies (lawsuits are, to a first approximation, limited to the value of the denied services), employment-based health insurance is effectively unregulated. ERISA does provide that the state can indirectly regulate an employee benefit plan if the plan purchases insurance from a state-

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21. See 29 U.S.C. § 1001-17 (1995). See also Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 NEW ENG. J. MED. 1986 (1997) (reviewing effects of ERISA on state regulation). ERISA does not apply to employees of local, state, and federal governments, or of churches or other religious organizations. See 29 U.S.C. § 1003 (1995).

regulated insurer (an “insured” employee benefit plan).<sup>22</sup> However, if the employer provides its own insurance (a “self-funded” employee benefit plan), the plan is effectively not subject to any state regulation.<sup>23</sup> In like fashion, though courts have grown more willing to allow some common law causes of action to proceed, ERISA’s broad preemption provision means that many traditional common law causes of action are non-starters.<sup>24</sup>

ERISA’s preemption of state regulation and common law causes of action, coupled with the perception that managed care was the choice of employers rather than employees, created an accountability crisis for managed care. When this volatile mix was combined with the predictable hostility of providers to managed care, and a chorus of claims that MCOs were more interested in constraining cost than ensuring quality, a legislative backlash was virtually ensured. However, the scope of the backlash was still extraordinary, as detailed in Part II.D.

#### D. THE RISE OF THE PATIENT BILL OF RIGHTS

Legislators responded to the perception that managed care was unresponsive and had degraded quality with a wide array of bills and regulations. As noted previously, these initiatives quickly broadened from the targeting of particularly offensive practices to more comprehensive regulatory frameworks. Legislators settled on the idea of a patient bill of rights—a list of universal non-waivable provisions which MCOs would be required to include in their arrangements with subscribers and providers. In relatively short order, most of the states enacted patient bills of rights, although there was significant state-by-state variation in the provisions which were included.<sup>25</sup>

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22. See *Shaw v. Delta Airlines*, 463 U.S. 85 (1983) (upholding authority of Massachusetts to regulate insured employee benefit plans, and restricting authority of Massachusetts to regulate self-funded employee benefit plans).

23. The precise boundaries of the preemption of state regulation have become increasingly controversial. See Hyman, *Drive-Through Deliveries*, *supra* note 4, at 14 n.36. However, any significant regulatory mismatch provides an incentive to employee benefit plans to become self-funded, in order to avoid the costs associated with state-level regulation. Thus, the efforts of the states to regulate in this area have effectively backfired, since they have become increasingly aggressive at regulating a vanishing market—and their efforts increase the rate at which the market vanishes.

24. See Robert Pear, *Series of Rulings Eases Constraints on Suing H.M.O.’s*, N.Y. TIMES, Aug. 15, 1999, at A1 (noting increasing strictness with which judges are construing the scope of ERISA preemption, but “‘it’s still pretty clear that you cannot directly sue a plan for denial of benefits, no matter how egregious the denial is’”); Milo Geyelin, *Courts Pierce HMOs’ Shield Against Lawsuits*, WALL ST. J., Apr. 30, 1999, at B1 (same).

25. See *Hit and Miss*, *supra* note 3.

The development of the federal patient bill of rights has been more tortuous, but provides a useful model for assessing the promise and peril of a patient bill of rights. During the 1996 presidential election campaign, President Clinton promised to create a commission to study how consumers could be protected in the new health care market.<sup>26</sup> The Advisory Commission on Consumer Protection and Quality in the Health Care Industry was appointed on March 26, 1997, and charged with advising the President “on changes occurring in the health care system and recommend[ing] such measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system.”<sup>27</sup> More concretely, President Clinton specifically asked the Commission to draft a Consumer Bill of Rights and Responsibilities.

The Commission was co-chaired by two cabinet members: Alexis M. Herman, the Secretary of Labor, and Donna E. Shalala, the Secretary of Health and Human Services. The thirty-four Commissioners were drawn “from a wide variety of backgrounds including consumers, business, labor, health care providers, health plans, State and local governments, and health care quality experts.”<sup>28</sup> The drafting of the Consumer Bill of Rights and Responsibilities was delegated to a Subcommittee on Consumer Rights, Protections, and Responsibilities, and then debated by the full Commission.

In November 1997, the full Commission issued a proposed Bill of Rights and Responsibilities which contained eight provisions.<sup>29</sup> The specific Rights and Responsibilities were as follows:

1. Information Disclosure—Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals, and facilities.
2. Choice of Providers and Plans—Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.
3. Access to Emergency Services—Consumers have the right to access emergency health care services when and where the need arises.

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26. See Robert Pear, *Clinton to Name Health-Care Panel, With Eye to Second Term*, N.Y. TIMES, Sept. 5, 1996, at A20.

27. Advisory Comm’n on Consumer Protection and Quality in the Health Care Indus., *Consumer Bill of Rights and Responsibilities* (visited August 21, 1999) <<http://www.hcqualitycommission.gov/cborr>> [hereinafter Advisory Comm’n].

28. *Id.*

29. *See id.*

4. Participation in Treatment Decisions—Consumers have the right and responsibility to fully participate in all decisions related to their health care.
5. Respect and Nondiscrimination—Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances.
6. Confidentiality of Health Information—Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected.
7. Complaints and Appeals—All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.
8. Consumer Responsibilities—Consumers should exercise, not smoke, eat a healthy diet, become involved in specific health care decisions, avoid knowingly spreading disease, and show respect for other patients and health workers.<sup>30</sup>

Interestingly, the Commission did not propose any specific legislation to implement the Patients' Bill of Rights and Responsibilities.<sup>31</sup> Indeed, the Commission expressly reserved the issue of implementation, and observed that "the rights enumerated in this report can be achieved in several ways including voluntary actions by health plans, purchasers, facilities, and providers; the effects of market forces; accreditation processes; as well as State or Federal legislation or regulation."<sup>32</sup> Despite this limitation, one Commissioner dissented from the Bill of Rights and Responsibilities, citing her concern that compliance would increase the cost of health insurance coverage and would be unduly burdensome for small businesses.<sup>33</sup>

Although the Commission was unable to agree on whether legislation was necessary, the President and most members of Congress were less shy. The Democrats and some Republicans unsuccessfully sought to pass a

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30. See generally *id.*

31. See Robert Pear, *Presidential Panel Sees No Need for a Law on Patients' Rights*, N.Y. TIMES, Mar. 13, 1998, at A17.

32. Advisory Comm'n, *supra* note 27. In its final report, the President's Commission did suggest that two entities be created to address issues of health care quality at a national level. However, these entities would have no role in implementing the Consumer Bill of Rights and Responsibilities. See *id.* at <<http://www.hcqualitycommission.gov/final>>.

33. See Robert Pear, *Clinton to Call for Health-Plan Regulation*, N.Y. TIMES, Nov. 20, 1997, at A22.

patient bill of rights during the 105th Congress.<sup>34</sup> President Clinton implemented some of the provisions through executive orders.<sup>35</sup> In the 106th Congress, both Republicans and Democrats offered competing versions of a patient bill of rights, with considerable diversity with regard to both ends and means. None of the offerings track the rights agreed upon by the President's Commission; the Democrats' version goes well beyond it, by including liability provisions and mandating that medical necessity decisions shall be made by the treating physician, while the Republicans' version falls short of it, by focusing on those in self-funded employee benefit plans.<sup>36</sup> Regardless of the outcome of these competing bills, it seems likely that the issue will remain on the legislative agenda for the foreseeable future.

#### E. MARKET FAILURE AND REGULATORY FAILURE

It is elementary health economics that there are a variety of imperfections in the markets for health care coverage and delivery. These imperfections affect virtually every aspect of the relationships between providers, payers, and consumers. A non-exhaustive list of these imperfections would include the reality that physicians are, at best, imperfect agents for patients in providing diagnostic services and treatment options, and employers are, at best, imperfect agents for employees in selecting health plans and coverage terms. The ERISA vacuum compounds these problems. In addition, information is costly and it is frequently inefficient for any given patient to invest the necessary effort to learn about such matters in advance. Quality is difficult to assess, let alone value—and employers and employees are likely to differ on the appropriate mix of cost, quality, and access, even before illness strikes. Many employers provide few (or no) health plan alternatives to their employees. Because plans are a “bundled” product aimed at a diverse workforce, the alternatives which any given employer offers frequently do not include desired and desirable features from the perspective of any given employee.

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34. See Amy Goldstein & Helen Dewar, *Senate Kills 'Patients' Rights' Bill*, WASH. POST, Oct. 10, 1998, at A1.

35. See Robert Pear, *White House Adds Broad Protection in Medicare Rules*, N.Y. TIMES, June 23, 1998, at A1; Robert Pear, *Clinton Prohibits H.M.O. Limit on Advice to Medicaid Patients*, N.Y. TIMES, Feb. 21, 1997, at A22.

36. See Amy Goldstein & Helen Dewar, *Senate Backs Republican Patient Plan*, WASH. POST, JULY 16, 1999, at A1 (contrasting Republican and Democrat approaches to consumer protection); Alison Mitchell, *Senate Approves Republican Plan For Health Care*, N.Y. TIMES, July 16, 1999, at A1.

Additional difficulties are created by the bounded rationality of consumers. Even if consumers behave rationally when it comes to health care coverage and delivery (itself a contested assumption), there may be circumstances in which it is rational not to pay much attention to one's health insurance contract. The chronically ill may care a great deal about whether their physician is covered by their new insurance plan, but those who are in good health are understandably less concerned with such matters. Life is short, and reading the fine print in one's insurance contract is not high on most peoples' list of favorite weekend activities—particularly when they do not perceive that their efforts will have any effect on the terms of the contract. Even if one is prepared to read the insurance contract, it does not follow that one will pay attention to the specific terms which, after the fact, turn out to be important. Against this backdrop, “bounded rationality” constrains the operation of market forces which would normally ensure the optimal mix of quality and price.<sup>37</sup>

Managed care can correct for some of these problems, but creates new problems and aggravates old ones.<sup>38</sup> Even if there is a dispute about the severity and relative significance of these market imperfections, there is no question that the health care coverage and delivery markets are dogged by most of them.

In the view of many commentators, the government can correct these imperfections with judicious regulation. The argument is quite straightforward. The government has the information, resources, and expertise to develop optimal managed care contract terms. Indeed, if such terms are a public good, no private MCO would be willing to invest the necessary effort to develop such terms. Because the terms will be universal, the distorting effects of adverse selection are greatly attenuated. The government also has the credibility to resolve these matters impartially, because it has no economic interest in the outcome. Finally, the whole point of living in a representative democracy is to provide a legislative forum for addressing such matters, and to protect those who cannot protect themselves.

Although these arguments might seem appealing, there are significant reasons to be skeptical about the likely merits of government intervention into these markets. It is easier to identify agency conflicts and bounded

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37. See Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1 (1999).

38. See Lawrence D. Brown, *Management By Objection? Public Policies to Protect Choice in Health Plans*, 56 MED. CARE RES. & REV. 145, 148-51 (1999).

rationality than it is to solve such problems.<sup>39</sup> A regulatory solution will not necessarily solve these problems and it may well make them worse. The internal plan trade-offs must be made by somebody, and there are no guarantees that the government can do it better than anyone else, particularly in light of the heterogeneity of employee preferences, and the reality that quality and value are difficult for both employers and government to assess. Government is also subject to symbolic blackmail on behalf of sympathetic identifiable patients, and interest group lobbying.

Similarly, claims of bounded rationality are subject to severe hindsight bias. After illness strikes, everyone involved has an understandable incentive to exaggerate how their behavior would have been different “had they only known”—including their willingness to have paid higher premiums to secure coverage. Ex ante, willingness to pay is not nearly so apparent. These facts significantly undermine the validity of bounded rationality as a basis for regulation.

Even if bounded rationality is a significant problem, the bounded rationality of any given individual is compensated for by the presence of knowledgeable repeat-player agents in the employee benefits department, who negotiate on behalf of employees.<sup>40</sup> Finally, if bounded rationality is actually a serious problem in the health insurance market, it is hard to explain the far-better documented phenomenon of adverse selection.<sup>41</sup> Stated more concretely, adverse selection can only occur if consumers understand the terms of their insurance contracts and act accordingly, while bounded rationality can only exist if consumers do not understand the terms

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39. See Christine Jolls, Cass R. Sunstein & Richard Thaler, *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471, 1543 (1998) (“Any suggestion that the government should intervene in response to people’s mistakes raises the question whether the government will be able to avoid such errors.”).

40. Employees in one study valued the involvement of employers in the health insurance market. See Lave et al., *supra* note 8, at 114-15 (presenting results of focus groups indicating that employees appreciate the involvement of employers in structuring and implementing health insurance coverage, because employers provide bargaining power, serve an advocacy role for employees, and compensate for complexity of market.). See also EBRI Issue Brief No. 211, *Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion* (visited Sep. 13, 1999) <<http://www.ebri.org/ibex/ib211.htm>> (“Employment-based health plans are popular because they offer many advantages over other forms of health insurance and types of delivery systems. . . . The advantages include reduced risk of adverse selection, group-purchasing efficiencies, employers acting as a workers’ advocate, delivery innovation, and health care quality.”).

Of course, it does not follow that employers are the only entity that could provide these services, and the use of employers as agents has certain disadvantages. See *id.* (“[D]isadvantages include an unfair tax treatment, lack of portability and job lock, little choice of health plans, and lack of universal coverage.”).

41. See MARK HALL, MAKING MEDICAL SPENDING DECISIONS 53 (1996) (outlining cases where severe adverse selection has been documented).

of their insurance contracts. It is difficult to see how these circumstances could exist simultaneously, unless, of course, only some consumers are boundedly rational. The issue is therefore an empirical one as to which effect is larger—and that issue can not be resolved on theoretical grounds.

It is also important to note that markets can function even in the presence of severe bounded rationality, since it only takes a few knowledgeable purchasers to drive the market. How many of those reading this Article know the identity of the manufacturer of the spark plugs in their cars—let alone the technical specifications for those spark plugs? I think it unlikely that more than one percent of the readers of this Article can answer the first question, and I daresay none can answer the second question. Despite this severe bounded rationality, I am quite confident that all of the spark plugs work just fine—and they do so because some anonymous engineer cared enough about the issue to make sure the correct ones were used, and the car manufacturer cared enough about its reputation to hire and appropriately compensate the anonymous engineer.

The legislative process also has its own set of distortions—a fact which regulatory enthusiasts are prone to overlook. Legislators tend to identify “necessary reforms” on the basis of bad anecdotes and popular appeal, but that strategy is hardly a recipe for sensible public policies. Legislators also tend to discount the trade-offs and costs which result from their reforms. In a voluntary insurance market, cost-increasing consumer protections will predictably price some people out of the market—and it is hardly self-evident where the cost/quality/access equilibrium should be set, let alone whether there should be a single standard for all coverage. The drafting of consumer protections is also readily hijacked by entrenched providers, who have their own interests at heart. Finally, the emotional implications of these issues ensure that legislators will be reluctant to embrace the necessary trade-offs.

These considerations demonstrate that the merits of the managed care backlash cannot be resolved on the basis of platitudes about “market failure,” “voice,” and “accountability.” Congress and the state legislatures may have shown great enthusiasm for rewriting the terms of managed care contracts, but enthusiasm is not a sufficient precondition to ensure that the resulting legislation will improve on the status quo. The critical institutional competence questions are whether legislators have the necessary information, preferences, and incentives to beat the alternatives in setting the terms of trade. In economic terms, the issue is which agency relationship (consumer/employer-insurer or constituent/state-federal legislature) is less imperfect across the relevant dimensions of cost, quality,

and access. Part III addresses the information on which legislators have relied in embracing the patient bill of rights. Part IV analyzes legislative preferences and incentives. Part V assesses whether the bill of rights model actually fits the problem at which it is aimed.

### III. WHAT INFORMATION ARE LEGISLATORS RELYING ON?

There is a considerable amount of empirical research available on the quality of care provided by MCOs and by American medicine in general.<sup>42</sup> Unfortunately, the legislators who are advocating for a patient bill of rights have, without exception, completely ignored this research. Instead, the case for consumer protection has been built on a foundation of anecdotes about patients who suffered death, disability, or serious inconvenience because of actions taken by their managed care plan.<sup>43</sup> For the past two years, congressional debates and hearings on managed care regulation have centered on such anecdotes. In the 105th Congress, Democrats opened each day of Congress during the summer of 1998 with a managed care horror story.<sup>44</sup>

In the 106th Congress, both sides routinely presented anecdotal evidence to bolster their position.<sup>45</sup> The Republicans offered anecdotes about small businesses that would go under or drop health coverage if a patient bill of rights was passed.<sup>46</sup> In the Senate, the Democrats offered two days of "chilling, heart-breaking stories,"<sup>47</sup> and in the House they offered as their prime example the emotional account of one woman who testified about "losing her baby after an insurance company refused to pay for hospital bed rest ordered by her doctors."<sup>48</sup> The Democrats also prepared a web page featuring twenty-one cases which purported to

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42. See *infra* notes 69-79 and accompanying text.

43. See Hyman, *Call 911*, *supra* note 4, at 410-15.

44. See U.S. Senate Democratic Leadership Comms., *Patients Before Profits: The Patients' Bill of Rights* (visited July 14, 1998) <[http://www.senate.gov/~dpc/patients\\_rights](http://www.senate.gov/~dpc/patients_rights)>.

45. See Alison Mitchell, *Senate Takes Up Patients' Rights Bill*, N.Y. TIMES, July 13, 1999, at A12.

46. See *id.* ("[S]mall-business owners . . . said that already they could barely afford health insurance for themselves and their employees, or could not afford it at all.")

47. *Excerpts from Debate on Lawsuits Over Health Care*, N.Y. TIMES, July 16, 1999, at A14 (quoting Senator Richard J. Durbin).

48. Bruce Alpert, *Slidell Woman Gets Share of Credit For Bill's OK*, TIMES-PICAYUNE (New Orleans), Oct. 9, 1999, at A5 ("She helped humanize what at times was an arcane debate. . . . Her testimony emotionally moved members of Congress in ways that hours of debate could never achieve.") (quoting Ron Pollack, executive director of Families USA).

“illustrate the current inadequacies of the HMO system and its tendency to put cost savings before life saving.”<sup>49</sup>

To be sure, legislators have not had to work very hard to find these materials. On the Internet, one can readily locate a managed care hall of shame and an atrocity of the month,<sup>50</sup> testimonials from people who have been “victimized” by managed care,<sup>51</sup> an “infamous collection of ‘true’ managed care horror stories,”<sup>52</sup> an “ERISA casualty of the day,”<sup>53</sup> an anonymous whistle-blower recounting tales of the “craziness” of insurance companies,<sup>54</sup> and the like. There is at least one book which is little more than a collection of such anecdotes.<sup>55</sup> A wide array of interest groups aggressively solicit and promote such stories; as one commentator has aptly noted, “[t]he marketing of personal tragedy has become a cottage industry.”<sup>56</sup>

Horror stories of this sort may appear exceedingly persuasive, but there are good reasons to be cautious about generalizing from anecdotal bad outcomes.<sup>57</sup> Such anecdotes invariably present the perspective of only one side to a dispute. As a result, they are frequently exaggerated, and sometimes are simply fabricated.<sup>58</sup> Even if a horror story is truthful, the

49. U.S. Senate Democratic Leadership Comms., *supra* note 44.

50. See Physicians Who Care, Inc., *The HMO Page* (visited Aug. 23, 1999) <<http://www.hmopage.org>>.

51. Foundation for Taxpayer and Consumer Rights, *Patient Stories* (visited Aug. 23, 1999) <[http://www.consumerwatchdog.org/public\\_hts/medical/horror/file\\_idx.html](http://www.consumerwatchdog.org/public_hts/medical/horror/file_idx.html)>.

52. National Health Ins. Citizens Network, *The Famous List of Managed Care Horror Stories* (visited Aug. 23, 1999) <<http://www.his.com/~pico/1-25.htm>>.

53. Consumers For Quality Care, *Patients Without Remedies Due to ERISA Loophole Launch Casualty of Day Campaign* (visited Aug. 23, 1999) <[http://www.consumerwatchdog.org/public\\_hts/medical/press/me100149.htm](http://www.consumerwatchdog.org/public_hts/medical/press/me100149.htm)>.

54. Dr. Anonymous, *Consumer Protection Healthcare Handbook Homepage* (visited Aug. 23, 1999) <<http://www.dranonymous.com>>.

55. See generally GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* (1996).

56. Howard Kurtz, *Some Managed-Care Sagas Need Second Examination*, WASH. POST, Aug. 10, 1998, at A1. The observation is not new. See also Stuart Auerbach, *Managed Care Backlash: As the Marketplace Changes, Consumers Are Caught in the Middle*, WASH. POST, June 25, 1996, at Z12 (“[A] cottage industry has developed to solicit patients who have bad experiences with managed care and market their stories to the press, television, state legislatures, and Congress.”).

57. See David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L.J. 797, 820-30 (1998).

58. See *id.* at 830-45. See also Kurtz, *supra* note 56, at A1 (presenting several examples of one-sided, exaggerated and fabricated anecdotes).

The few cases which have been litigated are less subject to this distortion, but even here one must be sensitive to the impact of the judge’s views of the defendant’s conduct on the presentation of the facts. For a particularly egregious example, which reflects more on the judge than the alleged conduct, see *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998), *reh’g en banc denied*, 170 F.3d 683 (7th Cir. 1999), *cert. granted*, 120 S.Ct. 10 (1999). Further discussion of this point may be found in David A.

representativeness of the story and the frequency with which such events occur are critical issues.<sup>59</sup> It requires more than mere assertion to conclude that any given anecdote *is* representative—not that one could tell that from the way in which anecdotes have been employed in the campaign against managed care.<sup>60</sup>

One should also consider the source of the horror stories in assessing their veracity. These anecdotes did not emerge by accident, but as part of a campaign against managed care, spearheaded by provider groups and self-styled consumer advocates.<sup>61</sup> These groups troll for bad anecdotes, and then produce them with the hope they will influence public opinion.<sup>62</sup> Consider whether the following solicitation is likely to result in a fair cross-section of views on managed care:

1. Do you have a problem/complaint about your health care plan?
2. Have you or a loved one, friend, patient been hurt by poor quality health care?
3. At the hospital or health facility where you work, have you seen problems with unsafe staffing levels, early discharge of patients, etc.?

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Hyman, *Medicine in the New Millenium: A Self-Help Guide for the Perplexed*, 26 AM. J.L. & MED. (forthcoming 2000).

59. See Hyman, *supra* note 57, at 842.

60. See 144 CONG. REC. H1849 (daily ed. Mar. 31, 1998) (statement of Rep. Ganske) (asserting that managed care horror stories are not “mistakes or aberrations or anecdotes,” but are “exactly the outcomes we would expect in a system that rewards those who undertreat patients”); *Managed Care Quality: Hearing Before the Subcomm. on Health and Environment of the House Comm. on Commerce*, 105th Cong. 8 (1997) (statement of Rep. Norwood) (asserting, without providing any evidence, that horror stories are representative of health care under managed care).

61. See Auerbach, *supra* note 56, at Z12 (“Patients who feel wronged by the system have joined in a potent lobby with doctors, nurses, hospitals and other health care providers whose professional survival, incomes, and long-held practice patterns are threatened by managed care.”); Hyman, *Call 911*, *supra* note 4, at 456-58; Samuelson, *infra* note 159 at A14 (“[T]he backlash against managed care is most powerful among doctors, not patients. It is doctors whose independence and incomes are most threatened. Their decisions are reviewed and sometimes reversed. They face maddening rules and reimbursement practices. In negotiations, their fees are squeezed.”).

Perhaps the supreme irony of the campaign against managed care is that it has caused physicians to wholeheartedly embrace proof-by-anecdote—even though the systematic rejection of this sort of proof forms the foundation of modern medicine. See Hyman, *Drive-Through Deliveries*, *supra* note 4, at 38.

62. See, e.g., Kurtz, *supra* note 56, at A1:

Families USA, an advocacy group for better medical care, solicits “health care hardship stories” on its Web site and provides them “to print and television reporters, members of Congress, administration officials and other advocacy groups.” The American Medical Association also solicits such anecdotes, saying: “You don’t have to wait to tell the grandkids your managed-care war stories. The AMA wants to hear them right now.”

*Id.*

4. Has your HMO ever refused to send you to a specialist or cover the cost of your care? If so, we want your personal story with poor quality care!<sup>63</sup>

One prominent advocacy group which routinely relies on such anecdotes has admitted that there is a problem with employing anecdotes to make the case for consumer protection legislation:

Even while unleashing numerous horror-story anecdotes, the authors of the Families USA study advise caution: "An individual story cannot and should not be used to substitute for solid data as to the quality of care provided or be the sole basis upon which new, far-reaching laws are legislated."<sup>64</sup>

Unfortunately, Families USA has made no effort to disseminate this significant caveat to its shilling of bad managed care anecdotes and continues to seek "examples of negligence and/or wrong-doing on the part of HMOs" through its web site.<sup>65</sup> Other advocacy groups offer a simple "ends-justifies-the-means" argument in favor of their use of such anecdotes.<sup>66</sup> Senator Thomas Daschle, the Senate minority leader, has done no better, with his assertion that one bad managed care anecdote is one too many.<sup>67</sup>

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63. Consumer Coalition For Quality Health Care, *The Quality WatchLine* (visited Aug. 23, 1999) <<http://www.consumers.org/wline.htm>>.

64. Marilyn Werber Serafini, *Reining in the HMOs*, NAT'L J., Oct. 26, 1996, at 2280, 2283.

65. Families USA, *What Consumers Need to Know* (visited Aug. 23, 1999) <<http://www.familiesusa.org/managedcare/consumer.htm>>.

66. See Andrew Pontious, *Who Works for Patients' Rights?*, WASH. POST, Aug. 18, 1998, at A14 ("The guerrilla means used by patient advocacy organizations working with shoestring budgets, such as Consumers for Quality Care's 'Casualty of the Day' campaign, are the only responses available to patients competing against the astronomical advertising budgets of HMOs."). Of course, to the extent these "guerrilla means" are engaged in the dissemination of untruthful or atypical stories, it is hard to view these tactics as a virtue. See also *Health Care Horror Stories Are Compelling but One-Sided*, N.Y. TIMES, Oct. 12, 1999, at A29 ("The groups distributing [the stories] are also unable to insure their veracity. 'We tell the story in the patients' own words, or from a parent,' conceded Jamie Court, director of Consumers for Quality Care. . . . 'All we can do is report on what people tell us.'").

Notwithstanding these perils, at least one academic believes these tactics are appropriate, because he believes that MCOs have the resources to ensure that the "truth will out." David A. Rochefort, *The Role of Anecdotes in Regulating Managed Care*, 17 HEALTH AFF. 146 (1998). Not surprisingly, MCOs have instead decided that their best strategy is to offer their own anecdotal success stories to counter the bad press. See *HMOs Can Use Success Stories to Counter Those Horror Stories*, MOD. HEALTHCARE, Mar. 25, 1996, at 76. These events vindicate the continuing merits of Gresham's Law—that bad money will drive out good, given half a chance.

67. See Thomas Daschle, *Defending Patients' Rights*, WASH. POST, Aug. 21, 1998, at A23 (arguing that even if the horror stories are exceptions, it is still a "worthy effort to struggle to eliminate those exceptions").

The strategies have been extraordinarily effective in demonizing managed care.<sup>68</sup> However, anecdotal horror stories provide no basis on which to assess the overall merits and inadequacies of a system with hundreds of millions of annual encounters between health care providers and patients. More importantly, anecdotes provide no evidence as to whether additional regulation of the health care market is required (as opposed to more aggressive enforcement of existing laws), and what form, if any, such additional regulation should take. Indeed, regulation by anecdote can actually make things worse, by inclining legislators toward policies that do not address the real problem, aggravate existing problems, or create new problems. The irony of anecdote-driven campaigns is that the more compelling the anecdote, the less likely we are to consider issues of typicality and frequency—meaning the risk of being led astray is a direct function of the persuasiveness of the anecdote.<sup>69</sup> Unfortunately, these considerations have not kept Congress and the state legislatures from playing doctor—and doing so in ways that increasingly entangle them in dictating the specifics of health care coverage and the practice of medicine.

If one moves from anecdote to empirical reality, there is a substantial body of medical literature on the quality of services rendered by managed care organizations—as well as on the quality of services rendered by American medicine in general. This literature convincingly demonstrates that MCOs perform at least as well, and often better than fee-for-service health care.<sup>70</sup> Even if one imputes the most negative spin to the quality

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68. See Louise Kertesz, *Backlash Continues: Survey Finds Managed Care Is Still the Bad Guy in Many Americans' Eyes*, MOD. HEALTHCARE, Nov. 10, 1997, at 33 (“People seem to generalize from anecdotal reports in the news about problems with managed care. When asked about specific examples taken from news stories about the problems some people have reported . . . with managed care, the public’s perception is that these are fairly common occurrences.”).

69. See Hyman, *supra* note 57, at 849-50 (“‘Good’ narrative appeals directly to our passions and prejudices—and the better it is at doing so, the more likely it is to be credited as truthful and representative—whether it is or not.”).

70. See Donald M. Berwick, *Payment by Capitation and the Quality of Care*, 335 NEW ENG. J. MED. 1227, 1228 (1996) (“In general, the literature in this area . . . consistently shows that costs are lower in managed care systems, with quality control equal to or better than that in fee-for-service care.”); Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 716 (1994); Fred J. Hellinger, *The Effect of Managed Care on Quality: A Review of Recent Evidence*, 158 ARCHIVES INTERNAL MED. 833 (1998) (“[M]anaged care has not decreased the overall effectiveness of care. However, evidence suggests that managed care may adversely affect the health of some vulnerable subpopulations.”); Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1513-517 (1994) (collecting studies showing quality of care is comparable to or better than fee-for-service); Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, 16 HEALTH AFF. 7 (1997) [hereinafter *Quality of Care*] (updating earlier research, and finding mixed, but still generally favorable evidence on quality of care

issue, the most anti-managed care conclusion one can come to is that “HMOs produce better, the same, and worse quality of care, depending on the particular organization and particular disease.”<sup>71</sup>

A more serious problem is raised by the general issue of health care quality in the United States. Although managed care has been widely blamed for destroying the quality of American medicine, the reality is that serious quality problems with American health care developed and flourished well before managed care appeared on the scene. Although it did not attract nearly as much attention as the consumer bill of rights (which it issued as an interim report), the President’s Commission issued a final report titled *Quality First: Better Health Care for All Americans*.<sup>72</sup> The report notes that American health care is dogged by persistent quality problems relating to overutilization of certain services, underutilization of other services, unexplained variations in service utilization, and errors in health care practice. The report further observed that quality of care is effectively uncorrelated with the institutional arrangements through which care is delivered:

[Q]uality problems are not new, nor are they unique to any particular type of arrangements through which health care is financed and delivered . . . both the best and the worst health care our system has to offer can be found in managed care plans, as it can in traditional fee-for-service (or indemnity) arrangements.<sup>73</sup>

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provided by MCOs). See also Larry Katzenstein, *Beyond the Horror Stories, Good News About Managed Care*, N.Y. TIMES, June 13, 1999, § 15, at 6.

To be sure, some studies have found that the quality of care provided by MCOs for certain conditions is lower than is the case in fee-for-service practice, and there is an overriding question as to whether studies from the early days of managed care, in which homogeneous subscriber populations were served by non-profit MCOs, are applicable to the current environment in which neither is the case. See *Quality of Care*, *supra*, at 13-18; Hellinger, *supra*, at 840.

71. *Quality of Care*, *supra* note 70, at 14.

72. See PRESIDENT’S ADVISORY COMM’N ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUS., *QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS* (1998) [hereinafter *QUALITY FIRST*].

73. *Id.* at 12. See also Randall R. Bovbjerg & Robert H. Miller, *Managed Care and Medical Injury: Let’s Not Throw Out the Baby with the Backlash*, 24 J. HEALTH POL. POL’Y & L. 1145, 1147-48 (1999) (noting that “[c]ommentators and reformers often assume as self-evident that HMOs and other plans *must* decrease quality and increase injury when they reduce payments or shift patterns of utilization,” but there is no evidence of increased medical injury or lower quality in such plans); Mark R. Chassin, Robert W. Galvin & the National Roundtable on Health Care Quality, *The Urgent Need to Improve Health Care Quality*, 280 JAMA 1000, 1003 (1998). According to the authors:

The evidence is compelling. Millions of Americans are not reached by proven effective interventions that can save lives and prevent disability. Perhaps an equal number suffer needlessly because they are exposed to the harms of unnecessary health services. Large numbers are injured because preventable complications of medical treatment are not averted. These problems exist in managed care and fee-for-service systems, in large and small communities, and in all parts of the country.

As one well-known health services researcher nicely framed the issue in the pages of the *Journal of the American Medical Association*, “Managed Care Is Not the Problem, Quality Is.”<sup>74</sup>

The extent to which there are fundamental problems with the quality of health care delivered in the United States is actually quite extraordinary. One set of prominent commentators recently noted that “[o]ne fourth of hospital deaths may be preventable, and one third of some hospital procedures may expose patients to risk without improving their health. One third of drugs may not be indicated, and one third of laboratory tests showing abnormal results may not be followed up by physicians.”<sup>75</sup> The President’s Commission similarly observed that “millions of people do not receive care they need and suffer needless complications that add to health care costs and reduce productivity.”<sup>76</sup> Almost 20,000 people die every year from heart attacks because they did not receive effective interventions.<sup>77</sup> Millions of Americans also “receive health care services that are unnecessary, increase costs, and often endanger their health.”<sup>78</sup> Finally, there are unacceptably high error rates, “including missed diagnoses, errors in the interpretation of laboratory or imaging studies, medication, administration or prescribing errors, surgical errors, and errors in the care furnished by doctors, nurses, and other health care professionals.”<sup>79</sup> The net result is chilling: “more people die in a given year as a result of medical errors than from motor vehicle accidents, breast cancer, or AIDS.”<sup>80</sup>

It is rather striking that given this empirical evidence of longstanding quality problems throughout the entirety of American medicine, legislators have instead targeted an unpopular institutional arrangement for “reform”—and done so on the basis of anecdotal complaints. To be sure, Congress is under no obligation to tackle problems in any particular order—although there are reasons to wonder about a reform strategy which ignores the overwhelming evidence of quality-based problems with most of American medicine, and focuses on an institutional arrangement which is effectively uncorrelated with the problem. More importantly, the anecdote-driven nature of the campaign, and its targeting of managed care as the

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*Id.*

74. Robert H. Brook, *Managed Care Is Not the Problem, Quality Is*, 278 JAMA 1612 (1997).

75. Brook, *supra* note 15, at 477.

76. QUALITY FIRST, *supra* note 72, at 10.

77. *See id.* at 12.

78. *Id.*

79. *Id.*

80. INSTITUTE OF MED. COMM. ON QUALITY OF HEALTH CARE IN AM., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM I* (1999).

cause of all ills, has made it more difficult to address the real quality problems which do exist with American medicine and which are largely attributable to the unconstrained discretion previously accorded providers.<sup>81</sup>

This is not to say that all is well with managed care. As Professor Havighurst recently observed:

[M]ost health plans seem to have suspended active searches for new solutions to the difficult organizational, incentive, and information problems that bedevil health care decision-making. Certainly, managed care has improved the quality of care in important respects, has substantially reduced the cost of care, and has generally given consumers better value for the money they spend on health services. But the overall performance of the managed care industry has largely disappointed those observers who expected competing health plans aggressively to organize providers in ambitious collaborative efforts to improve quality and achieve real efficiency in health care spending.<sup>82</sup>

These shortcomings are troubling, but the proposed patient bills of rights simply do not address these issues. Indeed, many of the provisions in the patient bills of rights actually undermine the ability of MCOs to address these problems, or flatly prohibit them from pursuing certain strategies in order to do so.

In medicine, the options for treatment are dictated by the diagnosis. If we want our legislators to actually enhance the status quo, they should at least get the diagnosis right—and in both law and medicine, getting the diagnosis right requires accurate and complete information about the problem. Unfortunately, state and federal legislators have been singularly uninterested in performing this essential step, with consequences that border on legislative malpractice.<sup>83</sup>

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81. See Michael M. Weinstein, *In Denial; Managed Care's Other Problem: It's Not What You Think*, N.Y. TIMES, Feb. 28, 1999, § 4, at 1:

The media, courts, and consumer advocates are overlooking a problem that is precisely the opposite of the one everybody's complaining about. That problem is too many medical treatments rather than too few. . . . "There is," says Professor Alain Enthoven of Stanford University, "[an] urgent need for managed care to second-guess decisions by physicians to subject patients to needlessly risky surgery and needlessly costly test."

*Id.*

82. Clark C. Havighurst, *Managed Care—Work in Progress or Stalled Experiment?*, 35 Hous. L. REV. 1385 (1999). See also WALTER A. ZELMAN & ROBERT A. BERENSON, *THE MANAGED CARE BLUES & HOW TO CURE THEM* 121 (1998) (noting failure of managed care to "raise the ceiling").

83. The only thing that saves the conduct from being out-and-out legislative malpractice is that legislatures routinely legislate on the basis of such evidence. See Hyman, *supra* note 57, at 850 ("Barring the unlikely development of a generalized sense of 'statistical compassion,' anecdotal evidence will continue to play a major role in the formulation of public policy."). Courts are

#### IV. DO LEGISLATIVE PREFERENCES AND INCENTIVES MATCH THOSE OF CONSUMERS?

It is commonplace to observe that employers and MCOs have different preferences and incentives than individual consumers—and the case for regulatory intervention is strengthened by this reality. Yet, it is important to note that individual legislators also have different preferences and incentives than those they represent, and the mismatch when one considers legislatures as a whole are even worse. Part IV.A considers legislative preferences, while Part IV.B considers legislative incentives. Part IV.C addresses whether legislatures can act as honest and impartial brokers in light of the mismatch of preferences and incentives identified in Parts IV.A and IV.B.

##### A. LEGISLATIVE PREFERENCES

Everyone has personal preferences for health care coverage and delivery. These preferences are greatly influenced by health, wealth, age, sex, number and health status of dependents, education, race, ethnicity, geography, past experiences, and the like. Some of these preferences are readily apparent, while others are more inchoate or contingent. Preferences can also be modified by changes in personal circumstances and new information.

Circumstances that are salient to individual consumers have a great impact on preference formation and modification. Thus, single males and women using birth control are unlikely to know the details of their maternity coverage, while couples who are considering pregnancy are likely to be quite attentive to these terms. Few of those who are healthy are likely to know or care whether they are covered for hospice care, but those diagnosed with terminal cancer will feel quite differently about this issue.

Legislators have personal preferences which influence their assessment of these issues.<sup>84</sup> However, legislators are charged with representing the interests of their constituents. To arrive at the contract

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understandably exceedingly reluctant to second-guess Congress on such matters. *See* United States R.R. Retirement Bd. v. Fritz, 449 U.S. 166 (1980) (outlining the modest extent to which Congressional action is subject to judicial scrutiny pursuant to the rational basis test). Since the standard for tort liability is breach of the standard of care in the field. . . .

84. *See* Hyman, *supra* note 57, at 806 n.34 (noting that Congress added prostate cancer screening as a Medicare benefit because several members of Congress had positive experiences with the test, even though evidence for universal screening was equivocal at best, and bankruptcy of Medicare Part A trust fund was imminent).

terms most appealing to constituents, a legislator presumably aggregates constituent preferences. The larger the constituent pool being aggregated, the greater the predictable preference dispersion—and the greater the disjunction between the “consensus” contract term selected by the legislator and the desires of an increasingly large number of his constituents. Alternatively, legislators can simply vote for the coverage terms they deem optimal, regardless of the preferences of their constituents. In either case, legislators will predictably and necessarily slight the preferences of a sizeable number of their constituents, whether the relevant nexus for preference aggregation is an individual district or a state. Further disjunction between the “consensus” contract term and the desires of any given legislator’s constituents is induced by the need to obtain a majority vote of the legislature as a whole.<sup>85</sup>

Treated as a purely numerical proposition, the distortions in preference aggregation are much more severe at the federal level than at the state level—and more severe at the state level than at the level of any given employer or insurer. This might not be a particularly severe problem if the patient bill of rights was a set of default rules which could be adopted or contracted around, depending on the preferences of those affected. However, the legislation, by design, specifies mandatory minimum contract terms. Thus, the issue of preference mismatch undermines the ability of both legislators and employers to be effective agents for constituents and employees—but it cuts more against legislators, particularly at the federal level.

## B. LEGISLATIVE INCENTIVES

Many commentators have suggested that employers are likely to be poor agents for their employees with regard to the selection of MCO contract terms because employers are exceedingly price-sensitive and relatively unconcerned with quality. As such, employers are unlikely to spend much time or effort pursuing optimal coverage terms. Since legislators are not subject to these incentives, they are theoretically better agents than employers in selecting coverage terms.

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85. Indeed, it is somewhat of a misnomer to speak of a “consensus” term, since the substantive content of the “consensus” term will vary greatly, depending on the level of legislative aggregation. See Thomas W. Merrill, *Institutional Choice and Political Faith*, 22 *LAW & SOC. INQUIRY* 959, 981 (1997) (“If, for example, the question of clear-cutting old growth forests in the Pacific Northwest is resolved by the political system, the outcome will likely depend on the jurisdictional level at which the issue is resolved.”).

The employer-employee incentive mismatch problem is problematic, but easily overstated. Employers are price-sensitive in the selection of MCO contract terms, but so are employees. Some employers don't care about quality, but many do. The real issue is not whether the employer-employee relationship is perfect, but the extent and significance of the incentive mismatch, compared to the legislature/constituent relationship. Although often overlooked, there are at least two serious incentive mismatches which are unique to the legislator-constituent relationship. The first incentive mismatch arises from the significant benefits legislators receive from milking the issue of managed care regulation for political gain. As noted previously, the identification of managed care "problems" and the selection of regulatory responses has been heavily influenced by perceived political appeal. Specific consumer protections have become legislative priorities simply because they appear to benefit a specific group of voters, or because they play well in the press—regardless of the practical significance of the problem, or the benefits of the reform. Indeed, legislators have targeted issues for no better reason than that they are reducible to an appealing sound bite.

Consider "drive-through deliveries." This pejorative sound bite describes the practice of discharging women and newborns from the hospital less than forty-eight hours after a vaginal delivery and ninety-six hours after a Cesarean section.<sup>86</sup> From a legislative perspective, the issue had everything going for it: vulnerable mothers and babies exploited by faceless health plans, grieving witnesses complaining of specifically identifiable (and immensely sympathetic) victims, suited villains with MBAs, and CPAs overriding the decisions of selfless physicians in white coats, a normatively loaded catch-phrase to describe the practice, and last (but by no means least), a largely off-budget solution. In relatively short order, an overwhelming majority of the states and the federal government mandated more extensive coverage.<sup>87</sup> Despite the popular appeal of this consumer protection, it is hard to make the case that such mandated stays provide *any* benefit—let alone a benefit worth the substantial associated cost.<sup>88</sup> Such difficulties are not unique to this one issue, but are the predictable consequence of the legislative incentive to mine issues for political gain.<sup>89</sup>

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86. See Hyman, *Drive-Through Deliveries*, *supra* note 4, at 8.

87. See *id.* at 40-50.

88. See *id.* at 90-95.

89. Legislators have engaged in a similar process of grandstanding in dealing with insurer reluctance to pay for non-emergency care provided in emergency departments, see Hyman, *Call 911*, *supra* note 4, at 426-29, and gag clauses, see Hyman, *Scenes From a Maul*, *supra* note 4.

An additional incentive mismatch results from the reality that most legislators wish to be reelected, and will accordingly favor MCO contract terms that are appealing to constituents who are likely to vote in their favor, or can be persuaded to do so. Constituents who would never vote for the legislator (and, to a lesser extent, constituents who would vote for the legislator no matter what) are unlikely to have their preferences respected. The preferences of non-voters are likely to be ignored completely. Thus, incentive mismatches undermine the ability of both legislators and employers to be effective agents for constituents and employees—but they cut at least as much, if not more against legislators.

These incentive and preference mismatches are compounded by considerations of salience. Coverage and delivery issues that are salient to consumers will be handled without much difficulty through normal market mechanisms so long as consumers are actually willing to pay for the desired services. However, in order for an issue to attract legislative attention, it must be salient to consumers as well.<sup>90</sup> If the issue is not salient to consumers, it will have little or no appeal to legislators, who must allocate their scarce political capital to bills that will be perceived by their constituents as beneficial. The result is that legislative initiatives promoting cost-justified contract terms will generally duplicate contract terms already prevalent in the coverage market. To the extent the legislation does not duplicate existing contract terms, it is exceedingly likely that the proposed contract terms will have already been rejected as non-cost-effective, either by the market as a whole, or, in a well-differentiated market, by some of the market participants and their customers. Such contract terms are embraced by the legislature for their symbolic value or as a political pay-off, and not because they provide a cost-justified benefit to consumers.<sup>91</sup>

### C. CAN THE GOVERNMENT BE AN HONEST BROKER?

Advocates of consumer protection insist that the government can be an honest broker of these disputes—or at least a better designer of contract

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90. See Korobkin, *supra* note 37, at 85-88.

91. Of course, an issue can be both salient and symbolic—which is the case with many of the provisions offered to ensure consumer protection against managed care. See Hyman, *With Friends Like These*, *supra* note 4, at 295; Eugene Declercq & Diane Simmes, *The Politics of “Drive-Through Deliveries”: Putting Early Postpartum Discharge on the Legislative Agenda*, 75 MILBANK Q. 175, 184 (1997) (“[L]egislators will no doubt seek further instances where low cost (financially and politically) actions can be taken against unpopular institutions (i.e. insurers, tobacco companies) to reassure constituents symbolically that they are concerned about their interests.”).

terms than those currently doing the job. There is no question that those currently involved (employers, employees, providers and insurers/MCOs) have quite different (if not polar) interests with regard to the design and administration of managed care contracts. For example, every dollar of coverage cost for employers and employees is a dollar of income for insurers/MCOs, and, in turn, eighty-five cents of income for providers. Employers who select lower-cost plans do not incur the full physical and financial costs which result if low-quality care is delivered to their employees. Each of the participants will have quite different responses if asked about the optimal structure for the delivery of health care, the proper allocation of coverage premiums between direct patient care, dividends to MCO shareholders, and MCO overhead, as well as the best way to compensate everyone involved for their efforts. Conflicts of interest are both inevitable and intractable. The case for an impartial arbiter to design optimal contract terms seems compelling.

However, legislators have their own conflicts of interest, wholly apart from their preference for non-cost-justified symbolic legislation. Because the government provides coverage for a minority of those who are insured, the majority of the costs of “reforms” considered by legislators are off-budget. Predictably enough, the result is more and costlier consumer protection than would be the case if the costs were on-budget. The campaign against drive-through deliveries also exemplifies this point. By August 1996, twenty-nine states had responded to the issue by mandating coverage of extended postpartum stays. Approximately two-thirds of these states excluded Medicaid beneficiaries and state employees.<sup>92</sup> Since Medicaid pays for forty percent of the births in the U.S., with the percentage much higher in some states, including either population in the legislation would result in substantial on-budget expenses. When Congress passed its own legislation mandating coverage of extended postpartum stays, it included state employees and excluded Medicaid. Congress subsequently added Medicaid beneficiaries so long as they were in a managed care plan. Since approximately two-thirds of these states had indicated their unwillingness to foot the bill for such protections, and the federal government incurred none of the costs for state employees and only a share of the costs for Medicaid, it is hard to resist the conclusion that legislators are no more virtuous in weighing off-budget and on-budget costs and benefits than the rest of us.<sup>93</sup>

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92. See Hyman, *Drive-Through Deliveries*, *supra* note 4, at 260.

93. The problem is obviously not limited to health care regulation. Consider the classic example of *Lucas v. South Carolina Coastal Council*. South Carolina passed a law which prohibited building on

Similar difficulties apply to the popular enthusiasm for appealing negative managed care coverage decisions to an independent agency. There is certainly a role for an independent enforcement agency to ensure that the MCO delivers what it promises. However, to the extent the independent agency is second-guessing the cost-quality-access trade-offs implicit in the managed care contract, it is overriding the trade-offs which were the premise of the contract in the first place. Still worse is the proposal to allow individual physicians to effectively dictate the scope of coverage based on their individual professional judgment, instead of respecting the cost-quality-access trade-off made by their patients in signing up for an MCO.<sup>94</sup>

It is also useful to consider how well the state and federal governments have done in managing their own health care programs, since we should not expect them to do better as regulators than they have done as market participants. Congress has quite deliberately insulated certain aspects of the Medicare program from judicial review, while its members criticize ERISA for accomplishing the same result.<sup>95</sup> The managed care plans offered by the state and federal governments to Medicare and Medicaid beneficiaries have been dogged by many of the problems at which the consumer protection initiatives are aimed, including “inadequate” appeal mechanisms and non-payment of emergency

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certain beachfront property on grounds of public safety. The Supreme Court held this law to constitute a taking, absent a common law nuisance. See *Lucas v. South Carolina Coastal Council*, 505 U.S. 1003, 1030-31 (1992). After the Supreme Court’s opinion, the South Carolina Coastal Council (“SCCC”) settled the case by purchasing the two lots in question for \$425,000 per lot plus interest and legal fees. See Gideon Kanner, *Not with a Bang, but a Giggle: The Settlement of the Lucas Case*, in *TAKINGS: LAND DEVELOPMENT CONDITIONS AND REGULATORY TAKINGS AFTER DOLAN AND LUCAS* (David L. Callies ed., 1996). During the years of litigation, the SCCC had consistently claimed that there was a “threat to life and property” if the beachfront lots were built upon. *Id.* Once it actually owned the lots, the SCCC underwent a “neck-snapping, intellectual about-face,” and concluded that it was “reasonable and prudent” for houses to be built on the lots. *Id.* When the lots were offered for sale, a \$315,000 bid was made on one of the lots with the understanding that it would remain unimproved. See *id.* SCCC refused this bid, and ultimately sold both lots to a developer for \$392,500 per lot. See *id.* Thus, once it owned the property, SCCC was unwilling to take a loss of \$77,500 to keep one lot unimproved, but it was perfectly happy in its role as regulator to impose a cost of more than ten times that amount on Mr. Lucas to keep both lots vacant. See *id.*

94. The extent to which signing up for an MCO actually constitutes agreement to a particular cost-quality-access trade-off has been extensively debated. Compare HALL, *supra* note 40, at 15-56 (arguing that it does), with Gail Agrawal, *Chicago Hope Meets the Chicago School*, 96 MICH. L. REV. 1793, 1812-19 (1998) (arguing that it doesn’t, at least not under current market arrangements).

95. See 42 U.S.C. §§ 405(h), 1395hh(a)(2) (1994). See also Eleanor Kinney, *National Coverage Policy Under the Medicare Program: Problems and Proposals for Change*, 32 ST. LOUIS U. L.J. 869, 960-66 (1988).

department visits.<sup>96</sup> In *Grijalva v. Shalala*, the Department of Justice unflinchingly defended practices by Medicare managed care organizations which have been widely criticized by members of Congress when they occurred in the private sector.<sup>97</sup> The Medicare program is now encouraging doctors to use the “least costly alternative” treatment—a position which has prompted the same squeals of outrage from physicians as when MCOs seek to dictate what they will pay for.<sup>98</sup> States have significant discretion in restricting coverage under their Medicaid managed care programs,<sup>99</sup> and Medicare recently adopted caps on rehabilitative-therapy treatments.<sup>100</sup> MCOs may not be paying their bills on time,<sup>101</sup> but state Medicaid agencies have long had the same problem, and the Medicare program has just developed it.<sup>102</sup> The medical care provided by the Department of Veterans Affairs has the same geographic variation as care in the private sector,<sup>103</sup> and there have been serious quality and cost problems in this program for decades.<sup>104</sup> Columbia/HCA and Quorum Health Group may have been keeping two sets of books as part of a plan to

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96. Gordon Bonnyman Jr. & Michele M. Johnson, *Unseen Peril: Inadequate Enrollee Grievance Protections in Public Managed Care Programs*, 65 TENN. L. REV. 359, 370-74 (1998); *Patients Face Big Bills as Insurers Deny Emergency Claims*, USA TODAY, May 4, 1999, at 12A (“ER doctors in California complain that Medicaid-sponsored health plans routinely fail to pay for ER care, despite state and federal requirements to do so. Other states have received similar reports . . .”).

97. 946 F. Supp. 747, 747 (D. Ariz. 1996), *aff'd*, 152 F.3d 1115 (9th Cir. 1998), *vacated and remanded for reconsideration*, 119 S. Ct. 1573 (1999).

98. Louise Schiavone, *Medicare Cost Cutting: Prostate Treatments Come Under Controls* (visited Aug. 23, 1999) <<http://cnn.com/HEALTH/9812/14/medicare.prostate/>>:

In the fight for survival, patient and doctor become a team. And many don't appreciate Medicare's involvement with a new policy called “least costly alternative.” Don't come in between my relationships with my patients,” said oncologist Dr. Steven Strum. “It's not right; it's not reasonable; it's not part of your skills to tell me how to practice medicine.”

*Id.*

99. See Axelrod, *supra* note 18, at 253-57. This discretion is not new, although its scope has been dramatically expanded. See *Alexander v. Choate*, 469 U.S. 287, 309 (1985) (upholding Tennessee's fourteen day annual limit on coverage of inpatient hospitalization, even if longer stays were medically necessary); *Virginia Hosp. Ass'n v. Kenley*, 427 F. Supp. 781, 786 (D. Va. 1977) (same).

100. See Laurie McGinley, *Medicare Caps For Therapies Spark Protests*, WALL ST. J., Apr. 26, 1999 at B1.

101. See Milt Freudenheim, *Dragging Out H.M.O. Payments*, N.Y. TIMES, April 17, 1997, at D1.

102. See Robert Pear, *Medicare Billings Face More Delays*, N.Y. TIMES, Apr. 27, 1998, at A1 (“In an effort to save money, the Clinton Administration is slowing the payment of Medicare claims submitted by doctors, hospitals and other health care providers, according to Federal officials and Government documents.”).

103. See Carol M. Ashton, Nancy J. Petersen, Julianne Soucek, Terri J. Menke, Hong-Jen Yu, Kenneth Pietz, Marsha L. Eigenbrodt, Galen Barbour, Kenneth W. Kizer & Nelda P. Wray, *Geographic Variations in Utilization Rates in Veterans Affairs Hospitals and Clinics*, 340 NEW ENG. J. MED. 32, 32 (1999).

104. See John K. Iglehart, *Reform of the Veterans Affairs Health Care System*, 335 NEW ENG. J. MED. 1407, 1407 (1996).

extract more reimbursement from the federal government,<sup>105</sup> but the Department of Justice did precisely the same thing as part of what appears to be a multi-decade knowing violation of the Federal Employees Pay Act.<sup>106</sup> If running one's insurance arrangements in the black and ensuring that providers are available are preconditions to giving others advice on the subject, it is worthy of note that the Medicare Part A trust fund is scheduled to run out of money in 2011 even though it is funded by a direct tax on the wages of all working Americans; the rate of cost increases in the Medicaid program have been absolutely staggering; and the Medicare managed care market has been battered by the withdrawal of many MCOs.<sup>107</sup> Given this history, is it really plausible that Congress and the state legislatures will be able to beat the alternatives in identifying and implementing cost-justified consumer protections—particularly when their contributions to date have been cost-increasing?<sup>108</sup>

In our enthusiasm to find solutions to the problems of managed care, we should not overlook the fact that legislation is invariably bedeviled by

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105. See David S. Hilzenrath, *U.S. Sues Two Hospital Firms; Columbia/HCA, Quorum Accused of Defrauding Medicare*, WASH. POST, Feb. 3, 1999, at E2.

106. See David Johnston, *Overtime Policy Earns Date With Law For Justice Dept.*, N.Y. TIMES, Aug. 25, 1999, at A1. The article states,

Surprisingly candid internal Justice Department documents . . . show that department officials knew they were in violation, but kept, in effect, two sets of books. One set, on which paychecks were based, required lawyers to state that they worked 40 hours a week, no matter how much time they actually put in. Department officials also kept a second set of records—detailed, computerized time sheets that clocked overtime hours. The records were used by superiors to measure their lawyers' effort, to ask Congress for bigger budgets and even to bill legal fees to losing adversaries . . . [Documents] indicate that the Justice Department has continued to violate the law long after its officials plainly knew they were breaking it.

*Id.*

107. See Richard Manski, Douglas Peddicord & David Hyman, *Medicaid, Managed Care, and America's Health Safety Net*, 25 J.L. & MED. ETHICS 30, 31-32 (1997) (outlining financial woes of Medicare and Medicaid); Robert Pear, *H.M.O.'s Are Retreating From Medicare, Citing High Costs*, N.Y. TIMES, Oct 2, 1998, at A18 (noting withdrawal of Medicare HMOs "from 300 counties in 18 states because medical costs were higher than expected, while Medicare payments were lower than anticipated," and the "Clinton Administration had refused to let them raise premiums or cut prescription drug coverage for the elderly").

Once it realized these changes would affect 400,000 Medicare beneficiaries, the Clinton administration dropped its attitude that this withdrawal was simply a "business decision" by the MCOs and it aggressively encouraged new entrants and sought legislation to prevent a recurrence. See Robert Pear, *Clinton Plans To Intervene As H.M.O.'s Exit Medicare*, N.Y. TIMES, Oct. 8, 1998, at A28. As usual, it did not occur to those involved that exit restrictions made it much less appealing to enter the market—or that exit was a useful signal and not an example of misconduct by anti-social MCOs.

108. See Agrawal, *supra* note 94, at 1798 n.25 ("Most medical-spending decisions made by legislators and regulators with respect to managed care enrollees are decisions to spend, rather than decisions to ration."); Taylor, *supra* note 16, at 61 ("[T]he majority of legislative initiatives aimed at increasing consumer choice ignore the issue of access to a health plan and instead focus on assuring a wide choice of providers and related rights for health plan members. Most of these initiatives increase the cost of insurance.").

similar difficulties, and equal or greater avenues for private opportunism. As Richard Epstein has pointedly noted, “it would be easy to assume that collective responses are preferred when markets are corrupt and governments virtuous. It is far harder to reach that conclusion when self-interest and corruption creates difficulties from both quarters.”<sup>109</sup>

#### V. DOES A PATIENT BILL OF RIGHTS FIT MANAGED CARE?

Given these difficulties with regard to information, preferences, and incentives, it should not come as a surprise that the patient bills of rights which have emerged from the legislative process do not really fit the problems which do exist with American medicine and managed care. To be sure, there is no question that the decision to frame the debate over regulating managed care around a patient bill of rights was inspired political theater. Who, after all, wishes to be on record opposing a bill of rights? The bill of rights formulation has also allowed for further permutations—with Democrats deriding Republican proposals as a bill of goods<sup>110</sup> and a bill of wrongs,<sup>111</sup> and Republicans arguing that the Democrat’s approach creates a lawyer’s right to bill.<sup>112</sup>

As a matter of health care policy, the bill of rights stratagem is less compelling. Those who are uninsured gain nothing from a bill of rights, and their ranks will actually increase if the bill of rights raises the cost of health insurance—although by how much remains a matter of controversy.<sup>113</sup> Those who are insured will pay more for a different

109. Richard A. Epstein, *Why Is Health Care Special?*, 40 KAN. L. REV. 307, 311 (1992).

110. See, e.g., Michael Janofsky, *A Fleet Gore Is Far From the Maddening Washington Crowd*, N.Y. TIMES, Sep. 14, 1998, at A30 (“One of [Vice-President Gore’s] best laugh lines generally follows a comparison of the Administration’s proposal for a patient’s ‘Bill of Rights’ and the Republicans’ version, which he calls a ‘Bill of Goods.’”); James P. Pinkerton, *Poll Winds Propel Clinton Health Plan*, NEWSDAY (N.Y.), Aug. 13, 1998, at A47 (“‘We need a bill of rights, not a bill of goods!’ So said President Bill Clinton in Louisville Monday, campaigning for a patient’s ‘bill of rights.’”).

111. See Thomas Daschle & Edward M. Kennedy, *For Patients, a Better Bill of Rights*, WASH. POST, July 13, 1999, at A19 (“The American people deserve a genuine bill that lives up to the name, not a phony bill of wrongs.”).

112. See Kay Bailey Hutchison, *National Health Scare*, N.Y. TIMES, July 21, 1998, at A15.

113. See General Accounting Office, *Private Health Insurance: Impact of Premium Increases on Number of Covered Individuals Is Uncertain*, GAO/HEHS-98-203R (1998). However, it is noteworthy that approximately five million Americans who had access to employer-based health insurance declined coverage and are uninsured—and the number of such individuals has increased significantly in the last decade. See Philip F. Cooper & Barbara Steinberg Schone, *More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996*, 16 HEALTH AFF. 142, 144 (1997); EBRI Issue Brief No. 213, *Employment-Based Health Benefits: Who Is Offered Coverage vs. Who Takes It* (visited Sep. 13, 1999) <<http://www.ebri.org/ibex/ib213.htm>> (“The 13.7 million workers who were offered coverage but declined it gave a number of reasons for doing so. In the majority of cases (61 percent),

package of goods and services than they would otherwise have purchased, with the differences driven off by the idiosyncrasies of the legislative process. Some of the insured will predictably like that result—particularly if they lobbied for a particular right, or mandatory coverage of something or another. Those who pay but receive benefits they do not value are likely to be less enthusiastic.

The essential assumption driving the bill of rights strategy is that certain terms are an irreducible component of “fair” health insurance coverage, and regulation is necessary because the market is incapable or unwilling to deliver those terms. In reality, insurance is a bundled product sold into a diverse market, with varying preferences for different cost-quality-access trade-offs. The notion that there is one right answer to these trade-offs is belied by the reality that all Americans do not want (nor can they afford) coverage which incorporates these positive rights—and some who could pay do not choose to. Thus, for many consumers, the patient bill of rights actually overrides their preferences, instead of protecting them, and does so at their expense. Not surprisingly, public support for a patient bill of rights quickly erodes once the associated price tag is presented.<sup>114</sup>

The issue is also complicated by the way in which the costs of regulation have been presented. Costs are typically expressed in terms of the increased premium per subscriber per month or in terms of the annual percentage increase in premium costs. For example, in the Senate, the Democrats argued for their version of the patient bill of rights by claiming that it would only increase costs for the average subscriber by the cost of a Big Mac per month.<sup>115</sup> This approach has the advantage of stating costs in terms that are readily accessible to consumers. However, the use of individual costs elides the aggregate cost/benefit issue, which must be

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the worker was covered by another health plan. Of the remainder, 20 percent reported that health insurance was just too costly.”).

114. See Everett C. Ladd, *Health Care Hysteria, Part II*, N.Y. TIMES, July 23, 1998, at A25 (reporting drop in support for “tougher government regulation of managed care” from 60% to 37% if regulation raises health care costs); Kaiser Family Foundation, *New Survey Finds the Public More Worried About Managed Care and More Supportive of Patient Protection Legislation, But Criticisms Still Register* (visited Jan. 1, 2000) <[http://www.kff.org/content/archive/1438/legislation\\_rel.html](http://www.kff.org/content/archive/1438/legislation_rel.html)> (“Support for comprehensive consumer protection drops from 78 to 40 percent (with 40 percent opposed) when people are told that it could raise the cost of a typical family health insurance policy by \$200 per year. . .”).

115. See Michael Grunwald, *Burger Beef Shakes Up Debate on Health Care*, WASH. POST, July 15, 1999, at A8. To be sure, if the cost was really this low, one would expect it to be readily available as an optional rider. Scoring the cost of proposed legislation is a highly imprecise art.

considered in weighing the merits of the regulation.<sup>116</sup> The point may be more apparent if one compares this costing strategy to that employed in a typical design defect case against a car manufacturer. The plaintiff invariably argues that the manufacturer could have prevented some horrific accident by spending a nominal amount per car to make a particular improvement. If the jury only considers the cost per car in deciding whether the automobile manufacturer was negligent, the failure of the automotive manufacturer to incur these nominal costs virtually ensures a whopping verdict. However, if the jury must multiply the cost per car by the number of cars sold, and then evaluate how many lives would be saved and lost by incurring that expense, the trade-offs look vastly different.<sup>117</sup> In like fashion, the relevant inquiry for assessing the merits of a patient bill of rights is whether it will improve the mix of health care with regard to cost, quality, and access, and by how much, and at what aggregate cost. A debate which focuses on the cost per subscriber per month provides no useful information about the desirability or lack thereof of a patient bill of rights.<sup>118</sup>

The bill of rights strategy might still be defended as a traditional health and safety regulation which sets mandatory minimum quality standards for health care coverage.<sup>119</sup> Unfortunately, although Part III makes clear that while the common consensus is that managed care provides significantly lower quality care than fee-for-service medicine, the reality is that quality of care does not neatly correlate with the institutional arrangement through which care is delivered. Indeed, as noted previously, American medicine is marked by highly variable quality which is effectively uncorrelated with the price that is paid for it.

If one assumes for the sake of argument that a patient bill of rights is actually intended to enhance health care quality, it is striking how few of

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116. Stated in terms of the Hand formula, an investment in a particular consumer protection is worth doing only if the cost of the initiative (B) is less than the probability of an adverse outcome (p) multiplied by the resulting costs and damages (L). See *United States v. Carroll Towing*, 159 F.2d 169, 173 (2d Cir. 1947).

117. See Michael M. Weinstein, *The Ins And Outs Of Putting A Price Tag On Product Safety*, N.Y. TIMES, Aug. 12, 1999, at C2.

118. The argument sometimes made by defense attorneys that the cost of a particular treatment was so de minimus that the MCO had no real economic interest in denying coverage is meritless for precisely the same reason.

119. See, e.g., George J. Annas, *Women and Children First*, 333 NEW ENG. J. MED. 1647, 1647-51 (1995); George J. Annas, *A National Bill of Patients' Rights*, 338 NEW ENG. J. MED. 695, 695-99 (1998).

the provisions actually have anything to do with quality.<sup>120</sup> Ensuring the right to a choice of providers or direct access to particular providers is a decidedly indirect mechanism of ensuring quality—especially if providers are subject to guidelines or must obtain prospective authorization before providing treatment. Regardless, it was precisely when individual patients had complete freedom to choose their providers that the quality problems outlined in Part III developed and flourished—a fact which casts serious doubt on the wisdom of the provision in the Democrats’ patient bill of rights to have one’s own physician decide both care and coverage. The right to appeal adverse coverage decisions also has, at best, an indirect connection with quality, and depends for its integrity on the continuation of a fee-for-service based model of the interactions between health care coverage and delivery—but that model has largely vanished from the health care marketplace.<sup>121</sup>

The only provision in the patient bill of rights which fits neatly within a model of market failure with regard to quality is the right to information disclosure. It is hard to argue that more information might not be a good thing, but there are complexities even here, including the cost of the information, the content of the disclosure and its nexus to quality, whether any benefit is likely to result from additional disclosure, and the risk of information overload.<sup>122</sup> This problem is not limited to disclosure; the

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120. Ironically, several of the provisions are based, at least in part, on the assumption that there are no significant informational asymmetries in health care—but it was the presence of informational asymmetries that justified regulation of health care in the first place.

121. Consumers can only vindicate their interest through an independent appeal if they (i) know that there is a treatment recommended for their condition; (ii) are denied coverage for that treatment; (iii) can obtain the support of their provider or other providers to justify obtaining the treatment; and (iv) can perform steps (i)-(iii) expeditiously. The convergence of coverage and care, with the associated growth of treatment guidelines, capitated reimbursement of providers, and without-cause termination provisions in MCO contracts have undermined the ability of consumers to satisfy any of these preconditions.

On the other hand, a staggering amount of information about particular medical conditions is now available to patients who are concerned about the incentives created by the rise of managed care. See David A. Hyman, *A Second Opinion on Second Opinions*, 84 VA. L. REV. 1439, 1460 (1998) (noting growing use of the Internet and second opinions to reassure patients concerned about managed care). Of course, there is plenty of chaff amidst the wheat. See *id.* at 1461 n.105; Jane E. Brody, *The Health Hazards of Point-and-Click Medicine*, N.Y. TIMES, Aug. 31, 1999, at F1.

122. See, e.g., William Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701 (1999) (systematically canvassing the implications of using disclosure to regulate health care); Judith H. Hibbard, Paul Slovic & Jacquelyn J. Jewett, *Informing Consumer Decisions in Health Care: Implications From Decision-Making Research*, 75 MILBANK Q. 395, 412 (1997) (“[T]he limitations of human information processing coupled with the complexity of the information appearing in health care report cards suggests that many consumers will not use performance information in making choices.”); James S. Lubalin & Lauren D. Harris-Kojetin, *What Do Consumers Want and Need to Know in Making Health Care Choices*, 56 MED. CARE RES. & REV. 67

unfortunate reality is that in regulating managed care, “the sort of regulatory tools we have do not match up well against the essence of the problem that any meaningful policy needs to address.”<sup>123</sup>

Another problematic aspect of a patient bill of rights is its aspirational character. What is “reasonable” access to specialists? What is a “fair and efficient process” for appeals? What is “culturally competent” care? How will these issues be decided, and what remedies will be available when someone decides (as always, well after the fact) that a provider or insurer has fallen short? Although the competing patient bills of rights pending before the 106th Congress are considerably more explicit than the recommendations of the President’s Commission, they are still riddled with provisions requiring MCOs to provide “reasonable,” “adequate,” “appropriate,” or “sufficient” services, and notice that is “prompt,” “timely,” or “as soon as possible.”<sup>124</sup> Even if these provisions simply incorporate what most MCOs are already providing, the cost of resolving these issues through lobbying and litigation will be reflected in the cost of coverage—and it seems unlikely that the level will be set that low, given the dynamics of the process that gave rise to the patient bill of rights in the first place.<sup>125</sup>

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(1999). The issue is not unique to health care. See Kathy Bergen, *Investors See Stars, But Only So Much Light*, CHI. TRIB., June 15, 1997, § 5, at 4 (noting difficulties with “star” ratings of mutual funds).

It is important to note that arguments in favor of disclosure are invariably offered as non-falsifiable assertions. Consider the comments of Arthur Levitt, chairman of the SEC, who bemoaned “the sad truth that investors in the corporate bond market do not enjoy the same access to information as a car buyer or a home buyer or, dare I say, a fruit buyer.” Robert D. Hershey, Jr., *Trading in Bonds On Line, At Last*, N.Y. TIMES, June 27, 1999, § 3, at 1. Notwithstanding these pious concerns for the welfare of corporate bond traders, it is worth noting that \$350 billion in bonds are traded every day in the United States—twelve times the daily volume of the New York Stock Exchange—even though extensive pricing information is available on the latter, but insufficient information is available on the former, if Commissioner Levitt is to be believed.

123. Donald W. Moran, *Federal Regulation of Managed Care: An Impulse in Search of a Theory*, 16 HEALTH AFF. 7, 8 (1997).

124. For example, the Bipartisan Consensus Managed Care Improvement Act of 1999 uses “appropriate” forty-four times, “timely” ten times, “reasonable” nine times, “sufficient” five times, “as soon as possible” four times, and “adequate” and “prompt” twice. The Republican and Democrat bills of patient rights use comparable numbers of these terms. It should not come as a surprise that Congress opted for this approach. See *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990) (“[A]ppropriate’ is one of the most wonderful weasel words in the dictionary, and a great aid to the resolution of disputed issues in the drafting of legislation. Who, after all, can be found to stand up for ‘inappropriate’ treatment or actions of any sort?”). The real Bill of Rights uses the words “appropriate,” “sufficient,” “adequate,” “prompt,” “timely,” and “as soon as possible,” not at all, and the word “reasonable” only once. To be fair, it does use the words “speedy,” “excessive,” “due process,” and “just compensation”—but only once each.

125. Indeed, it is quite clear that some MCOs wish to use consumer protection laws to restrain their competitors from offering “low-rent” managed care products. See Robert Pear, *3 Big Health Plans Join In Call For National Standards*, N.Y. TIMES, Sep. 25, 1997, at A28. The article states,

Finally, and most importantly, consider the model of a bill of rights against MCOs from the perspective of institutional “fit.” The reason why we actually enjoy the negative rights specified in the Bill of Rights in the U.S. Constitution is because the constitution specifies a structural arrangement that shares power among three branches of government, and gives each branch the appropriate incentives to make the other branches behave. As Justice Scalia powerfully noted:

What the people care about, what affects them, is the Bill of Rights. . . . That is a *profoundly* mistaken view. . . . For the fact is, that it is the structure of the government, its constitution, in the real sense of the word, that ultimately destroys freedom. The Bill of Rights is not more than words on paper unless. . . it is addressed to a government which is so constituted that no part of it can obtain excessive power.<sup>126</sup>

Absent the appropriate institutional arrangements, the first ten amendments to the Constitution would remain rhetorically powerful, but they would be functionally meaningless. Many countries have far-stronger Bills of Rights than the United States on paper, but far fewer rights in practice, because they lack the necessary institutional framework.<sup>127</sup>

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[T]hree big health maintenance organizations joined two consumer groups today in calling for more regulation of managed health care, saying all health plans should be subject to “legally enforceable national standards” . . . Kaiser, HIP and the Group Health Cooperative see themselves as having a deeper commitment to consumer protection than many commercial H.M.O.’s, but they say it is difficult to fulfill that commitment if they can be undercut by competitors not bound by the same standards.

*Id.* Such conduct is not consumer protection. *Cf.* David Hyman & Charles Silver, *And Such Small Portions: Limited Performance Agreements and the Cost/Quality/Access Trade-Off*, 11 GEO. J. LEGAL ETHICS 959, 978 (1998). The authors state,

Clients who can afford the best do not necessarily want to pay for it. They may happily purchase limited legal services and put the money they save in the bank, the stock market, or whatever else strikes their fancy. A person wealthy enough to own a Rolls Royce can drive a Plymouth and keep the change—at least as long as the Rolls Royce dealers have not put the Plymouth dealers out of business.

*Id.*

126. CHRISTOPHER E. SMITH, JUSTICE ANTONIN SCALIA AND THE SUPREME COURT’S CONSERVATIVE MOVEMENT 41 (1993) (quoting Remarks of Justice Antonin Scalia at Washington, D.C., Panel Discussion on Separation of Powers (audio tape of C-SPAN broadcast, November 15, 1988)).

127. See Larry Rother, *In Latin America, ‘The Constitution Is What I Say It Is’*, N.Y. TIMES, Aug. 30, 1998, § 4, at 5 (noting governmental refusal to observe constitutionally guaranteed rights in South America, because necessary institutional arrangements to ensure fidelity are absent). See also *Nomination of Judge Antonin Scalia to be Associate Justice of the Supreme Court of the United States: Hearing Before the Comm. on the Judiciary*, 99th Cong. 32 (1986) (noting that the Soviet Constitution has some language similar to that in the Bill of Rights, but in the absence of the appropriate institutional arrangements, language did not prevent despotism); Antonin Scalia, *Morality, Pragmatism and the Legal Order*, 9 HARV. J.L. & PUB. POL’Y 123, 126 (1986) (observing that the United Nations’ Universal Declaration of Human Rights declares a right of just compensation for work was adopted by the Soviet constitution and not the United States constitution, but the United States comes closer to achieving the aspiration).

Unfortunately, the institutional framework that currently exists for the delivery of health care has little or no nexus with the rights specified in the patient Bill of Rights—and to the extent it has any nexus, managed care is eroding the foundations. The necessary institutional arrangements for implementation of a patient bill of rights must therefore be created from scratch.<sup>128</sup>

Remarkably enough, this issue has attracted little or no attention from Congress. Instead, the focus of legislative attention has been a dispute over whether quality is better protected through external appeals or elimination of the preemptive effects of ERISA. The weight of public opinion and scholarly commentary has clearly been in the direction of making MCOs legally accountable for their coverage decisions, but even if ERISA is amended in this fashion, it seems unlikely that the plaintiff's bar will focus its attention on whether any given person had a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care. There may well be social benefits from being able to sue MCOs for negligent coverage and treatment decisions, although it is important to remember that the tort system has its own set of flaws.<sup>129</sup> Regardless, it is unlikely that the patient bill of rights will be effectively implemented as a result of such lawsuits. Implementation issues will require considerably more attention than they have received in the current debate over a patient bill of rights.<sup>130</sup>

## VI. ARE COMMISSIONS THE ANSWER?

There is, of course, a third way. Instead of leaving these issues up to the unrestrained forces of the marketplace, or the tender mercies of the legislative process, we could create an expert commission. The commission would provide a mechanism for systematically resolving the necessary trade-offs between cost, quality, and access. The President's Commission reached near-unanimity on a patient bill of rights and responsibilities, and there is no obvious reason why this structure could not be employed to compensate for the difficulties outlined previously.

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128. The design of these institutional arrangements, and the necessary adjustments that will have to be made in the regulatory framework, lie beyond the scope of this Article. *See generally* Harold Ingram & Albert Schneider, *Improving Implementation Through Framing Smarter Statutes*, 10 J. PUB. POL'Y 67, 68 (1990); JEFFREY L. PRESSMAN & AARON WILDAVSKY, *IMPLEMENTATION: HOW GREAT EXPECTATIONS IN WASHINGTON ARE DASHED IN OAKLAND* (3d ed. 1984).

129. *See Hyman, Accountable Managed Care, supra* note 4, at 10.

130. Indeed, in policy circles, it is a truism that reform is 10% legislation, and 90% implementation.

Unfortunately, experience does not provide much assurance that this institutional arrangement will improve on the admittedly imperfect status quo. First, one must make the counter-factual assumption that there is only one acceptable set of trade-offs between cost, quality and access.<sup>131</sup> Second, consider the make-up of the commission. If the commissioners are selected from the ranks of MCO executives, they will predictably have different views than those selected from the ranks of providers. Consumer representatives are also hard to identify, since many groups are little more than a front for provider groups, or have views which diverge significantly from those they purport to represent.<sup>132</sup> Including representatives of all the affected groups ensures that their voices will be heard, but stalemate is a real possibility. In addition, if commissioners advocate for their own parochial interests, or outnumber those advocating for the public interest, the process is likely to be little more than a disguised spoils system.

Third, one must come up with marching orders for the commission. A commission charged with making recommendations that balance costs and benefits is likely to come to quite different conclusions than one which is instructed that cost is irrelevant, or that quality is paramount. The President's Commission had cost matters as one of its guiding principles, and its report noted that it sought to balance the need for stronger consumer rights with the need to keep coverage affordable. However, the charge to

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131. See Clark C. Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POL. POL'Y & L. 471, 491 (1977) ("No single standard and style of health care can be appropriate for all Americans, given their widely varied attitudes, tastes, and religious convictions, their other needs, and the necessarily limited resources at their disposal, including the public funds available to some of them.").

132. One prominent organization describes itself as a "national, non-profit membership organization of consumer groups dedicated to protecting and improving the quality of health care for all Americans." *The Consumer Coalition for Quality Health Care* (visited Sep. 10, 1999) <<http://www.consumers.org>>. However, their web page reveals that four major unions, representing health care workers whose jobs are threatened by the growth of managed care, have endorsed their efforts. The Coalition also boasts of its "new partnership with front-line health care workers." *Consumer Coalition for Quality Health Care* (visited Sep. 10, 1999) <<http://www.consumers.org/new.htm>>.

Similarly, Families USA describes itself as "the voice for health care consumers." *What Is Families USA* (visited Oct. 10, 1999) <<http://www.familiesusa.org/about.htm>>. In reality, Families USA "seeks to advance the goals of Mr. Villers [its founder] and his hand-picked board of directors." Tamar Lewin, *Hybrid Organization Serves as a Conductor for the Health Care Orchestra*, N.Y. TIMES, July 28, 1994, at A1. In addition, Families USA was "the de facto public relations manager of the Clinton Administration's campaign for comprehensive health care legislation." *Id.* The view of the director of Families USA is that "health care should be a right." Tamar Lewin, *Health-Care System Is Issue In Jailing of Uninsured Patient*, N.Y. TIMES, Jan. 8, 1993, at A10. The American public rejected the Clinton Administration's comprehensive health care initiative, and it has systematically rejected the notion that health care is a right. It is fair to wonder whether Families USA is actually "the voice for health care consumers" when it is so out-of-step with public opinion on these issues.

the Commission clearly focused on quality rather than cost or value, and as a result “quality comes first” was the initial guiding principle. Not surprisingly, the result was that the Commission supported recommendations that may prompt additional spending in cases where such spending may represent an investment in higher quality health care and better health outcomes. A different charge would have led to different recommendations, or no recommendations whatsoever.

Finally, it is important to remember that the commission’s recommendations must be enacted by the legislature if they are to become law. Given the legislative incentives outlined previously, it is unlikely that legislators will take a “hands off” approach as the commission develops its recommendations. In addition, even if legislators generally approve of the commission’s work, they are unlikely to consider themselves bound by its recommendations if they conclude that the commission has omitted politically popular provisions or included politically unpopular ones.<sup>133</sup>

Consider the fate of the patient bill of rights drafted by the President’s Commission. As noted previously, the Commission agreed on the necessity for certain universally applicable rights. The competing versions of the patient bill of rights include many of the provisions recommended by the President’s Commission, but legislators added their own pet terms, and dropped or ignored other provisions. Both Republicans and Democrats embraced a universal prohibition on drive-through mastectomies, but that provision was not recommended by the President’s Commission. Both Republicans and Democrats ignored the last provision drafted by the President’s Commission, which specified the responsibilities of patients. Democrats added a provision expressly rejected by the Presidents’ Commission, abrogating ERISA’s preemption of common law causes of action. The Democrats’ proposal that medical necessity (and therefore coverage) decisions should be made by the treating physician is so outlandish it was not even considered by the President’s Commission. Republicans focused most of their provisions on self-funded employee benefit plans, even though the President’s Commission recommended universal application. The Republican proposal also added a provision allowing all patients diagnosed with cancer to get a second opinion—but

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133. Legislators could seek to bind themselves prospectively, by mandating an up-or-down vote on the commission’s recommendations. Congress has experimented with this approach. *See* Defense Authorization Amendments and Base Closure and Realignment Act, Pub L. No. 100-526m 208, 102 Stat. 2623, 2632-633 (1988) (precommitting to limited debate and up-or-down-vote on the recommendations of a base closing commission). However, such arrangements are very much the exception.

both supporters and opponents of a patient bill of rights agreed that this was not an issue which required legislative action.<sup>134</sup>

Delegation of these issues to a commission also does little to ensure that the legislation will not become a partisan hot potato. When Congress considered the recommendations of the President's Commission, the legislative process quickly fractured along partisan lines, and "[e]ach side armed itself with maze-like charts, grisly photographs and superheated language to promote its own plan and demonize the alternative."<sup>135</sup> Given the fate of the recommendations made by the President's Commission, why should we expect the next commission's recommendations to fare any better?

One other recent example provides compelling evidence that expert commissions do not do much to defuse legislative opportunism when there is political hay to be made from an issue. The medical community has been sharply divided over the issue of whether women in their forties should receive routine mammograms. In 1996, an expert panel of the National Institutes of Health concluded that the available scientific evidence did not provide sufficient support for universal screening, and instead recommended that the issue should be resolved by individual patients and physicians. That decision was not popular with Congress, which quickly responded:

Critical of the NIH panel, senators took it upon themselves—through a resolution, subcommittee hearings, and televised speeches—to refute its conclusions and to give American women “clearer guidance” about the need for mammograms. . . .

Equally troubling is Congress' role in pressuring the NCI to change its guidelines. Politicians targeted the National Cancer Advisory Board (NCAB), which was to advise the NCI, based on the consensus conference, whether to revise its 1993 decision to not recommend screening for this age group. In a unanimous resolution, the Senate made its first attempt to “strongly urge” the NCAB to endorse universal screening for women ages 40 to 49 years. The next day, the director of the NCI was summoned before an investigative hearing. When the NCAB later announced that it needed to delay its report by up to 2 months and would probably not propose blanket recommendations for this age group, Sen[ator] Arlen Specter intervened. Specter, who chairs the subcommittee that appropriates the \$12 billion NIH budget,

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134. See Helen Dewar & Amy Goldstein, *Senate Backs GOP's Modest Steps on Protecting Rights of Patients*, WASH. POST, July 15, 1999, at A8.

135. Helen Dewar & Amy Goldstein, *Partisanship, Pathos Open Patients' Rights Debate*, WASH. POST, July 13, 1999, at A1.

pressured the NCAB, the directors of the NCI and NIH, and the secretary of the Department of Health and Human Services to endorse universal screening, adding that further delay was “unacceptable.” The White House also made its views known. Not long after, the NCAB and NCI announced the new recommendations for universal screening of women ages 40 to 49 years.<sup>136</sup>

It is implausible that our elected representatives knew or cared about the scientific merits of the arguments for and against routine mammograms for women in their forties. Legislative second-guessing was instead attributable to the political gain from embracing the issue—particularly when the cost of the recommended mammograms would be the responsibility of private insurers.<sup>137</sup>

#### VII. A NARRATIVE PERSPECTIVE ON CONSUMER PROTECTION AND MANAGED CARE

For those who prefer narrative scholarship, I offer a story.<sup>138</sup> When I was growing up, my father used to go to the local hardware store a lot. Some of the jobs necessitating the trip were to obtain supplies for

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136. See Steven H. Woolf & Robert S. Lawrence, *Preserving Scientific Debate and Patient Choice: Lessons From the Consensus Panel on Mammography Screening*, 278 JAMA 2105, 2107 (1997) (citations omitted).

137. Similar difficulties have dogged the issue of the appropriateness of bone marrow transplants for advanced breast cancer. Patient advocacy groups and physicians successfully lobbied for mandated coverage in a dozen states, and persuaded Congress to do the same for federal employees. See Gina Kolata & Kurt Eichenwald, *Business Thrives on Unproven Care, Leaving Science Behind*, N.Y. TIMES, Oct. 3, 1999, at A1. Objections that the procedure was experimental and could cause more harm than good were shrugged off by legislators intent on appealing to soccer moms. See *id.* Coverage litigation was less obviously affected by such pandering, but many judges were willing to deem the procedure nonexperimental, even in the face of ongoing clinical trials. See, e.g., *Adams v. Blue Cross/Blue Shield of Md., Inc.*, 757 F. Supp. 661 (D. Md. 1991).

Ironically, when controlled studies of bone marrow transplant for breast cancer were finally completed, they demonstrated that the treatment was ineffective. See Kolata & Eichenwald, *supra* at A1. Whether anything useful will be learned from this debacle is another matter. Compare David Eddy & Craig Henderson, *A Cancer Treatment Under A Cloud*, N.Y. TIMES, April 17, 1999, at A17 (“We should know whether treatment works before we routinely pay for it. . . . We should also recognize that insurers are generally justified in withholding routine payments for a new treatment until its effects are known. The reason is not the bottom line; it is quality of care.”), with Sara Rosenbaum, David M. Frankford, Brad Moore & Phyllis Borzi, *Who Should Determine When Health Care Is Medically Necessary*, 340 NEW ENG. J. MED. 229, 232 (1999) (arguing that determinations of treating physician should control, absent proof that “the proposed treatment conflicts with clinical standards of care or that there is substantial scientific evidence, regardless of clinical practices, that the proposed care would be unsafe or ineffective or that an alternative course would lead to an equally good outcome”).

138. Narrative scholarship has been booming, despite criticisms of its typicality and truthfulness. See generally Hyman, *supra* note 57. Those who doubt the typicality or truthfulness of my narrative can visit their closest mall. See also *infra* notes 139-43.

refinishing the top floor of the house; others were due to routine upkeep in a house almost eighty years old; but the largest fraction was simply to obtain what was necessary to repair the damage caused by four boys and a dog. The hardware store was cluttered and not very well lit, but it had all sorts of stuff in nooks and crannies, and they always seemed to be able to come up with whatever you asked for, or be able to get it in a day or two. There were a couple of older gentlemen working in the store who were expert tradesmen. They knew exactly where everything was in the store and what you would need to fix any problem. Even the vaguest description of the symptoms or the smallest fragment of a broken part was sufficient to get a wealth of good advice about how to solve the difficulty, and the precise tool and replacement part that was required.

About the time I left for college, a warehouse hardware store opened up a few miles away. Not surprisingly, it offered a much larger selection of tools, parts, and just about everything else in brightly lit surroundings with lots of eye-catching displays. The prices were spectacularly low. There wasn't a whole lot of help—and what there was seemed to be there mostly to restock the shelves and, if you were lucky, direct you to the aisle in which you might be able to find what you needed—assuming of course that you knew what it was you were looking for, what it looked like, and how to find it in an 300-foot long aisle with two sides and multiple displays going up 30 feet in the air. My dad complained about the service, but he liked the range of products and he loved the prices. When he needed a special part, he still went to the local hardware store, but most of his purchases were made at the warehouse hardware store—and he had plenty of company.<sup>139</sup> The net result was the rapid demise of many local hardware stores—followed by the demise of less successful warehouse hardware stores.<sup>140</sup> In

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139. In 1998, home centers accounted for 49% of total hardware sales of \$145 billion, even though they had only 23% of the stores. See Chris Jensen, *Industry Firms Scramble to Stake Their Claim With Electronic Commerce Ventures*, DO-IT-YOURSELF RETAILING, Nov. 1999, at 67, 70-71. During the period 1994-1998, sales by the top 25 hardware, home center, and lumberyard chains grew from 34.4% of the industry to 44.7%, while their share of total stores went from 7.1% to 8.8%. See *id.* The two biggest home center chains accounted for \$42 billion, or 28% of the market, with only 2.8% of the stores. See *id.* Of course, the fact that warehouse stores are bigger induces some significant skewing, but there is still a substantial discrepancy in terms of sales per square foot of retail space (\$127 v. \$254), average size of transaction (\$13 v. \$41), sales per employee (\$105,514 v. \$166,915) and turns of inventory (3.4 v. 5.1) if one compares retail hardware stores to home centers. See *id.* at 75-76. If one looks at Home Depot, the largest and most successful chain, the disparity is considerably larger (\$371 in sales per square foot of retail space, average transaction of \$45, sales per employee of \$192,000, and 7.0 turns of inventory). See *id.* at 79.

140. See James R. Hagerty, *Tough As Nails: Home Depot Raises The Ante, Targeting Mom-and-Pop Rivals*, WALL ST. J., Jan. 25, 1999, at A1 (noting that Home Depot has been "roughest on regional

retail circles, the success stories are known as “category killers,” because once they are entrenched, no other vendors can survive in the category.

Continuing the narrative into the next generation suggests some additional subtleties on the supply and demand sides. My older brother usually shops at category killer hardware stores because he likes the wide selection. However, he goes to the local hardware store when he needs specialized assistance, such as when he purchased a chain saw. My younger brother hates category killers, and shops only where he can get first-rate service. My youngest brother always seems to have a friend in the business. I go to category killers when I have lots of stuff to buy, but find it extraordinarily inconvenient to wander the aisles when I only need a single (usually obscure) part in the middle of a job. I also find that I know more about hardware and home repair than many of the employees at the local category killer hardware store.

With my law and economics hat on, I would call this a natural experiment, with frequent voluntary purchasing decisions requiring customers to balance cost against quality and access.<sup>141</sup> The results are just what you would predict—and as it goes in hardware, so goes the nation—whether one is looking at bookstores, grocery stores, tire stores, shoes, gas stations, appliance stores, funeral homes, eyeglasses, banks, hospitals, videotape rentals, computer stores, or auto dealerships. Category killer stores are the retailing success story of the 1990s.<sup>142</sup> Despite repeated complaints about the quality of service that is provided by category killers,

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chains of midsize ‘home center’ stores,” and family hardware stores have proved “surprisingly resilient”).

141. Of course, this is an oversimplification, since other factors (for example, open evenings and weekends, convenient parking, easy return policy) enter into the quality and access issues, and most people would say that warehouse stores come out ahead on many of these other indicia. See Robin Pogrebin, *Shakespeare & Co. to Exit the Scene*, N. Y. TIMES, June 13, 1996, at B1 (“personalized bookstore” closes after category killer moves in one block north; bookstore had “developed something of a reputation for surly service,” and “many people—whether or not they would admit it—clearly liked . . . wide selection and deep discounts, the comfortable chairs and bustling coffee bar”); Joe Morganstern, *In You’ve Got Mail, Cyber-Love Conquers All, Even a Predictable Script*, WALL. ST. J., Dec. 18, 1998, at W1 (“Another problem was my inexpungible memory of Shakespeare & Company’s condescending clerks, who barely deigned to wait on readers with ordinary tastes.”).

142. See Michele Conklin, *New Breed of Category Killers Are on the Prowl*, ROCKY MOUNTAIN NEWS (Denver), Jan. 17, 1996, at 38A. The article states,

The next generation of category killers are just around the corner, waiting to further erode department store sales and shut down independent retailers. . . .

“Many say there are no more categories to be killed, but there are still lots left to be slaughtered. . . .”

Categories ripe for new superstores include: bedding and back care; health care; workout accessories; gardening; cooking and food; athletics (especially golf); hobbies; home decorating and accessories; home security; and large-size apparel.

*Id.*

and the length of time required to get to such stores and locate what one needs, millions of individual decisions reflect a systematic bias toward one-stop warehouse convenience and low prices—and the inexorable conversion, through competition, of “producer surplus into consumer surplus.”<sup>143</sup> This effect has become particularly pronounced now that category killers are competing with one another. People may complain about category killers, but their purchasing decisions reflect their real assessment of where their interests and needs lie.<sup>144</sup>

If hardware were treated the same as health care, one would expect local hardware stores to start a campaign to “protect” customers from the category killers. Of course, these laws would be justified on grounds of public safety: Increased traffic at hardware category killers spoils the peaceful atmosphere of the community, and endangers the children who are playing in the streets.<sup>145</sup> More importantly, the public interest is endangered by poor sales help at the hardware category killers—particularly in the aisles selling gas barbecues, electrical wiring, power tools, lawnmowers, and pesticides. Based on the model of consumer helplessness which underlies patient bills of rights, one would expect to see the following laws in short order:

- (a) Category killers should be forced to hand out disclosure statements at the door, which describe the potentially bad consequences of shopping there, compared to the more expensive local hardware stores;
- (b) Category killers should be forced to hire more sales help, test their employees on their knowledge of the field, and provide a certain ratio of expert to inexperienced sales help for every 100 customer visits;
- (c) Category killers should be forced to stock the same (high quality) products offered by the competition, instead of offering lower priced (and allegedly inferior quality) merchandise;

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143. Richard A. Posner, *The Deprofessionalization of Legal Training and Scholarship*, 91 MICH. L. REV. 1921, 1921-22 (1993) (“Competitive markets are not much fun for sellers; the effect of competition is to transform producer surplus into consumer surplus.”); Uwe Reinhardt, *Table Manners at the Health-Care Feast: ‘Regulation’ v. ‘Market’*, NAT’L J., May 9, 1981, at 855 (“A competitive market system is, after all, a social arrangement whereby life is made hell for providers to make life cheap and easy for consumers.”).

144. See Clyde Haberman, *Fear and Shopping in Queens*, N.Y. TIMES, Sep. 24, 1996, at B1 (“New Yorkers seem deeply ambivalent. . . . [M]ost people cherish mom-and-pop stores for giving their neighborhoods character, yet they are also charmed by the megastores’ siren call of easy shopping and low prices.”).

145. See Eleanor Charles, *Coping With the Big Headaches ‘Big Boxes’ Bring*, N.Y. TIMES, Feb. 25, 1996, § 9, at 10.

(d) Category killers should be prohibited from paying their employees on a commission basis, and their employees should have the right to bad-mouth the products offered by the category killer.

Even a hardened lobbyist would be embarrassed to argue on behalf of such proposals.<sup>146</sup> Advocates of consumer protection against managed care are less shy. Of course, one could object that health care and hardware are not the same thing—and, of course, they are not.<sup>147</sup> At the same time, it is important not to overstate the extent to which the analogy is imperfect. The market for hardware is not perfect by a long shot. There are persistent informational asymmetries, and the consequences of choosing wrongly can be severe, irreversible, and even life-threatening.<sup>148</sup> Even among category killer hardware stores, some are better than others. Search costs are often high, even with brand name products. Judging the quality of the products that are sold by the category killers is not easy, since one could be a repeat customer, but rarely for the same thing. It was always possible to save money at the front end (by buying something more cheaply at the warehouse store) but end up spending more overall (when it was not exactly the right part, and some expert assistance at the local hardware store would have let you know that). High quality providers find it difficult

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146. Instead, small retailers have used existing zoning laws or sought new laws to keep out category killers. See Carol Emmert, *Assembly Bill Threatens Superstores*, S.F. CHRON., Sep. 10, 1999, at B1 (noting passage by California assembly of bill prohibiting building of stores larger than 100,000 square feet if more than 15,000 square feet devoted to food and drugs; author of bill “said the legislation is designed to protect smaller retailers. ‘Economic fascists have already wiped out all of our downtown businesses.’”); Evelyn Nieves, *Taking on Wal-Mart, Ahead of Time*, N.Y. TIMES, Aug. 1, 1995, at B5 (potential competitors and quality of life proponents oppose category killers); Vivian S. Toy, *Small-Business Owners Prepare for a Megabattle*, N.Y. TIMES, Oct. 22, 1996, at B3 (opposition to changes in zoning to allow category killers consistent and strong among small business owners).

Antitrust law has also provided a tool for small retailers to challenge the growth of category killers. See, e.g., *In re Brand Name Prescription Drugs Antitrust Litigation*, 186 F.3d 781 (7th Cir. 1999) (affirming judgment as a matter of law in case alleging discriminatory pricing in sales of prescription pharmaceuticals to retail drugstores); *Wal-Mart Stores v. American Drugs, Inc.*, 891 S.W.2d 30 (Ark. 1995) (reversing chancery court’s determination that Wal-Mart had engaged in predatory pricing by selling certain items below cost).

147. Stated more positively, the claim is that health care is “special.” For varying perspectives on this issue, compare Epstein, *supra* note 109, at 310 (it isn’t), with Mark V. Pauly, *Is Medical Care Different? Old Questions, New Answers*, 13 J. HEALTH POL. POL’Y & L. 227 (1988) (maybe it is, but only a little), and Timothy Stotzfus Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 535-58 (1988) (it is, but only in some areas), and Rand Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067, 1109-13 (1981) (it is).

148. Obviously, the “public interest/safety” stakes are considerably higher in the aisles at category killer hardware stores selling tools and substances which are potentially dangerous (e.g., power tools, barbecues, pesticides and the like) than they are at the category killer video rental store. Many of the category killers fall somewhere in between these extremes.

to make that fact known, and free-riding prevented them from capturing all of the gains from their expertise. As category killers dominated the market, it became harder and harder to find old-fashioned local hardware stores—and category killers used their market power to change the mix of products which were available to the public.<sup>149</sup> On the supply side, entry was difficult, especially if one wanted to compete with the category killers. On the demand side, one could find agents, but they cost a lot. I had a better (free) agent than most, but I was known to disregard his advice.

Thus, many of the imperfections which dog the health coverage and delivery markets also dog the hardware market. Yet even with all these deficiencies from the economists' definition of a perfect market, the hardware market worked efficiently and even ruthlessly—albeit not quite the way local hardware stores wished it did.

The supply-side picture is also heterogeneous. Category killers have struggled or gone out of business when their mix of price and quality was not quite right.<sup>150</sup> Small vendors have successfully challenged category killers in some markets and created or exploited market niches in which category killers find it difficult to compete.<sup>151</sup> Category killers can become successful on a certain mix of price and quality, but that is no guarantee if

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149. See, e.g., G. Bruce Knecht, *Book Superstores Bring Hollywood-Like Risks to Publishing Business*, WALL ST. J., May 29, 1997, at A1 (noting impact of book superstores on book retailing practices); Neil Strauss, *Wal-Mart's CD Standards are Changing Pop Music*, N.Y. TIMES, Nov. 12, 1996, at A1 (cataloging impact of Wal-Mart and Blockbuster on content of music and films). On the other hand, opinion leaders can have similar effects, but no one seems to be complaining about them. See D.T. Max, *The Oprah Effect*, N.Y. TIMES, Dec. 26, 1999, at 39 (charting impact of Oprah Winfrey on book publishing, including responsibility for 28 bestsellers, \$175 million in sales, skewing of books published and promoted to Oprah's tastes, and boost in careers of authors and publishing executives with an "Oprah-type" sensibility).

150. The hardware market is quite competitive even in the category killer segment. Handy Andy, Builder's Square, and Hechingers have all gone out of business, while Home Depot and Lowe's are thriving.

151. See, e.g., Dan M. Tratensek, *Survival of the Fittest out in the D-I-Y Retail Market*, DO-IT-YOURSELF-RETAILING, Nov. 1999, at 78 ("Retail Darwinism continued among home improvement chains last year, as the strong continued to thrive and the weak were either absorbed or forced into extinction."); Liz Bowie, *They Survived the Superstore Invasion*, BALT. SUN, Oct. 5, 1997, at 1H (profiling small music and office supply stores which focused on small niches and provide better service); Calmetta Y. Coleman, *Retailing: How Grocers are Fighting Giant Rivals*, WALL ST. J., Mar. 27, 1997, at B1 (supermarkets are holding their own against superstores by "promoting the quality and freshness of their perishables"; some stores adding general merchandise to their more traditional fare); Jeffrey A. Tannenbaum, *Small Bookseller Beats the Giants at Their Own Game*, WALL ST. J., Nov. 4, 1997, at B1 (noting rapid growth of small booksellers offering restricted stock at low prices).

tastes change. Even small hardware stores are finding ways to survive—and thrive.<sup>152</sup>

Three points should be drawn from this narrative. First, providers and consumers will often differ on the optimal mix of cost, quality, and access. Allowing providers to dictate the terms of trade will sometimes protect consumers, but it is more likely to harm them.<sup>153</sup> As such, the fact that providers are in favor of one institutional arrangement and opposed to another does not even create a *prima facie* case in favor of the former and against the latter.<sup>154</sup> Unless we are willing to allow the proprietors of local hardware stores to dictate the terms of trade on which their category-killer competitors can deal, we should be quite reluctant to embrace a similar strategy in regulating MCOs.

Second, although there are persistent imperfections in the market for health care, such imperfections are present to a lesser (and sometimes greater) extent in all markets. Well-functioning markets do not require consumer bills of rights, because it is in the interest of vendors to serve their customers. The impetus for a patient bill of rights issue is not really market imperfections, but provider disdain for the terms of the contracts the market has cleared.<sup>155</sup> The real issue is not whether providers like or

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152. See, e.g., Barnaby J. Feder, *In Hardware War, Cooperation May Mean Survival*, N.Y. TIMES, June 11, 1997, at D1. The article states,

Dealer casualties are mounting as mega-stores march across the land, and the member-owned co-ops are far from united, battling among themselves for turf as the pressure mounts. But small hardware stores are not being crushed as easily as many independent toy stores and bookstores have been by giants like Toys 'R' Us and Barnes & Noble. And many larger hardware dealers . . . are thriving.

*Id.*

153. See Robert Pitofsky, *Prepared Statement of Federal Trade Commission Concerning H.R. 1304* (visited Sep. 2, 1999) <<http://www.ftc.gov/os/1999/9906/healthcaretestimony.htm>> (“The collective judgment of health care professionals concerning what patients should want can differ markedly from what patients themselves are asking for in the marketplace.”); James F. Blumstein & Michael Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH POL. POL’Y & L. 382, 401 (1979) (“[T]he quality of care recommended as a norm by the medical profession may not be either a realistic or desirable standard to be adopted by individuals as consumers or by government as third party payer.”).

154. This point seriously undermines the claims of providers who happen to be members of Congress to speak with any particular authority on the issue of consumer protection against managed care. See Eliza Newlin Carney, *House’s Doctors Prescribe Bitter Medicine*, NAT’L J., July 24, 1999, at 2162 (“House leaders face open rebellion from a small but influential group of GOP lawmakers who are doctors.”).

155. A scene in the recent film *You’ve Got Mail* exemplifies this point. Meg Ryan plays the plucky owner of a small independent bookstore on the Upper West Side of Manhattan, which ultimately closes its doors when a category killer bookstore opens across the street. She visits the category killer, and it is a “vast and attractive emporium, where she finds people sipping coffee or perusing books while curled up on sofas.” Morganstern, *supra* note 141, at W1. One reviewer insightfully noted the self-

dislike the terms of trade, but whether regulation of those terms leads to better coverage and delivery designs, all things considered and across all cases. Given the difficulties with legislative information, incentives, and preferences outlined in Parts III and IV, and absent force, fraud, or duress, there seems little to gain (and much to lose) in setting MCO mandatory contract terms through regulation or legislation. This lesson has been learned for other regulated industries; the patient bill of rights approach is flatly inconsistent with developments in the transportation, telecommunications, and energy industries, where market-enhancing initiatives which maximize consumer choice have become the dominant regulatory strategy.<sup>156</sup>

Finally, market dominance is frequently a temporary phenomenon. In the commercial marketplace, today's has-beens were yesterday's success stories and last year's upstarts—and today's market goliaths may well be tomorrow's has-beens. Similarly, in the medical marketplace, today's settled standards became accepted because they were superior to last year's disproven treatments, and last decade's superstitious nonsense.<sup>157</sup> As such, past practices provide an exceedingly poor proxy for the boundaries of

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aggrandizing presumption of superiority that marks those who believe they are entitled to dictate the terms of trade when faced with a contrary market outcome:

At first, I thought the scene was meant generously, as evidence of the earnestness of life—book lovers happily adapting to new environments. But no, its meant only to show that Kathleen, unlike a clueless superstore clerk, can instantly recall the author of a children's book series for an inquiring customer. I never thought I'd be rooting for Barnes & Noble.

*Id.* See also Frank H. Easterbrook, *Cyberspace versus Property Law?*, 4 TEX. REV. L. & POL. 103, 111 (1999):

It is ironic that just as a global network and automation are reducing the costs of contracting, and moving us closer to the world in which the Coase Theorem prevails, people promote more and more contract-defeating schemes. One is tempted to think that they are concerned not about market failures but about market successes—about the prospect that the sort of world people prefer when they vote their own pocketbooks will depart from the proposers' ideas of what people *ought* to prefer. Next thing you know, why, economic transactions between consenting adults will break out *right in public view!*

*Id.*

156. See Joseph D. Kearney & Thomas W. Merrill, *The Great Transformation of Regulated Industries Law*, 98 COLUM. L. REV. 1323 (1998) (documenting regulatory paradigm shift, and concluding it developed because of ideological consensus that risk of regulatory failure under the old paradigm exceeded risk of market failure under the new paradigm).

157. In theory, path dependence could significantly impede the adoption of pareto-superior arrangements to managed care. See Mark J. Roe, *Chaos and Evolution in Law and Economics*, 109 HARV. L. REV. 641, 643 (1996). Three reasons suggest that this problem is unlikely to be significant. First, it is easier to articulate a theory of path dependence than it is to find empirical evidence of the phenomenon in the health care marketplace, let alone evidence that it can be fixed without inducing worse distortions. Second, the tumultuous restructuring of the health care economy in the past decade away from fee-for-service and toward managed care suggests that there are no real impediments to further restructuring—except those created by well-meaning legislators, that is. Finally, if medicine were really beset by path dependence, we would still be bleeding people for fevers.

acceptable medical care and coverage—even if the cost-quality and quality-quality equilibriums have remained stable in the interim—which they have not. Designing a patient bill of rights around idealized recollections of how health care was run before the rise of managed care virtually ensures costly and non-cost-worthy distortions in the health care coverage and delivery markets.<sup>158</sup>

### VIII. CONCLUSION

Set aside for just a moment what everyone “knows” about the perils of managed care and the need for a patient bill of rights. Set aside as well the inconvenient fact that customer surveys show a high degree of satisfaction among managed care participants,<sup>159</sup> and extensive research indicates that the quality of care is as good (or better) in managed care plans than in fee-for-service health care.<sup>160</sup> Instead, consider the case for regulation from an empirical perspective. If the absence of regulation is a bad thing, one would expect the frequency of complaints and avoidable bad outcomes to be higher (and the quality of care that is rendered to be lower) in managed care plans that are subject to fewer regulations. As Part II.C reflects, some forms of health insurance are heavily regulated, others are subject to only

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158. Cf. Walter A. Zelman, *Consumer Protection in Managed Care: Finding the Balance*, 16 HEALTH AFF. 158, 160 (1997) (“[T]he anti-managed care critique tends to implicitly or explicitly idealize a now fading fee-for-service system in which costs rose out of control.”).

159. See Robert J. Samuelson, *Myth of the Managed Care Monster*, WASH. POST, July 29, 1998, at A21 (“Most Americans rate their health care favorably: 66 percent of those in managed care compared to 76 percent in ‘fee for service’ medicine, finds a survey for the Kaiser Family Foundation.”); Ladd, *supra* note 114, at A25 (reporting high degree of popular satisfaction with health care).

The usual response to these results is to suggest that the modest percentage of patients who actually required and received health care during the period in question are considerably less happy with managed care than those who did not require such care. However, in one large survey, one-third of the respondents reported that they or someone in their family had experienced a serious illness or injury while under their current plan. Of that group, 93% in traditional arrangements and 88% in HMOs were satisfied with the medical care they received. See Karlyn Bowman, *Patients Don't Want Protection From Their HMOs*, WALL ST. J., May 11, 1998, at A22.

Obviously, patient satisfaction surveys do not provide a direct measure of the quality of care that was provided—and even if they did, high levels of dissatisfaction with managed care still might not translate into willingness to pay the necessary cost to fix the underlying problem. See E. Douglass Williams & Richard H. Sander, *The Prospects for “Putting America to Work” in the Inner City*, 81 GEO. L.J. 2003, 2047 n.180 (1993):

In a 1987 . . . poll, 71% of respondents agreed with the statement that “the government in Washington should see to it that everyone who wants a job has a job.” The high support level, however, tells us little about how much Americans would be willing to pay to accomplish this goal.

*Id.*

160. See *supra* notes 69-79 and accompanying text.

modest regulation, and others effectively fall into a regulatory “free-fire” zone. If there is any evidence suggesting that complaints and avoidable bad outcomes are less frequent in plans which are more aggressively regulated, I am unaware of it. Similarly, if there is any evidence suggesting that the quality of care is better in plans which are aggressively regulated, I am unaware of it. One would have thought such evidence would be readily available (and widely trumpeted by advocates of consumer protection) if the problems with managed care are as severe as the anecdotes suggest. In the absence of empirical evidence regarding such matters, the case for a patient bill of rights is based on fear (of markets) and faith (in anecdote-driven regulation), but not on fact.

Despite its popular appeal, a patient bill of rights is a deeply flawed strategy for addressing the inadequacies of managed care. The kinds of rights which are likely to result from the legislative process (and have emerged to date) are likely to make things worse, rather than better, whether one considers cost, quality, or access. The backlash against managed care may have been sold to the public as a response to concerns about quality, but the legislation that has emerged has more to do with “provider lobbying, gut instincts, negative anecdotes, and popular appeal” than with quality.<sup>161</sup> Indeed, the unfortunate reality is that quality has long been used as a stalking horse by providers wishing to disguise less public spirited objectives—a point which Robert Pitofsky, the chairman of the Federal Trade Commission, relied upon in explaining the FTC’s opposition to a bill authorizing health care providers to collectively bargain with health plans:

“[Q]uality-of-care” arguments . . . can be invoked as a justification for even the most egregious anticompetitive conduct. They have been advanced to support, among other things, broad restraints on almost any form of price competition, policies that inhibited the development of managed care organizations, and concerted refusals to deal with providers or organizations that represented a competitive threat to physicians.<sup>162</sup>

161. Hyman, *Call 911*, *supra* note 4, at 445.

162. Robert Pitofsky, *Prepared Statement of Federal Trade Commission Concerning H.R. 4277* (visited Sep. 2, 1999) <<http://www.ftc.gov/os/1998/9807/campstest.htm>> (citations omitted). *See also* PAUL FELDSTEIN, *HEALTH CARE ECONOMICS* 373 (1988):

It would appear . . . that the concern of the medical profession (as well as of other health professions) with quality is selective. Quality measures that might adversely affect the incomes of their member, such as reexamination and relicensing, are opposed, as are any measures that attempt to monitor the quality of care.

*Id.* *See also* David A. Hyman, *Professional Responsibility, Legal Malpractice, and the Eternal Triangle: Will Lawyers of Insurers Call the Shots?*, 4 *CONN. INS. L.J.* 353, 399 (1988) (“[O]ne should be cautious about generating a normative baseline for the cost/quality mix of professional services

Worse still, to the extent the patient bill of rights strategy is based on the sanctity of physician discretion, it makes it much more difficult to address the real quality-based problems with American medicine, which, in fact, *are* attributable to the unconstrained discretion previously accorded physicians. Legislators have ignored this basic point; the patient bills of rights that have been offered demonstrate a distinct preference for safeguarding physician decisionmaking from MCO interference. However, if physicians are such good agents for patients with regard to medical spending decisions, why is there such significant geographic variation in the delivery of health care services?<sup>163</sup> Why did hospital lengths-of-stay decline so precipitously after Medicare abandoned cost-based per-diem reimbursement, and moved to prospective payment based on discharge diagnosis?<sup>164</sup> Why did Secretary Shalala announce that the Clinton administration's anti-fraud and abuse initiative for Medicare was a "top personal priority"—and why was the initiative named Operation Restore Trust?<sup>165</sup> Why did the Institute of Medicine recommend a systems-based approach to improving health care quality?<sup>166</sup>

Of course, we should not indulge in the nirvana fallacy in assessing the merits of a patient bill of rights, but neither should we deploy regulations merely because managed care delivers something short of perfection.<sup>167</sup> The government brings a great deal to the table, but so do

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based solely or even largely on the assessment of the affected professionals. Given their track record, professional pronouncements on the appropriate and/or necessary level of quality should be viewed with jaundiced eye.”)

Given this dynamic, it should not come as a surprise that the patient bill of rights initiative has led physicians to abandon their historical allies in the Republican party, and embrace their long-time enemies in the Democratic party. See Laurie McGinley, *Republicans Don't Feel Too Good as Doctors Cut Across Party Lines*, WALL ST. J., Sep. 28, 1999, at A1 (“Aghast that the GOP leadership hasn't brought managed care to heel, physicians are crossing party lines for help, and rewarding Democrats with votes and political contributions.”). The extent of the change in mindset (and the degree to which it is driven by narrowly defined provider self-interest) is exemplified by the comments of one orthopedist: “Republicans represent capital, and Democrats represent labor. . . . Physicians used to be capital, but now we're labor in the view of managed care.” *Id.*

163. See Brook et al., *supra* note 15, at 478 (“Where we reside determines to a large extent the procedures or services we receive, with use of many services varying more than 3-fold by geographic area”); Hyman, *Drive-Through Deliveries*, *supra* note 4, at 25-30.

164. See Brook et al., *supra* note 15, at 479 (noting immediate 25% decline in length of stay following introduction of prospective payment); David A. Hyman & Joel V. Williamson, *Fraud and Abuse: Regulatory Alternatives in a 'Competitive' Health Care Era*, 19 LOY. U. CHI. L.J. 1133, 1139-40 n.41 (1988) (noting impact of prospective payment system on hospital length-of-stay).

165. HCFA Press Releases, *Secretary Shalala Launches New "Operation Restore Trust"* (visited Aug. 23, 1999) <<http://www.hcfa.gov/news/pr1997/n970520.htm>>.

166. See Institute Of Med. Comm. On Quality Of Health Care In Am., *supra* note 80.

167. See Harold Demsetz, *Information and Efficiency: Another Viewpoint*, 12 J.L. & ECON. 1, 1 (1969) (“The view that now pervades much public policy economics implicitly presents the relevant

private parties.<sup>168</sup> Regulatory enthusiasts are prone to forget that in a world of imperfect alternatives, it is unhelpful to catalog the weaknesses of an existing market, and disregard the deficiencies of the proffered solution.<sup>169</sup>

What then should be done? Our goal should be to create the appropriate institutional arrangements for ensuring a range of coverage—including considerable variation in quality, access, and pricing—while minimizing the sum of error, incentive, and administrative costs, and preventing force, fraud, and duress. Stated differently, “structural problems demand structural solutions”—and to the (limited) extent the competing patient bills of rights include any structural solutions, they are the wrong ones.<sup>170</sup> A better approach is to simultaneously target cost, quality and access through a variety of market-enhancing regulatory strategies. These would include the leveling (preferably down, but more likely up) of the tax consequences of purchasing health insurance through employer and non-employer-based markets, the aggregation of purchasing power by small employers, the development of better measures for assessing quality of care

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choice as between an ideal norm and an existing ‘imperfect’ institutional arrangement. This *nirvana* approach differs considerably from a *comparative institution* approach in which the relevant choice is between alternative real institutional arrangements.”)

168. See Blumstein & Zubkoff, *supra* note 153, at 389-90:

Decentralized choices by nongovernmental decisionmakers . . . has greater potential for precluding symbolic concerns from becoming inextricably involved in policy formulation and will likely point more attention to necessary economic tradeoffs. The design of institutions and policies should therefore take into account the “susceptibility to symbolic blackmail” of governmental institutions when health issues are directly implicated.

*Id.*; See also Richard A. Epstein, *Living Dangerously: A Defense of Mortal Peril*, 3 U. ILL. L. REV. 909, 927-28 (1998):

[B]efore embarking down the road to [regulation] one has to make some estimate of the relative chances of success or failure, given the danger of regulatory capture and excess that can subvert a legislative program from any direction . . . Private markets are more resistant to these pressures because exit and entry possibilities keep established players in line. State monopolies, on the other hand, can easily misbehave. . . .

*Id.*; Uwe E. Reinhardt, *Demagoguery and Debate over Medicare Reform*, 14 HEALTH AFF. 101, 103 (1995) (“One great advantage of cost and quality control through private regulators is that the latter are swift and usually not open to appeal.”).

169. Professor McChesney cuttingly described the problem as follows:

Real-world private markets must be compared with real-world government, not some unrealistically benign caricature thereof. Students of regulation know too much about how government actually works to believe that its coercive intervention in markets will necessarily increase public welfare. That managers’ incentives ‘may diverge’ from those of shareholders is not sufficient to justify government intervention by politicians and bureaucrats, whose interventions will almost certainly diverge from those of shareholders. And to argue for replacing private contracting with mandatory government rules because private parties are underinformed or cannot control management is illogical in a world where politicians and bureaucrats (like everyone else) are underinformed as well, and almost certainly are subject to even less shareholder control.

Fred S. McChesney, *Economics, Law, and Science in the Corporate Field: A Critique of Eisenberg*, 89 COLUM. L. REV. 1530, 1548 (1989).

170. Hyman, *Accountable Managed Care*, *supra* note 4, at 40.

and disclosing that information to purchasers, the development and adoption of compensation systems tied to outcome and quality of care, and greater ability to contract out of or in to regulation. To the extent the government can not resist additional regulation, it should reject the notion that there is one correct solution to any given problem, and limit its efforts to disclosure-oriented provisions. Finally, any reform whose costs fall off-budget should be rejected more or less as a matter of course.

It is understandable that managed care horror stories trigger outrage and a demand for additional regulations. However, any given rule or standard for making coverage and treatment decisions will necessarily have imperfections.<sup>171</sup> So long as we have created the appropriate institutional arrangements—and there certainly remains much to do with regard to that goal—leaving well enough alone with regard to the specifics of the resulting coverage is likely to be sufficient unto the day.<sup>172</sup> Such a strategy lacks the moral certainty of stringing up a few managed care desperados in black hats, but it will do more to improve the status quo than any ten patient bills of rights.

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171. Cf. NEIL K. KOMESAR, *IMPERFECT ALTERNATIVES: CHOOSING INSTITUTIONS IN LAW, ECONOMICS, AND PUBLIC POLICY* 204 (1994) (“Bad is often best because it is better than the available alternatives.”).

172. Cf. Frank H. Easterbrook, *Cyberspace and the Law of the Horse*, 1996 U. CHI. LEGAL F. 207, 210, 215:

Well, then, what can we do? By and large, nothing. If you don't know what is best, let people make their own arrangements.

....  
“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.

*Id.*