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EMPOWERING PATIENTS TO ACT LIKE CONSUMERS: A PROPOSAL CREATING PRICE AND QUALITY CHOICE WITHIN HEALTH CARE

ANDREW RUSKIN

INTRODUCTION

Although America's health care industry has undergone a tremendous evolutionary surge in the past decade, there is no indication that the pace of change will relax anytime soon. Before the pace could relent, the American public would need to be largely content with its health care system. Yet there are many signs that the public is still discontented with its care. The media are filled with reports concerning dissatisfaction of enrollees in managed care plans, the lack of choice of physicians imposed by their plans, and the delay or ultimate denial of payment for necessary care. Managed care has thus become a major focus of the criticism launched against the present health care system. All of the negative attention focusing on managed care has led to a general distrust of the present health care system, and a fear of

1 See Health Care Access for the Uninsured Through Tax Increases Would be Supported by 64% of Americans, W.K. Kellogg Foundation Survey Finds, HEALTH NEWS DAILY, Jan. 14, 1999, available in 1999 WL 10482995 (citing a poll conducted by the W.K. Kellogg Foundation which found that 50% of Americans are dissatisfied with health care in the United States).

2 See, e.g., George Anders & Ron Winslow, Turn for the Worse: HMOs' Woes Reflect Conflicting Demands of American Public, WALL ST. J., Dec. 22, 1997, at A1 (stating that the movement towards point-of-service plans, which allow easier access to out-of-network physicians, is partially in response to consumer criticism regarding lack of choice of providers); Louise Kertesz, Trouble for HMOs?, MODERN HEALTHCARE, May 12, 1997, at 48, 50 (chart) (indicating that as HMO markets mature, consumers experience an increasing number of problems with delays in care or problems receiving care).

3 See Abigail Trafford, Commentary, Who's Dissing Managed Care?, WASH. POST, Jan. 20, 1998, at Z06 (describing the results of a Kaiser Family Foundation study that noted a dramatic increase in negative media stories focused on managed care from 1990 to 1997).
eroding quality of the medical care provided in this country.\(^4\) Clearly, managed care is not the panacea for what ails the country's health care delivery system. Despite the problems wrought by managed care, it is also evident that the American public does not want to pay more for its health care.\(^5\) Thus, it is unlikely that there would be any public mandate in favor of returning to the costly fee-for-service health care system that preceded the inception of managed care.\(^6\) Neither extreme has succeeded in satisfying the American public.\(^7\) Therefore, the next evolutionary phase in health care will require empowering the American public to make the difficult choice between the denial of resources associated with managed care and the skyrocketing costs associated with fee-for-service medicine.

This Article proposes changes to the present health care system to allow the American people to maximize their satisfaction with their health care system by facilitating informed decision-making in their health care consumption choices. In most other

\(^4\) See Health Care Opinion Poll Finds Confusion, Worry over High Costs, Future of System, 6 Health Care Pol'y Rep. (BNA) 766 (May 4, 1998), available in WESTLAW, 6 HCP 766 (noting that Americans are losing trust in the health care system and a majority believe that a major change is necessary).

\(^5\) See id. (citing surveys that show dissatisfaction with health insurance costs).

\(^6\) A fee-for-service payment system compensates providers for each service they render. See HENRY BERMAN AND LOUISA ROSE, CHOOSING THE RIGHT HEALTH CARE PLAN 49 (1990).

Fee-for-service arrangements create incentives to overutilize health care services and thus drive up costs. See MARC A. RODWIN, MEDICINE, MONEY, AND MORALS 55 (1995). Between 1980 and 1993, a period during which fee-for-service payments were largely considered the norm, expenditures on health care grew more than twice as fast as the national inflation rate. See PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM: REPORT TO THE CONGRESS 16–17 (1995) [hereinafter PROPAC].

This led to an increased number of uninsured people, increased cost shifting from employers to employees, and increased consumption of household resources on health care spending. See id. at 23–27. Between 1988 and 1993, however, the prevalence of conventional insurance decreased while managed care penetration increased. See id. at 23 & tbl.9 (noting that the market share of traditional indemnity plans had fallen from 72.6% in 1988 to 33.3% in 1993). In 1995, the inflation rate increased more than the health care premiums. See Gail A. Jensen et al., The New Dominance of Managed Care: Insurance Trends in the 1990s, HEALTH AFF., Jan.–Feb. 1997, at 125, 134 (cautioning, however, that this correlation does not prove any cause-effect relationship).

\(^7\) See Anders & Winslow, supra note 2, at A1 (commenting that it is difficult to get consumers, doctors, employees, and regulators to agree on what changes would constitute an improvement of the health care system).
markets, consumers are provided with choices among similar products that vary in cost and quality. From these choices, consumers can choose the product that most suits their preferences, thereby maximizing their satisfaction. If a potential patient were treated as a consumer, she also would be able to choose health insurance and health care delivery services based on price and quality, thereby increasing her satisfaction with the system. Due to the many obstacles in purchasing health care insurance and health care delivery services along price and quality lines, however, such satisfaction does not seem presently attainable.

After examining current health care market imperfections preventing price and quality choices within health care purchasing, and the historical trends that have created these imperfections, this Article proposes a system that seeks to correct these flaws, thereby facilitating satisfaction with health care consumption. Since the payment of insurance premiums accounts for most of the resources expended by consumers in procuring health care, this Article initially proposes offering consumers choices among different price levels at the time of enrolling in an insurance plan. These price levels would be tied to different levels of compensation to be paid to providers when administering care to the plan enrollees, which would correspond with different levels of expected efficacy of the treatment provided. As these levels would only reflect the intended efficacy level, this Article further proposes that health care providers be required to disclose their performance records in providing care as well as the costs incurred in achieving these results. The consumer could thus de-

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8 The use of the feminine pronoun throughout is not intended to reflect the author's view of the role of women in the health care industry. Rather, it is simply to provide balance in scholastic writing. The intent of this author is to alternate between masculine and feminine pronouns in successive publications. In addition to physicians and patients, the feminine pronoun is also used in this Article to refer to providers. The meaning of the term provider includes physicians, hospitals, nursing homes, and other health care-related entities.

9 The efficacy of a treatment regimen is the most important determinant of the quality of care. Therefore, it naturally has a significant impact on the satisfaction patients derive from the medical process. See Thomas Rice, Can Markets Give Us the Health System We Want?, 22 J. HEALTH POL., POL'y, & L. 383, 414 (1997) (stating that within the health care setting, the measure of the medical effectiveness of a service can be considered a proxy for the utility of a health care good). Utility refers to the satisfaction one obtains from consuming goods. See THEODORE MORGAN, INTRODUCTION TO ECONOMICS 116 (1956).
termine for herself whether the actual price and efficacy level of the treatment administered by a given provider meets with the consumer's expectations at the price level that she chose when she enrolled in the health plan. Through this encouragement of price and quality health care purchasing, it is expected that health care markets would more closely resemble other well-functioning markets. Consequently, this would greatly enhance the public's satisfaction with its health care system. In this way, the evolution of the health care system would finally result in a meaningful benefit to the American people.

I. THE DIVERGENCE OF THE HEALTH CARE INDUSTRY FROM THE MODEL OF THE PERFECT MARKET

A. Model of the Perfect Market

Consumer dissatisfaction with the health care industry stems from the ways in which the allocation of scarce health care resources appear to negatively impact the cost and quality of health care. Therefore, economic analysis can be instrumental in finding solutions to this perceived misallocation. Economic analysis centers around the concept of efficiency, which is the production of the most aggregate benefit at the lowest aggregate cost. In a perfect market, consumers contribute to the market's efficiency by purchasing an ideal bundle of goods from which they derive the most benefit. Assessing the benefit of any individual good is necessarily subjective, and it is dependent in part on the amount of the good that has already been purchased. Since the value of goods decrease with each incremental increase in the

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10 See Ryan L. Everhart, New York Managed Care Legislation: A Substantive Response to Corporate Medicine or a Token Gesture to Ease Consumer Concerns?, 46 BUFF. L. REV. 507, 537 n.195 (1998) (claiming that individual tastes and preferences can find expression through market forces (citing Alain C. Enthoven & Sara J. Singer, Markets and Collective Action in Regulating Managed Care, HEALTH AFF., Nov.–Dec. 1997, at 26, 26)).

11 See A. MITCHELL POLINSKY, AN INTRODUCTION TO LAW AND ECONOMICS 7 (1989).

12 See Rice, supra note 9, at 386 (discussing utility maximizing behavior).

13 See MORGAN, supra note 9, at 116 (describing how an object that is appealing to one individual is not necessarily appealing to others).

14 See id. at 117 (explaining the concept of marginal utility).
consumption of each good, consumers need to have a choice with respect to the amount of a good they can purchase to allow them to maximize the benefit they attain from their purchases.

Once consumers are given this choice, they can compare the desirable qualities and price of the good in question to those of all alternative goods to determine how many units of each good to purchase. In purchasing this perfect set of goods, the consumer maximizes the satisfaction attainable within the limits of her resources. This ability of the consumer to maximize her satisfaction is dependent on various conditions, including whether information about the goods to be consumed is too costly to acquire. The market is said to be in a state of equilibrium when it is characterized both by consumers acting in a way that maximizes their satisfaction and by firms producing goods that suit consumer preferences at their lowest cost. In this ideal state, resources are allocated in a manner that maximizes consumer satisfaction because resource allocation is dictated by people’s choices. This means that goods are consumed by those who value them the most.

Further, wasteful uses of resources are minimized because only goods and services demanded by consumers would be produced. By avoiding waste and the costs associated therewith, this ideal market further serves to maximize consumer satisfaction because the benefits derived from the resources consumed are even cheaper to attain. This satisfaction only grows over time because an ideal market encourages innovation, which increases the benefits derived from goods while decreasing costs.

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15 See id. (noting that the increased availability of a commodity leads to its decreased marginal utility).
16 See Rice, supra note 9, at 386 (noting that individuals maximize their utility by purchasing according to their desire or taste for alternative goods, subject to their available income).
17 See id.
18 See GARY S. BECKER, THE ECONOMIC APPROACH TO HUMAN BEHAVIOR 6–7 (1976) (noting that an individual’s behavior may appear to be irrational when information is incomplete).
19 See Rice, supra note 9, at 385–86.
20 See id.
21 See id.
Because of these positive attributes, economists often use this optimal state as the benchmark against which markets are measured.

B. Health Care Market Imperfections

Unlike the perfect market, most health care markets are characterized by various attributes that prevent consumers from making ideal health care consumption choices. One fundamental obstacle to purchasing the ideal amount of health care is the manner in which consumers enroll in insurance plans.

Most Americans receive their insurance through an employer.24 Many employers only offer one type of insurance, thereby removing the ability of employees to choose a plan based on its price and quality.25 Although other employers provide a choice of insurance options, they subsidize the more expensive plans such that each plan costs the same to the employee.26 Employees lose the opportunity to choose other goods of more value when they are denied pay increases by an employer who chooses to expend resources on health care subsidies.27 The federal government has also traditionally distorted the value of health insurance for employees by excluding the provision of health insurance at the workplace from personal income. This creates a disparity in the value attributed to health care consumption between those individuals receiving insurance through employers and those purchasing insurance individually.28

In addition to these obstacles encountered by consumers at the time of choosing insurance, their satisfaction with their health care plan is also limited at the time of seeking medical treatment. This is a result of the inadequate information that has been provided, concerning the cost and quality of health care

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24 See MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS 252 (1997) (stating that more than 75% of all private insurance is sold through employer groups).
25 See id. at 262 n.17 (indicating that 84% of employers providing insurance only offer one option for an insurance plan).
26 See Helen Lippman, Are Employers Missing the Signs?, BUS. & HEALTH, Dec. 1997, at 36, 39 (citing a study that found that over half of the nation's large employers engage in this practice).
27 See also Uwe Reinhardt, Managed Care is Still a Good Idea, WALL ST. J., Nov. 17, 1999, at A22.
28 See HALL, supra note 24, at 20.
services rendered by providers. As a result of these various market imperfections, the production and consumption of health care goods and services deviates substantially from the ideal state of production and consumption that would occur in a state of equilibrium. As long as this deviation exists, the health care system will remain incapable of fulfilling the expectations of the American people.

II. DEVELOPMENT OF PRESENT HEALTH CARE MARKET IMPERFECTIONS

Although it is often believed that the special nature of health care goods and services invariably leads to the market anomalies presently found within the health care industry, an examination of the historic trends within the industry shows that the present imperfections in the system stem from an evolutionary process. The imperfections are merely adventitious so they can be removed through further refinement to market forces.

To some degree, the health care industry operated similarly to most other industries during its early stages. Just as transactions usually occur between an individual buyer and an individual seller in most markets, doctors provided services to patients and looked to the patient alone for payment. Yet even in its earliest form, the health care industry exhibited differences from other industries due to the patient's need to rely on her physician's judgment, which engenders a relationship of trust. The physician has traditionally been responsible for making important decisions on behalf of her patient with respect to treatment. Consequently, the patient becomes the principal and the physician becomes the agent in the patient-physician relationship.

See THE PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS 73 [hereinafter PRESIDENT'S ADVISORY COMMISSION] (stating that useful information is neither uniformly nor widely available).

Cf. supra notes 19-23 and accompanying text (discussing the benefits arising from a market in a state of equilibrium).


See RODWIN, supra note 6, at 6.

The dual role of the physician as the vendor of services and as the agent of the patient has always demonstrated the potential for conflicts of interest. The physician can gain financially at the expense of the patient who is usually unable to fully evaluate the potential benefits of the course of treatment proposed by the physician.\textsuperscript{34} In the early stages of the industry, however, this potential conflict was constrained largely by the limited finances of the patient.\textsuperscript{35} The physician could not be compensated for providing more services than the patient could afford.

Over time, the tensions caused by the financial constraints imposed by the patient's limited resources intensified. Health care became more expensive with the rise of hospitals as the center of the provision of health care.\textsuperscript{36} Seeking to remedy the financial limitations imposed upon them, hospitals collaborated in the late 1930s to form Blue Cross plans, which provided coverage for health care rendered by hospitals.\textsuperscript{37}

Soon thereafter, physicians founded Blue Shield plans to provide insurance for physician services.\textsuperscript{38} In effect, insurance companies were supplanting the patient as the purchaser, thereby removing any incentive on the part of the patient, in her capacity as principal, to constrain providers in their provision of services.\textsuperscript{39} The ability to obtain insurance became easier in the 1940s when various Internal Revenue Service rulings stated that employers could give workers insurance without tax consequences, which led to increased incentives for employers to pro-

\textsuperscript{34} See Kenneth J. Arrow, Agency in the Market, in 3 HANDBOOK OF MATHEMATICAL ECONOMICS 1183, 1183 (Kenneth J. Arrow & Michael D. Intriligator eds., 1986) (stating that the trust placed by a principal in her agent only causes problems where the availability of information is unequal, a usual occurrence within the patient-physician context); Rex O'Neal, Note, Safe Harbor for Health Care Cost Containment, 43 STAN. L. REV. 399, 401–02 (1991) (noting that the principal-agent relationship between patient and physician is jeopardized when the two parties' interests are not synchronized).

\textsuperscript{35} See \textit{Starr}, supra note 31, at 235–36 (discussing how physicians regulated fees according to the patient's ability to pay, which did not provide economic security for the doctor, but was more favorable to the physician than having a powerful organization dictate limits on the doctor's income or practice conditions).

\textsuperscript{36} See \textit{id.} at 259.

\textsuperscript{37} See \textit{id.} at 295–97.

\textsuperscript{38} See \textit{id.} at 307 (stating that the first Blue Shield plan was formed in 1939 in California).

\textsuperscript{39} See O'Neal, \textit{supra} note 34, at 402 (asserting that insurance makes patients insensitive to their health care costs).
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vide health insurance. In so doing, the employer became a secondary purchaser of health care services ancillary to the primary role assumed by the insurance company who was making direct payments to providers. Thus, the patient became further removed from the financing of her health care.

The third party payor system also underwent tremendous expansion in 1965 with the enactment of the Medicare and Medicaid systems. Originally designed to cover the aged and the impoverished, respectively, these programs have expanded to insure a significant portion of the populace. Like other insurance enrollees, this newly covered population had little incentive to constrain their providers in their choice of treatment regimens. Besides removing the incentive from patients to perform any sort of cost-benefit analysis with respect to their health care, the rise of third party payors also removed the risk of non-payment associated with the reliance for payment exclusively on the financial resources of patients. Not surprisingly, the arrival of third party payors, thus, ushered in an era of tremendous growth for the industry.

Although third party payors became responsible for the bulk of the payment for health care, they minimized their role concerning providers' clinical judgment. Private and government programs reimbursed hospitals based on their costs, and they reimbursed physicians based on their charges. In so doing, these payors capitulated to physician demands that the physicians maintain control over all aspects of medical care. With the influx of funds from third party payors and the lack of con-

\[\text{\textsuperscript{40} See Brian P. Battaglia, The Shift Toward Managed Care and Emerging Liability Claims Arising from Utilization Management and Financial Incentive Arrangements Between Health Care Providers and Payers, 19 U. Ark. Little Rock L.J. 155, 162 (1997) (stating that IRS rulings in the early 1940s suggested that employer-provided health coverage might be deductible).} \]

\[\text{\textsuperscript{41} See STARR, supra note 31, at 369.} \]

\[\text{\textsuperscript{42} See id.} \]

\[\text{\textsuperscript{43} In 1996, there were 36.1 million Medicaid recipients, see BUREAU OF THE CENSUS, U.S. DEPT OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES: 1998, at 123 tbl.178 (118th ed. 1998), there were 38.1 million people enrolled in Medicare, see id. at 120 tbl.171.} \]

\[\text{\textsuperscript{44} See STARR, supra note 31, at 334.} \]

\[\text{\textsuperscript{45} In the period from 1960 to 1993, health care spending had gone from $27 billion to $898 billion. See PROPAC, supra note 6, at 14.} \]

\[\text{\textsuperscript{46} See STARR, supra note 31, at 385.} \]

\[\text{\textsuperscript{47} See id. at 387.} \]
straints in the provision of care, conditions were favorable for investment in technology. The increasing use of technological advances in treatment further exacerbated the disparity of information between patient and physician, further limiting the ability of the patient to restrict the provider's use of resources in administering treatment. Without any meaningful check on the scope of their agency, either from insurance companies, the government in their capacity as purchasers, or from patients in their capacity as principals, physicians were free to profit greatly from the system.

Since the country was not capable of perpetually withstanding spiraling costs, managed care logically followed as the health care industry's next evolutionary step. Managed care refers to a style of health care financing that strives to control the way providers practice and the way that they make referrals. Managed Care Organizations ("MCO's") try to control providers directly through utilization review, whereby providers need organizational approval before performing tests or procedures to assure that the proposed course of treatment is medically necessary. Indirectly, MCO's accomplish their cost savings through payment incentives to physicians to reduce care, such as the use of capitation and withholds. In dictating the limits of acceptable physician practices, the MCO has encroached upon the patients' right

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48 See id. at 384 (discussing investment in technology as one reason for increases in the cost of health care, but implying that investment in technology might have been more of a symptom of the lack of restraints in provider reimbursement, as opposed to an overriding cause of increased health care expenditures).

49 See id. at 4–5 (asserting that one of the reasons patients submit to their physician's authority is the close tie between physicians and science).

50 See RODWIN, supra note 6, at 138 (noting that managed care service providers do not have an incentive to perform many services because with each service provided they incur costs, not revenues).

51 See Battaglia, supra note 40, at 170–71 (noting that "peer review" of proposed treatment has evolved into "utilization management," which is a "critical link in the cost containment process").

52 See RODWIN, supra note 6, at 14. Capitation refers to periodic payments made to physicians that are based on the number of patients. See Wayne Blackmon, The Emerging Convergence of the Doctrine of Informed Consent and Judicial Reinterpretation of the Employee Retirement Income Security Act, 19 J. LEGAL MED. 377, 379 (1998). Withholds refer to the withholding of a certain portion of the physician's compensation to be released only if the MCO meets certain financial targets. See id.
as principal to determine the scope of the physician’s agency.\textsuperscript{53} In effect, providers operating in a managed care environment have two principals, potentially resulting in a conflict of interest. Moreover, since the MCO also has dual allegiances to both the patient, in her capacity as enrollee, and to the employer or government, in its capacity as purchaser, there is the potential for a second conflict of interest to indirectly impact the patient-physician relationship.\textsuperscript{54} Since patients lack sufficient information to adequately monitor the quality of their health care,\textsuperscript{55} they cannot determine what effect, if any, the potential conflicts of interest have on their treatment. Placed in this murky position, it is only natural for patients to have developed a sense of distrust of the system.\textsuperscript{56}

To address some of the concerns of health care consumers, reforms of managed care are taking place both in the public and private sectors. An overwhelming majority of states have passed some form of legislation regulating the operation of MCO’s.\textsuperscript{57} There have also been several bills proposed at the national level that would mandate coverage of emergency services that a “prudent layperson” would consider necessary,\textsuperscript{58} increase access to physician specialists,\textsuperscript{59} and make it easier for patients to sue their health plans.\textsuperscript{60} The managed care industry itself has tried to stave off the growing backlash against managed care by offer-

\begin{itemize}
\item \textsuperscript{53} See RODWIN, \textit{supra} note 6, at 153 (noting that the risk-sharing techniques of HMO’s and hospitals, which reward a physician if she administers a small amount of services, compromise the loyalty of a physician to her patient).
\item \textsuperscript{54} See \textit{Businesses, Insurers Rally Opposition to Federal Health Mandates}, \textit{HEALTH LAW. NEWS}, Mar. 1998, at 13 (quoting a Wall Street analyst who stated that HMO’s are agents of employers and the government).
\item \textsuperscript{55} See \textit{infra} Part IV.B (outlining proposed disclosure guidelines that would require physicians to keep their patients well informed).
\item \textsuperscript{56} See \textit{supra} notes 1–10 and accompanying text (pointing to signs of discontent with the health care system by the public).
\item \textsuperscript{57} At the present time, at least forty states have already enacted anti-managed care legislation. See Anders & Winslow, \textit{supra} note 2, at A1.
\item \textsuperscript{59} See \textit{id}.
\item \textsuperscript{60} See Rochelle Sharpe, \textit{Business Leaders Fight Regulation of Managed Care}, \textit{WALL ST. J.}, Jan. 22, 1998, at A20 (noting that businesses are opposed to the proposed Patient Access to Responsible Care Act because the statute would subject health care providers to numerous lawsuits, thereby raising the cost of health insurance).
\end{itemize}
ing more point of service plans.\textsuperscript{61} Both public and private initiatives, however, entail increased costs and will not necessarily increase health care consumption along price and quality lines.\textsuperscript{62} Accordingly, irrespective of the implementation of these reforms, public dissatisfaction with the health care system is not likely to dissipate anytime soon.

III. GIVING CONSUMERS CHOICES WITH RESPECT TO THE COST AND EFFICACY OF THEIR CARE

A. \textit{Creating the Levels of Care}

As is evident from a historical analysis of the failure of the health care industry to provide the amount of care the patient wants at reasonable price, any proposed reform must address the problems that come from both the insertion of intermediary purchasers between the patient and provider, and the greater amount of information available to the provider about treatment options. Since it is widely believed that insurance serves a valid purpose, it would not be a viable solution to simply remove all of the intervening parties between the patient and the physician.\textsuperscript{63}

\begin{thebibliography}{99}
\bibitem{61} See Anders & Winslow, \textit{supra} note 2, at A8. Point-of-service plans refer to plans that allow enrollees to receive care outside the network, but with higher copayments. \textit{See id.}
\bibitem{62} Point-of-service plans increase costs to HMO's because HMO's cannot control the prices charged by out-of-network physicians. Due to problems controlling costs, HMO's must raise their rates. \textit{See Anders & Winslow, \textsuperscript{supra} note 2, at A8.} According to one source, government regulation aimed at facilitating lawsuits against health plans has also raised the specter of higher premium rates by as much as 23%. \textit{See Sharpe, supra note 60, at A20; see also Robert M. Goldberg, Why HMOs Now Love Regulation, WALL ST. J., July 17, 1998, at A14 (asserting that contemplated regulations will not make HMO's more competitive and will not create incentives to improve the quality of care).}
\bibitem{63} The utility people attach to wealth increases with their level of wealth, but at a decreasing rate, because people do not value wealth as highly once they fulfill their more important needs. \textit{See STEVEN SHAVELL, ECONOMIC ANALYSIS OF ACCIDENT LAW} 186-92 (1987). With respect to losses, therefore, people give greater weight to the magnitude of the potential loss than to the probability of loss in determining the expected value of the loss. \textit{See id.} at 186. This concern is known as risk aversion. \textit{See id.} (noting that risk-averse people would choose to be in a position where they had a 10% chance of losing $10,000 rather than a position where they stand a 5% chance of losing $20,000). For these people, providing insurance maximizes their welfare without negatively affecting their behavior and is thus socially desirable. \textit{See id.} at 213; \textit{see also HALL, supra note 24, at 20 (stating that there are psychic benefits to buying}
It is possible, however, to provide consumers with the advantages of insurance without totally eliminating their control over the price of health care.

The purchase of health insurance can reflect the value of health care to the consumer by offering the consumer several different health insurance packages, each with its own price and features. Each package would represent a different level of reimbursement to be paid to a provider when the enrollee seeks medical treatment. The provider could submit a claim to the insurer containing both the enrollee’s Diagnosis Related Group (“DRG”) and reimbursement level, which together would determine the amount to be paid to the provider.\(^6\)

These levels of reimbursement would correspond to standardized levels of intended efficacy of care that would become recognized by consumers over time.\(^6^5\) For instance, there could be a base level that reimburses at a rate designed to cover all generally accepted practices provided by a physician of average ability. From this base level, adjustments could be made that would be designed to cover marginally beneficial procedures, or procedures carried out by a physician with a higher skill level, with corresponding higher rates.\(^6^6\) There could also be a level that reimburses all possible expenses generated in the provision of care, even for care that is experimental in nature. In addition to standardizing the character of each level, the number of levels would also need to be predetermined. The number should not be so large as to overwhelm the consumer, making it impossible for

\(^{6^4}\) DRG’s are the basis of Medicare’s payments to hospitals. See RODWIN, supra note 6, at 15. Medicare pays hospitals a flat rate per admission as determined by the patient’s diagnosis. See id. This flat rate is based on the average cost of treating patients within the patient’s DRG. See id.

\(^{6^5}\) Cf O’Neal, supra note 34, at 440 (suggesting that to create a threshold for what constitutes a socially optimal standard of care, an independent commission could be established that follows the process used in Oregon’s Medicaid reform initiative of ranking treatments according to their efficacy, and then determining a cutoff point).

Rather, a manageable number should foster an ability for the consumer to compare and contrast the levels, and ultimately choose one that fits her needs. Through the implementation of a system that allows the consumer to choose the desired level of cost and efficacy of her care, the insurance company would be, in effect, requiring the consumer to make the same choices about her care that, in the absence of the availability of insurance, she would have to make when seeking medical treatment. By simulating the health care purchasing process at the time of enrollment, the insurance company can allow the consumer to reap the benefits of insurance coverage without totally removing her from the role of purchaser.

Each reimbursement level is intended to cover health care services of a certain degree of efficacy; therefore, reimbursement rates must be set accordingly. Ideally, consumers would possess sufficient information to describe the types of procedures and physician skill levels they would want covered by each reimbursement level. Since most consumers do not possess such information, the next best alternative would be to delegate the responsibility of setting reimbursement rates to an organization whose determinations would be sound and reliable. An independent physician board could be established in each field of

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67 See Mark A. Hall, A Theory of Economic Informed Consent, 31 GA. L. REV. 511, 578 (1997) (asserting that an adequate but limited number of choices is better than an infinite number of choices because, though short of perfect autonomy, the realistic goal of social legitimacy is achieved (citing CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 159–65 (1995)).

68 See Marc A. Rodwin, Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs, 32 HOUS. L. REV. 1319, 1369 (1996) (stating that it is necessary to restrict the number and type of insurance policies to a few standardized policies to foster ease of comparability). This limitation on type and number of variations between policies also means that all policies must provide care for all types of diseases, albeit at different levels of efficacy of treatment. Even though excluding certain illnesses can mean vast decreases in costs, the benefits of standardization, such as engendering ease of comparison, militate against permitting such policies. See, e.g., Lauren Merlin Walker, How We Keep Health Costs Under a Grand, BUS. & HEALTH, Aug. 1997, at 20, 21–25 (pointing out how one company managed to reduce health care costs for its employees by excluding coverage for neonatal illnesses).

69 See supra Part I.A (describing that in a perfect market, consumers have adequate information about the products available to allow them to express their preferences in their choice of purchases).

70 See supra notes 29, 32–34, 49 and accompanying text.
medical specialty to fulfill this role. Such a board would be comprised of professionals that have sufficient expertise to make sound determinations based on valid medical data. The board’s independence fosters reliance because these boards would not face conflicts of interest as would the physicians who provide the treatment and the insurers who pay for the treatment. These independent physician boards would only be a surrogate for direct consumer action, but they would help to remedy some of the imbalance of power in both the patient-physician-patient and the enrollee-insurer relationships that stem from unequal access to information.

The independent physician boards would be required to establish rates for each DRG at each reimbursement level. To accomplish this task, the independent physician boards would need to look at all possible procedures for each DRG. These procedures would need to be grouped into those that are clearly beneficial and those that are marginally beneficial. The independent physician boards would also look at physician rates to determine average charges generated for each DRG as well as the charges of physicians possessing superior skill. From this information, the independent physician boards could then establish rates for each DRG and for each level of intended efficacy within the DRG by adding the costs of the procedures with the labor to be included in each DRG level.

\[\text{71 Cf. Mehlman, supra note 66, at 390 (suggesting that physicians should take collective action to balance the needs of patients with the need to contain costs). The Federal Agency for Health Care Policy and Research has established the Office of the Forum for Quality and Effectiveness in Health Care, which is responsible for creating and updating clinical guidelines. See 42 U.S.C. §§ 299b, 299b-1 (1994); see also William R. Trail & Brad A. Allen, Government Created Medical Practice Guidelines: The Opening of Pandora's Box, 10 J.L. & HEALTH 231, 233–34 (1995-96). These guidelines are to be developed as aids to practitioners in making decisions about appropriate care. See id. at 234.}\]

\[\text{72 See supra Part II (discussing the potential conflicts of interest faced by providers and insurers).}\]

\[\text{73 See Clark C. Havighurst, Practice Guidelines as Legal Standards Governing Physician Liability, 54 LAW & CONTEMP. PROBS. 87, 114 (1991) (proposing that the formulation of guidelines with different standards of care that take cost into consideration, which could then be used by third party payors in their contracts). This cost evaluation would be feasible if there is an emphasis on determining the costs entailed in different procedures, which is an aspect of research that has not yet received much emphasis. See E. Andrew Balas et al., Interpreting Cost Analyses of Clinical Interventions, 279 JAMA 54, 54 (1998) (concluding that economic analysis}\]
within these cost parameters, physicians would find that the scope of their treatment is limited to the intentions of the patient as expressed by the choice of reimbursement level that she made at the time of insurance enrollment.

Though the physician's scope of authority would be limited by this choice-based system, it need not be totally removed. Both providers and patients should have access to the guidelines upon which the independent physician boards based their reimbursement rate assessments. The provider and patient should accordingly be allowed to agree to these guidelines throughout the course of treatment. A patient should, however, maintain the right to permit the provider to use other techniques that may prove more effective at about the same cost. In some cases, it may even be necessary to veer from the guidelines when it is clear to the physician that the patient will not receive the intended benefits due to the individual characteristics of the patient. In the event that the costs of treatment exceed the reimbursement rate, the provider would be the better risk-bearer because she could diversify this risk over the course of treating many patients. Thus, the provider should be responsible for costs that deviate by a certain percentage from the reimbursement rate. Where the treatment regimen agreed to by the patient and provider, however, is significantly different, such that the treatment no longer accords with the reimbursement level

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has not played a significant role in clinical trials, which has contributed to an inability of practitioners to consider the cost implications of their treatment regimens). See Trail & Allen, supra note 71, at 254 (suggesting that providers and the public should have access to guidelines).

This system would avoid the pitfall of stifling innovation through the use of practice guidelines, a criticism often associated with the use of guidelines. See, e.g., Arnold J. Rosoff, The Role of Clinical Practice Guidelines in Health Care Reform, 5 HEALTH MATRIX 369, 386 (1995) (quoting the AMA's concerns about the effect of guidelines on innovation, as stated by Edward Hirshfeld, Director of the Health Law Division, Office of the General Counsel of the American Medical Association).

Cf. HALL, supra note 24, at 84 (noting that treatment rules cannot anticipate all the problems that might arise in each individual episode of care).

Cf. RICHARD A. BREALEY & STEWART C. MYERS, PRINCIPLES OF CORPORATE FINANCE 153–56 (5th ed. 1996) (describing the reduction of risk of an individual stock through diversification, which is accomplished through ownership of several stocks simultaneously).

Cf. RODWIN, supra note 6, at 15 (explaining that hospitals are responsible for costs exceeding the DRG rate, but retain any amounts that the DRG rate exceeds actual costs under the Medicare reimbursement system).
chosen at the time of purchasing insurance, it is likely that medical costs will deviate beyond what would be deemed reasonable for the physician to bear. In these cases, the patient should be held liable for any additional amounts in excess of the deviation to be borne by the physician. By allowing further patient-physician agreements, the choice-based system avoids sacrificing the advantages of case-specific care in attaining treatment focused on patient expectations.

Similar to the need for adjustments within the patient-physician relationship, it is necessary to recognize that the changing nature of the information accessible to the independent physician boards requires that the reimbursement rates be periodically updated. The independent physician boards could periodically review the medical literature to determine if the efficacy of new procedures has been established. Initially, it would be necessary to determine whether the new procedure has proven to be so efficacious as to require its acceptance as a generally accepted practice, or whether it merely produces marginal benefits, allowing for inclusion only at a higher reimbursement level. Once included at the appropriate level, the costs of treatment of the affected DRGs would need to be recalculated, and corresponding adjustments to the reimbursement rates would need to be made. Further information about new, efficacious treatment regimens could come from discussions with practitioners about their results with different techniques, which could also be incorporated into the established guidelines as well as the reimbursement rate calculations. Not limited to a review of new practices, the independent physician boards would need to review physician charges to determine if economic factors require adjustments to the reimbursement rates. Through allowance of these adjustments, patient choice can be honored without limiting the evolution of the system.

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79 Cf. Trail & Allen, supra note 71, at 240-41 (referring to the AMA's pronouncements on practice parameters which state that, among other requirements, practice parameters must be updated to reflect current information).

80 Cf. id. (noting that the AMA pronouncements also require that the practice parameters be subject to peer review).
B. Reforms Required to Implement Consumer Choice

1. Reforms Relating to Financing Health Care

To implement a system centered on consumer choice, the roles of the various parties providing health care financing would need to undergo significant changes. Since Medicare covers a large percentage of the population, a choice-based system could not be meaningfully implemented without Medicare reform. Though limited in nature, Medicare does allow for some price and quality choices for its beneficiaries. Medicare beneficiaries are entitled to comprehensive hospital benefits and, with the payment of premiums, deductibles, and copayments, they are also entitled to comprehensive physician services. The deductibles and copayments are waived, however, when the beneficiary enrolls in a Medicare HMO. Thus, the beneficiary has a choice between the type of care associated with fee-for-service insurance at one price, and the type of care associated with MCO's at another price.

There are salient differences in the features of these types of care, affecting the degree of satisfaction a beneficiary would obtain in choosing one program over another. Since there are no standardized rules as to the breadth of services or the requisite skill level of providers administering care through each type of plan, important quality-related aspects of the treatment process are not subject to consumer choice. To allow greater expression of consumer choice within Medicare, the system should be revised to provide for Medicare vouchers. Each beneficiary would receive a voucher of a fixed amount that could be used to pur-

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81 In 1996, 38.1 million people were enrolled in Medicare. See BUREAU OF THE CENSUS, supra note 43, at 120 tbl.171.
82 See generally PROPAC, supra note 6, at 65–73 (discussing Medicare Parts A and B).
84 See Andrew Ruskin, Note, Unbridled Managed Care: When Consumers Experience Antitrust Welfare Loss from Exclusionary Contracts Between HMO Insurers and Health Care Providers, 6 HEALTH MATRIX 391, 416–21 (1996) (discussing the competitive differences between HMO's and fee-for-service insurance).
85 See Enthoven & Singer, supra note 10, at 27 (asserting that free markets can result in better selection of physicians than the government because the government must abide by due process principles and may only remove a provider after obtaining proof of very serious problems).
chase care through an insurer offering a choice among the standardized levels of intended efficacy of care. When enrollees are content with a level of care that is less costly than the voucher amount, they could opt either for cash or for funds to be placed in a Medical Savings Account ("MSA"). For those who want a higher level of care than that provided by the voucher system, they would be permitted to supplement the amount received from the government. For enrollees that are content with the level of care that they could purchase with the voucher alone, no adjustments would be required. In addition to the benefit of increasing enrollee satisfaction by prioritizing freedom of choice, this change would result in more predictability of Medicare program costs, thereby allowing better governmental planning, and limiting the risks of insolvency of the program. Hence, beyond the need to satisfy consumers, fiscal responsibility also dictates that these changes to the system be made.

Like the Medicare program, employers provide financing for health insurance for a large number of individuals; therefore, employer coverage practices would also need to be revamped to provide for greater consumer choice. Employers remove the ability of employees to purchase health insurance along price lines by either limiting employees to one choice of health plan or by subsidizing the more expensive plans to the degree that the employee pays the same amount, irrespective of the plan chosen. Furthermore, employers do not place great significance on quality when making health care decisions for their employees.

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66 See Heritage Offers Proposal for Reform Based on Federal Employees Model, 3 Health Care Pol'y Rep. (BNA) 1073 (July 3, 1995), available in WESTLAW, 3 HCP 27 d47 (describing a voucher system proposed to Congress in 1995 that would provide for vouchers whose value would correspond to a core set of basic services).

67 See id. An MSA is a tax-protected account where individuals can place money to pay out-of-pocket expenses relating to health care. See HALL, supra note 24, at 50.

68 See Medicare: Heritage Offers Proposal for Reform Based on Federal Employees Model, supra note 88, at 1073.

69 See Jonathan Gardner, GOP Seeks Fixed Payments, MOD. HEALTHCARE, Apr. 27, 1998, at 6, 6 (discussing the responses of Alan Greenspan to questions from the National Bipartisan Commission on the Future of Medicare about changing Medicare from a defined benefit structure to a fixed payment system to control costs).

70 See supra Part I.B (discussing this practice as one reason that health care markets do not function like perfect markets).

71 See Employers Say Health Cost Pressures Hurting Quality of Care, Survey Finds, 6 Health Care Pol'y Rep. (BNA) 435 (Mar. 9, 1998), available in WESTLAW, 6 HCP 435 (noting that while employers rank cost information as number one in
The government further distorts incentives in health care purchasing in the employment setting by allowing employers to provide health insurance without any tax consequences to the employee. To encourage choice based on consumer price and quality preferences, all tax incentives favoring the provision of health insurance through employers should be eliminated. Employers should still be allowed to provide health insurance to their employees, but employees would be taxed fully on whichever plan was offered. This would minimize any disincentive for employees to seek insurance outside of the workplace thereby encouraging them to choose the standardized level of intended efficacy of care that best reflects their preferences. Besides encouraging health care purchasing along price and quality lines, this system would foster uniform insurance pricing because employers would no longer have captive groups to promise insurance agents. Accordingly, rates for individuals would approximate rates for large groups. In this way, the benefits of the implementation of a choice-based system could accrue to all individuals that purchase insurance coverage.

Insurers would also need to change their business practices to make a choice-based system viable. Presently, insurers, especially managed care plans, subject claims to utilization review processes to ascertain whether the services provided were medically necessary. Upon standardizing the reimbursement rates

terms of its usefulness in rating health care plans, they rank quality-related information such as medical utilization and customer satisfaction, sixth and twelfth, respectively).

See supra Part I.B (highlighting this factor as creating market imperfections within health care).

Cf. David Nather, House GOP Working Group Developing Plan That May Go Far Beyond Patient Protections, 6 Health Care Pol'y Rep. (BNA) 731 (May 4, 1998), available in WESTLAW, 6 HCP 731 (stating that a congressional health care working group proposed to move away from employer-based health insurance to increase consumer choice by granting individuals and self-employed people the same tax benefits as employers).

Presently, large employers can use leverage to extract much lower rates from insurers than either individuals or small companies. See, e.g., Health Plans: A New Deal for Small Fry, BUS. WK., June 26, 1995, at 142 E2 (describing how the unequal bargaining power of small companies and individuals in Cleveland has motivated companies and individuals to create a purchasing cooperative consisting of these companies and individuals to reduce their health care costs).

See supra note 51 and accompanying text (describing how MCO's control providers' decisions through utilization review).
EMPOWERING PATIENTS

to be paid at each reimbursement level for each DRG, insurers would no longer need to check the medical necessity of the services rendered. They would pay the same amount, irrespective of the services provided. Instead of questioning medical necessity, they would largely function as underwriters who generate different insurance rates for each of the reimbursement levels. Insurers would of course need to continue to check for fraudulent claims, such as those where upcoding had occurred. Through this system, many of the complaints presently launched against insurers—that they substituted their judgment for the judgment of medical professionals—would no longer be applicable. Rather, this choice-based system would return the power to define the limits of the provider’s agency to the patient, who would make this determination based on her own price and quality preferences. These refinements to present insurance practices, as well as to other health care financing practices, would increase consumers’ satisfaction with their health care consumption.

2. Reforms Relating to Legal Liability Arising from the Financing of Health Care

Despite the rapid progress of the health care industry in the direction of cost containment, the law has not followed the same path. Spiraling health care costs have forced the country to consider the cost of its care. The law, however, has remained steadfast in its adherence to a unified standard of care that ignores the economic aspects of health care delivery. In taking this position, the courts have acted as a countervailing force against the problems that arise both from the insertion of third parties between the patient and the physician and from the imbalance of power resulting from the unequal access to informa-

96 Upcoding refers to the practice of submitting a claim to Medicare for a DRG of a higher reimbursement rate than the DRG actually evidenced by the patient’s records. See, e.g., Crozer-Chester Medical Center Settles Allegations of Medicare DRG Upcoding, 6 Health L. Rep. (BNA) 1749 (Nov. 13, 1997), available in WESTLAW, 6 BHLR 45 d13 (reporting how one Pennsylvania hospital had been found liable for regularly upcoding bills involving the treatment of patients with pneumonia).

97 See supra notes 4, 89 and accompanying text (discussing the public’s distrust and discontent with the health care system).

98 See John A. Siliciano, Wealth, Equity, and the Unitary Medical Malpractice Standard, 77 VA. L. REV. 439, 441 (1991) (“To date, medical malpractice law has refused to recognize formally the economic status of the patient as a factor legitimately influencing the kind or degree of care the patient receives.”).
tion of the parties in the patient-physician relationship. As this protective force would not be necessary to the same degree under a choice-based health care system, the law would need to be reformed to allow consumer choices to be fulfilled in accordance with their expectations.

Protecting the sanctity of the patient-physician relationship against outside encroachment, courts have found liability for MCO's and other insurers who try to affect physician decision-making processes. Courts have often imposed liability on these entities when they have tried to directly control the provision of services by denying payment for services not deemed "medically necessary." They also have discussed the possibility of imposing liability on these entities when their risk-sharing programs have been found to create an incentive for providers to forego necessary care. By imposing liability, courts have limited the ability of third party payors to significantly reduce health care costs.

The rationales relied upon in these third party payor cases would not be applicable to third party payors acting within a choice-based health care system. Therefore, courts should refrain from using the same rationales to find liability in such a

99 See supra Part II (describing how these phenomena have led to increasing dissatisfaction among the public with its health care system).


101 HALL, supra note 24, at 67–68 (stating that despite insurers' attempts to limit coverage to only medically necessary services, they lose almost 60% of coverage decision disputes in court); see also Patricia M. Danzon, Tort Liability: A Minefield for Managed Care?, 26 J. LEGAL STUD. 491, 505 (1997) (discussing Fox v. Healthnet, No. 219692 (Ca. Super. Ct. Dec. 23, 1993), where a jury found an HMO liable for, inter alia, breach of contract, because the HMO denied reimbursement for a bone marrow transplant as a treatment for breast cancer on the grounds that the procedure was still "investigational").

102 See Walsh, supra note 100, at 234–35 (discussing the potential of HMO financial incentive programs to induce a doctor to provide substandard care).
system. Under a choice-based system, the term "medical necessity" would no longer be necessary. This term, which has always lent itself to ambiguity,\textsuperscript{103} would be replaced in all agreements between enrollees and insurers with reference to the standardized levels of intended efficacy to be created by the independent physician boards. A patient assenting to a level of intended efficacy at the time of entering into an enrollment agreement would also be deemed to have assented to the corresponding cost constraints imposed by the insurer, provided that the enrollee had received adequate notice about the characteristics of each of the levels sufficient to make an informed choice.\textsuperscript{104} Since the enrollee would be limiting the discretion of the insurer through her enrollment choices, courts would better serve the interests of enrollees by not mandating any coverage in excess of the coverage dictated by the enrollee's contract.

Courts should also decline to find insurers liable for any of the indirect consequences of the implementation of the payment mechanisms built into a choice-based system. Payment of providers through a DRG system creates incentives to provide less care.\textsuperscript{105} However, this incentive in a choice-based system differs from the present use of incentives to underutilize medical services because the rates would be determined by an independent third party, which bases these rates on sound medical practices.\textsuperscript{106} Thus, the insurer would not have the necessary control over the payment process to be a substantial cause in any harm that might come to a patient receiving care from a provider under this system. Furthermore, all insurers would be paying similar rates, which would mean that they were adhering to industry standards. This adherence can serve to deflect liability for each

\textsuperscript{103} See, e.g., Medicaid: Medical Necessity Definition Variations will Affect Managed Care Plan Enrollees, 6 Health Care Pol'y Rep. (BNA) 558 (Mar. 30, 1998), available in WESTLAW, 6 HCP 558 (noting the results of one study that showed that the breadth of the definition of medical necessity correlated with a beneficiary's access to care).

\textsuperscript{104} See Hall, supra note 67, at 585 (stating that consumers must have choices before their consent can have any meaning); cf. id. at 556–57 (arguing that consumers either waive consent or give bundled consent to the economic limitations of their treatment when they make fully informed decisions to purchase financially constrained insurance plans).

\textsuperscript{105} See RODWIN, supra note 6, at 15.

\textsuperscript{106} See supra Part III.A (suggesting that independent physician boards create reimbursement rates).
individual actor. Accordingly, it would seem discordant with established legal principles to find liability potentially arising from the incentives created by these payment mechanisms for insurers operating under this proposed system.

Just as courts have acted to protect patients against third party payors, they have also sided with patients in disputes between patients and their physicians when the physicians have considered economic factors in their treatment decisions. Physicians have been found liable when they have not provided all the services deemed by a court to be necessary, irrespective of the physician's ability to receive compensation for such services. Likewise, physicians cannot take economic factors into account when making decisions with respect to terminating the patient-physician relationship. One court has even implied that it is the physician's personal responsibility to forego payment when the patient cannot otherwise pay. Thus, despite the fact that the rise of managed care has adversely impacted physicians' compensation levels, courts have prevented physicians from remedying the situation by reducing their expenses in providing care.

Under a choice-based system, courts would not have to protect patients from their physicians to the same degree. Underlying this protection of patients from physicians acting in their own interest is the concept that providers, who are the agents of the patients, owe their patients, the principals, a fiduciary duty

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107 See W. Page Keeton et al., Prosser and Keeton on the Law of Torts § 33 (5th ed. 1984) (asserting that acting similarly to others could be grounds for finding that the actor has conformed its conduct to the community's idea of reasonable behavior).

108 See, e.g., Dunn v. Praiss, 606 A.2d 862, 864–65 (N.J. Super. App. Div. 1992) (discussing how the physicians, who were under capitated contracts with an HMO, had failed to use diagnostic procedures that could have timely discovered the patient's testicular cancer, and were thus jointly liable with the HMO); Walsh, supra note 100, at 234 (discussing Bush v. Dake, where the plaintiff alleged fault of both the physician working under a risk-sharing arrangement, as well as the HMO establishing the risk-sharing arrangement, where the physician delayed giving the plaintiff a pap smear or a referral to a specialist).

109 See, e.g., Ricks v. Budge, 64 P.2d 208, 211–12 (Utah 1937) (stating that it would be inappropriate for a physician to discontinue medical treatment, for any reason, "so long as the [condition] requires attention").

110 See Wickline v. State, 239 Cal. Rptr. 810, 819 (Ct. App. 1986) (holding that a physician is "ultimately responsible" for the patient's care, irrespective of third party payor cost limitations).
of loyalty. Accordingly, when confronted with a conflict of interest between what is beneficial to the patient and what is beneficial to the physician, the provider must always act in the patient's interest. Since this duty arises from the patient setting out the terms of the physician's agency, the patient should be able to limit the scope of the provider's agency to only the provision of services intended to be covered by the level of reimbursement chosen by the patient at the time of enrollment in her insurance plan. In so doing, the patient could consent to any appearance of a conflict of interest that arises in receiving treatment. Removing liability from conflicts of interest through informed consent is already considered standard practice for law-

111 See Mehlman, supra note 66, at 368 (noting that in order to be protected from breach of fiduciary duties claims, the physician must not only act reasonably, but loyally).
112 See id. at 370–371.
113 See Martin Gunderson, Eliminating Conflicts of Interest in Managed Care Organizations Through Disclosure and Consent, 25 J.L. MED. & ETHICS 192, 195 (1997) (discussing how a patient's choice to enroll in an MCO can modify the underlying duty of the treating physician to allow her to take into consideration financial factors in exercising professional judgment).

114 Cf. id. (asserting that this consent actually eliminates conflict of interest because the physician's role has changed by virtue of the consent). But cf. id. at 197 (stating that the patient's consent has little value where the patient does not have many choices among health plans). Besides having the ability to choose among plans, the doctrine of informed consent to any conflicts potentially arising from the economic limitations of one's treatment presumes capacity to consent, which would not be true of children or adults who may not have such a capacity. Though only a second-best alternative, applicable laws would continue to govern who can consent for these individuals. Thus, parents would continue to make decisions for their children. See Erin A. Nealy, Medical Decision-Making for Children: A Struggle for Autonomy, 49 SMU L. REV., 133, 152–53 (commenting that the Supreme Court precedent establishes the rights of parents to make decisions with respect to their children's health care). There would also be a continuing need to have health care surrogates make decisions for those who lack the capacity to make such decisions. See, e.g., N.Y. PUB. HEALTH LAW § 2965(2)(a) (McKinney 1993) (providing a list of individuals whose relationship with a patient entitles them to make a decision with respect to an issuance of an order not to resuscitate the patient when the patient lacks the capacity to make the decision herself). By emphasizing the importance of choice in converting to a choice-based system, it is possible that there would be increased efforts to encourage people to pre-commit to the level of intended efficacy of care they are to receive upon becoming mentally incompetent, similar to the present use of advance directives. See Ben A. Rich, Advance Directives The Next Generation, 19 J. LEGAL MED. 63, 66 (1998) (labeling the right of patients to indicate their desires upon becoming incompetent, through such measures as written or oral advance directives, as prospective autonomy, which arises from the doctrine of informed consent).
yers.\textsuperscript{115} Since the patient's will still governs the terms of the patient-physician relationship, a court would not need to hold the physician to a higher standard than the one the patient has chosen for herself.

Similarly, tort liability should not attach to the physician's treatment only because of the physician's decision not to provide services that are not contemplated by the level of intended efficacy chosen by the patient. In determining liability based on malpractice for negligent services, courts usually look at what other practitioners would do under similar circumstances.\textsuperscript{116} Under a choice-based system, courts could look at whether the provider's care conformed to the independent physician board standards set forth for the patient's DRG at the level of intended efficacy chosen by the patient.\textsuperscript{117} Alternatively, when the provider and patient have agreed otherwise, courts could look at whether the proposed course of treatment was nevertheless reasonable.\textsuperscript{118} In any event, courts should not deem a decision not to provide services that may have been beneficial to be per se evidence of malpractice. In so doing, courts would be honoring the intentions of the patients in these relationships.

The patient's choice of the level of care should not remove all liability from the provider. Even where the provider's choice of services rendered accords perfectly with applicable guidelines, the provider should still be liable where she fails to act reasonably in administering her care.\textsuperscript{119} Not limited to negligence, courts should impose liability for the commission of intentional torts, such as battery or the related tort of the breach of the duty to obtain informed consent. The breach of this duty arises where a

\textsuperscript{115} See Model Rules of Professional Conduct Rule 1.7(b) (1995) (prohibiting lawyers from representing clients where such representation would be "materially limited by the lawyer's responsibilities to another client or to a third person, or by the lawyer's own interests, unless: (1) the lawyer reasonably believes the representation will not be adversely affected, and (2) the client consents after consultation").

\textsuperscript{116} See Mehlman, supra note 66, at 362; see also Keeton, supra note 107, § 32.

\textsuperscript{117} Cf. Mehlman, supra note 66, at 362 (noting that the profession can reinterpret its own standards to reflect resource constraints).

\textsuperscript{118} Cf. Siliciano, supra note 98, at 481–82 (proposing that even with a resource-sensitive standard of care, providers should be responsible for their methods of treatment and diagnosis).

\textsuperscript{119} Cf. id. at 482 (proposing that the competence of providers acting under a resource-sensitive standard should still be governed by a malpractice standard).
provider affected the patient's decision to undergo a suggested course of treatment to her detriment by omitting to disclose sufficient information about the risks and benefits of a proposed treatment regimen before administering it. Though the doctrine initially applied only to cases where a certain procedure had been performed with adverse consequences, the doctrine has been expanded in some jurisdictions to include cases where the provider failed to inform a patient of the risks and benefits of foregoing potential treatment options that could have had beneficial outcomes. Even in a choice-based system, courts should still uphold the doctrine of informed consent. Consent is provided at the time of entry into a health plan only as to the financial constraints that will arise within the treatment relationship. Though patients have consented to the financial constraints of their care at the time of enrollment, they should be informed of alternatives that might exceed the costs of their present reimbursement levels when undergoing treatment. The patient can then decide whether she will pay for the alternative treatment or seek alternative sources of financing. Without the obligation to obtain informed consent at the time of providing care, physicians would eliminate many of the advantages of a choice-based system by removing many of the choices that now exist at the time of treatment. By restructuring liability in this way, courts can still protect patients when they seek treatment without eviscerating the benefits to society of a system that promotes a patient's price and quality choices.

IV. GIVING CONSUMERS PROVIDER-SPECIFIC PRICE AND QUALITY INFORMATION

Once various efficacy levels have been established, mechanisms need to be put in place that protect the patient's right to

120 See Hall, supra note 67, at 538–39.
121 See id. at 540 (describing this tort as a violation of the right of "informed refusal").
122 See House GOP Bill Delayed Until June; Outline May Be Ready Before Recess, 6 Health Care Pol'y Rep. (BNA) 818 (May 18, 1998), available in WESTLAW, 6 HCP 818 (reporting that according to one poll, almost "97% of Americans would support legislation requiring health care providers to give their patients full information about their . . . treatment options").
123 See Hall, supra note 67, at 533 (reciting the views of philosophers Paul Menzel and Haavi Morreim).
receive the chosen level of care when actually obtaining treatment. Formulated by independent physician boards using sound, trustworthy judgment, the reimbursement rates paid to providers for administering care should be designed to allow providers to achieve the corresponding levels of efficacy of care that accord with patient expectations. If, however, there are no systems in place to foster accountability, providers will have incentives to provide less beneficial care while receiving the same reimbursement. Alternatively, providers will also have the incentive to encourage patients to pay out-of-pocket for services that they promise will dramatically increase the efficacy of the care provided, even when such services have either little or no benefit. Accordingly, providers should be mandated to disclose all information relating to the price and quality of their services that a reasonable patient would find material. Through such a mandate, the system would ensure that the patient receives the quality of care she is entitled to receive at the insurance premium price she chose, by allowing her to shop for providers whose performance results accord with the patient’s expectations, and whose costs match the reimbursement rates to which the patient is entitled.

A. The Function of the Disclosure Model in Securities Laws

As securities disclosure laws were enacted to address many of the same concerns that are raised in an examination of the present state of the health care industry, lawmakers can rely on the body of law regulating securities transactions to set up a disclosure system in the health care industry. Prior to the enactment of the securities disclosure laws in 1933 and 1934, the securities industry was confronting serious difficulty. At the root of most of these problems was the imbalance of information between securities sellers and purchasers. This imbalance allowed sellers to take advantage of purchasers by engaging in

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124 See supra note 105 and accompanying text (discussing DRG incentives).
fraudulent activities and in self-dealing.\textsuperscript{126} Unaware of the sellers' disingenuous conduct, purchaser demand was excessive, which led to the purchase of many worthless stocks.\textsuperscript{127} Upon being awakened to the dangers of the system by the stock market crash of 1929, the public grew distrustful of the securities industry.\textsuperscript{128} Public sentiment against the industry resulted in the government's decision to intervene.\textsuperscript{129}

President Franklin Roosevelt provided the vision necessary to advance the reform process. Roosevelt advocated a disclosure system that would prevent concealment of important information about a company. There was no guarantee, however, that the stock would maintain its value.\textsuperscript{130} Roosevelt's recommendation stood in sharp contrast with the contemporaneous regulatory framework based on "merit review," which required that a government authority approve the merits of a security and its price before it was offered for sale to investors.\textsuperscript{131} The disclosure model was seen as more flexible than a model based on merit regulation.\textsuperscript{132} It was also viewed as a better method of preventing wrongdoing in the securities industry.\textsuperscript{133} Despite initial criticisms that claimed self-regulation would be sufficient or that the cost factor would be too great,\textsuperscript{134} the act became law in 1933.\textsuperscript{135}

\textsuperscript{126} See id. (discussing how one seller raised over $200 million in selling securities for bogus corporations); Paul G. Mahoney, \textit{Mandatory Disclosure as a Solution to Agency Problems}, 62 U. CHI. L. REV. 1047, 1068–71 (1995) (describing how securities promoters would reap large undisclosed profits or commissions in selling securities).

\textsuperscript{127} See Keller & Gehlmann, \textit{supra} note 125, at 334 (citing H.R. REP. NO. 73-85, at 2 (1933), \textit{reprinted in} 2 \textit{LEGISLATIVE HISTORY OF THE SECURITIES ACT OF 1933 AND SECURITIES EXCHANGE ACT OF 1934}, item 18, at 2 (J.S. Ellenberger & Ellen P. Maher eds., 1973), which found that underwriters had to manufacture securities to satisfy the public demand they had created through their own marketing efforts).

\textsuperscript{128} See Keller & Gehlmann, \textit{supra} note 125, at 338 (noting that there had been a diminution of faith after the market collapse).

\textsuperscript{129} See id.

\textsuperscript{130} See id.

\textsuperscript{131} Mahoney, \textit{supra} note 126, at 1075–76.

\textsuperscript{132} See Keller & Gehlmann, \textit{supra} note 125, at 341 (stating that the drafters of the legislation wanted flexibility without creating the ability to evade congressional mandates).

\textsuperscript{133} See id. at 339 (discussing the notion of disclosure of which it has been said that "[s]unlight is said to be the best of disinfectants; electric light the most efficient policeman" (quoting \textsc{Louis Dembitz Brandeis, \textsc{Other People's Money and How the Bankers Use It} 62 (Richard M. Abrams ed. 1967))).

\textsuperscript{134} See id. at 337 (describing how Hoover adhered to a laissez-faire strategy despite the market crash with the hope that the stock exchange would apply more effective self-regulatory measures); \textit{see also} id. at 344 (noting that some critics warned
The disclosure laws work by promoting the distribution to investors of important, reliable information. They require the disclosure in the form of a prospectus of all information that would be material to a reasonable investor.\textsuperscript{136} This information is presented in a standardized format that complies with generally accepted accounting principles ("GAAP"), as established by the independent Financial Accounting Standards Board ("FASB").\textsuperscript{137} The credibility of this information is bolstered by the fact that it is audited by independent accountants.\textsuperscript{138} These auditors, as well as all other parties responsible for generating the prospectus, certify the veracity of the information contained within the prospectus.\textsuperscript{139} Because this certification could lead to liability for the auditors or individuals engaged in generating a prospectus,\textsuperscript{140} individuals are more attentive in preparing a prospectus than they would be without the potential liability.\textsuperscript{141} This enhanced risk of liability leads to assurances for investors of the accuracy of the information conveyed in the prospectus. Investors can find even further comfort in the fact that auditors must also comply with standards promulgated by the American Institute of Certified Public Accountants (the "AICPA"), a private organization that governs the manner in which auditors perform their duties.\textsuperscript{142} The required disclosure of all material informa-


\textsuperscript{136} See 15 U.S.C. § 77e(b) (1994) (stating that all sales of securities require the receipt of a prospectus by the investor prior to the sale); 15 U.S.C. § 77j(a)(1) (1994) (requiring that the information in the registration statement be conveyed in the prospectus); 15 U.S.C. § 77k(a) (1994) (creating liability for all untrue statements or omissions of material fact in the security's registration statement).

\textsuperscript{137} See STANLEY SIEGEL & DAVID A. SIEGEL, ACCOUNTING AND FINANCIAL DISCLOSURE 6–7 (1983) (noting that the SEC has largely deferred to FASB and its predecessors to establish the principles within GAAP).

\textsuperscript{138} See 17 C.F.R. §§ 210.3-01 (1998) (requiring audited balance sheets to be submitted with certain filings); 17 C.F.R. §§ 210.1-02(d) (1998) (defining an "audit" as "an examination of the financial statements by an independent accountant in accordance with generally accepted auditing standards").


\textsuperscript{140} See id. (providing that any individual who is misled may sue any person who signed the registration statement and every director, partner, accountant, engineer, appraiser, or underwriter involved).

\textsuperscript{141} See Keller & Gehlmann, supra note 125, at 345.

\textsuperscript{142} See SIEGEL & SIEGEL, supra note 137, at 130.
tion regarding securities allows investors to accurately assess the price and quality of potential investments and to accurately compare stocks.\textsuperscript{143} This has promoted extraordinary expansion of the securities industry over time.\textsuperscript{144}

B. Creating a Disclosure System for the Health Care Industry

Just as a lack of information about the value of securities available before 1933 led to many problems within the securities industry, many similar problems have arisen within the health care industry due to a lack of information about the price and quality of health care services. This similarity suggests that the health care industry could benefit from the same solutions proven to be effective in the securities industry context. There is a greater wealth of information available to the physician than to the patient in the patient-physician relationship.\textsuperscript{145} Physicians have taken advantage of this imbalance by engaging in fraudulent activities and in self-dealing.\textsuperscript{146} Since physicians who receive fee-for-service compensation stand to gain from providing additional services to patients who are unaware of the nature of the benefits attainable through these procedures, there has also been a chronic problem of overutilization in the provision of health care.\textsuperscript{147} With the increased prevalence of managed care, the public has become more sensitized to the financial aspects of

\textsuperscript{143} See BREALEY & MYERS, supra note 77, at 290–95 (asserting that the American securities markets can be characterized as efficient markets, where widely and cheaply available information about securities is reflected in their price); see also id. at 13, 143, 161 (explaining that an individual stock's volatility is compared against the market's volatility to derive a figure known as the stock's beta, which is then used to determine the stock's risk premium that correlates with its monetary value).

\textsuperscript{144} Presently, as many as 43% of all Americans own stocks, either directly or through retirement plans. See Maggie Jackson, The National Pastime: Welcome to Investing as a Participant Sport, SUN-SENTINEL (Ft. Lauderdale.), Sept. 20, 1999, at 19.

\textsuperscript{145} See supra notes 32–34 and accompanying text (discussing the problems that arise from this imbalance).

\textsuperscript{146} See RODWIN, supra note 6, at 56 (listing various abuses encouraged by fee-for-service payments, such as the acceptance of kickbacks by physicians and physician self-referrals); cf. supra note 126–27 and accompanying text (discussing these problems within the securities industry context).

\textsuperscript{147} See RODWIN, supra note 6, at 55; cf. supra notes 125–26 and accompanying text (discussing this issue within the context of the securities industry).
health care, which has led to a growing distrust of providers.\textsuperscript{148} Though voluminous in nature, the laws and regulations that govern the provision of medical services have not succeeded in providing a system satisfactory to the public.\textsuperscript{149} Attempts, however, to legislate a comprehensive disclosure model would likely be met with criticisms from members of the industry who would levy charges of burdensome costs or impermissible encroachment into an area better left to self-regulation.\textsuperscript{150} Despite these criticisms, the success of the disclosure model in the securities industry militates in favor of creating similar mechanisms to correct the problems that currently prevent the health care industry from satisfying consumers.

To maximize consumer satisfaction by allowing consumers to make informed choices about their health care consumption, all providers should be required to accumulate reliable, material information about the quality and cost of their care.\textsuperscript{151} Materiality

\textsuperscript{148} See Mehlman, supra note 66, at 374–75; cf. supra note 128 and accompanying text (discussing distrust of the securities industry after the stock market crash of 1929).

\textsuperscript{149} See David Nather, Bliley, Norwood Said to be Discussing Plan to Create Private Program Based on FEHBP, 6 Health Care Pol'y Rep. (BNA) 690 (Apr. 27, 1998), available in WESTLAW, 6 HCP 690 (quoting one politician as stating that the Health Care Financing Administration regulations comprise about 45,000 pages and are therefore overly “cumbersome”); supra notes 1–10 and accompanying text (discussing the dissatisfaction of the American public with its health care system). The securities industry also operated previously through regulation of every minute detail of securities offerings, but this system was discarded for the more flexible and effective disclosure system. See supra text accompanying notes 131–35 (discussing adoption of the disclosure system).

\textsuperscript{150} See Gwen Moulton, Private/Public Health Plan Quality Model Revisited with Mixed Reviews, 6 Health Care Pol'y Rep. (BNA) 343 (Feb. 23, 1998), available in WESTLAW, 8 HCP 343 (referring to the comments of an executive at Health Insurance Association of America that voluntary accreditation activities are working well); cf. supra note 134 and accompanying text (noting how these objections were raised against securities reform).

\textsuperscript{151} Mandatory disclosure of material information relating to providers is not a new concept. It has most recently been championed by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The Commission, in its report to the President, has suggested that core sets of quality measures be reported by each sector of the health care industry, including providers. See President's Advisory Commission, supra note 29, at 74. The report reinforces other governmental efforts at promulgating data collection. The Health Care Financing Administration has published proposed regulations that would require hospitals to collect, analyze, and track data on 12 different aspects of care. See Condition of Participation: Quality Assessment and Performance Improvement, 62 Fed.
could be based on whether there is a substantial likelihood that a reasonable patient would consider the information useful when choosing a provider.\textsuperscript{152} To determine the quality of a given provider, a reasonable patient would probably be interested in both medical and non-medical aspects of the provider's services.\textsuperscript{153} The medical aspects could be expressed through outcomes data, which would need to be adjusted for case mix severity to convey


The industry itself has also taken steps to monitor quality-related data. The National Committee for Quality Assurance ("NCQA") implemented a system that was to take effect in July, 1999 that would require the submission of health plan performance measures on an annual basis as part of its accreditation program. See \textit{NCQA Redefines Evaluation Process with Standards that Focus on Results}, 6 Health Care Pol'y Rep. (BNA) 593 (Apr. 6, 1998), available in WESTLAW, 6 HCP 593. Similarly, the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") has established a program requiring hospitals and nursing homes to collect patient outcome data. See J. Duncan Moore Jr. & John Morrissey, \textit{Ready, Set, Go}, MOD. HEALTHCARE, June 29, 1998, at 89, 89. Recently, the AMA has announced its plan to collect physician-related data. See Mary Chris Jaklevic, \textit{AMA Eyes Competition}, MOD. HEALTHCARE, May 18, 1998, at 42, 42. Though these efforts draw attention to the value and feasibility of data collection, the present design of each of these programs is limited in terms of the degree to which they promote disclosure of material information about providers that would be useful to prospective patients. The NCQA program collects data relating to health plans. See \textit{NCQA Redefines Evaluation Process with Standards that Focus on Results}, supra, at 593.

Yet studies indicate that consumers are more interested in provider-specific information than in information on health plans. See Paul D. Cleary & Susan Edgman-Levitan, \textit{Health Care Quality}, 278 JAMA 1608, 1609 (1997). Though the JCAHO program requires data collection on the hospital segment of the provider market, it is limited in the quantity of quality-related data accumulated. Only two clinical indicators to cover only up to 20% of the patient population are required under the current program. See Moore & Morrissey, \textit{supra}, at 89. Similar in its lack of breadth of coverage, the AMA program envisions a minimum credential issuing process whereby those providers who meet the set standards would receive a gold star. See Jaklevic, \textit{supra}, at 42. Thus, at the present time, no private body has established a program that truly accumulates all the material price and quality information that a health care consumer would want.

\textsuperscript{152} See \textit{Canterbury v. Spence}, 464 F.2d 772, 787 (D.C. Cir. 1972) (holding that a physician can discharge his duty to obtain informed consent by giving a patient all material information about the risks of treatment, which would be those risks potentially affecting the decision of an average, reasonable patient); cf. 17 C.F.R. § 230.405 (1999) (defining materiality as the information to which "there is a substantial likelihood that a reasonable investor would attach importance in determining whether to purchase the security registered").

\textsuperscript{153} See \textit{NCQA Redefines Evaluation Process with Standards that Focus on Results}, \textit{supra} note 151, at 593 (explaining that NCQA includes both medical data, such as immunizations, and non-medical data, such as member satisfaction, in its data collection program).
truly useful information to prospective patients. As the outcome results are likely achieved by a provider only with respect to her area of expertise, the reasonable patient would want to know what types of cases the provider treats most frequently in order to make a determination as to whether her needs would be met when receiving care from this particular provider. Accordingly, the provider should be mandated to disclose the types of illnesses she treats most often and the number of patients she has seen with each of these illnesses within the recent past.

The non-medical aspects of care could be expressed through a variety of statistics, including consumer satisfaction survey results. The treatment process is not an instantaneous exchange; therefore, a reasonable patient would benefit from a longitudinal component that would require providers to determine the status of the patient's health and the degree to which the patient is satisfied with the provider's aftercare. This would also result in the benefit of encouraging proper follow-up by providers. Similarly, as the treatment process is often not administered merely by one provider, a reasonable patient would probably want to see a set of measurements aggregating the outcomes and patient satisfaction data for all of the providers involved in the medical process that were recommended by the initial provider. This would encourage the initial provider (usually a

154 See Kathleen N. Lohr, How Do We Measure Quality?, HEAL TH AFF., May-June 1997, at 22, 24 (emphasizing that in addition to case-mix adjusted outcomes measurements, measurements of health care processes should also be considered).

155 See Mary Anne Bobinski, Autonomy and Privacy: Protecting Patients from Their Physicians, 55 U. PIT T. L. REV. 291, 296 n.9 (1994) (citing various studies that show that a practitioner's experience with performing a procedure is correlated with a successful outcome for the procedure).

156 See Cleary & Edgman-Levitan, supra note 151, at 1608-09 (discussing recent advances in consumer satisfaction surveys, such as the Consumer Assessment of Health Plans ("CAHPS") project).

157 See id. at 1609 (observing that researchers often focus on one point of time with respect to the treatment process, despite the fact that patients are interested in results over the course of time).

158 See id. (pointing to research that shows that patients do not form distinct images of isolated visits with single clinicians, but rather that they focus on the entire episode of care). By requiring providers to include information regarding other providers to whom she has referred her patients in her outcome results, this disclosure system would operate similarly to securities regulations requiring companies to disclose financial information about their subsidiaries, notwithstanding that they have a separate corporate existence, because of their ability to affect the quality of the parent's securities. See 17 C.F.R. § 229.301 Instructions to Item 301 (3) (1999)
primary care physician) to carefully select other providers for her patients along price and quality lines, irrespective of any opportunity to obtain personal gains for any such referral. Having received this information, the patient could rationally choose a provider based on the expected quality of care to be received.

In conveying this quality data, providers should have to follow standardized rules to encourage ease of comprehension and comparability for prospective patients. These rules could be developed by an independent board, similar in function to the role played by FASB in the accounting industry. These rules could mandate, at first, a simple presentation of some of the key quality of care data in the form of a set of ratings that would evaluate these data on a scale from one to ten. Initially the data presented would be limited in number and complexity, but the presentation could evolve over time as the public's comprehension of the data grows and its needs with respect to the data become more refined. By allowing flexibility to the standardized

(requiring all securities issuers to include their subsidiaries' financial information consolidated with their financial data).

159 Cf. RODWIN, supra note 6, at 57-67 (discussing how some providers “buy” referrals from other providers).

160 See PRESIDENT'S ADVISORY COMMISSION, supra note 29, at 74 (suggesting that there be standardization in accumulating quality measures for reporting). Since the three separate bodies of NCQA, JCAHO, and the AMA are presently mandating quality data collection on their own individual terms, their efforts could not be characterized as standardized. However, these three organizations have announced the intention of developing uniform quality data collection efforts. See J. Duncan Moore Jr., Standardizing Standards, MOD. HEALTHCARE, May 25, 1998, at 22, 22. Thus, quality data collection could become standardized in the near future.


162 Cf. House Approves Bill to Create Panel to Study What People Value in Health Care, 7 Health L. Rep. (BNA) 286 (Feb. 19, 1998), available in WESTLAW, 7 BHLR 286 (explaining how Vermont’s House has approved a bill to study what its constituents value in health care); Mahoney, supra note 126, at 1089 (noting how the SEC has greatly expanded the securities disclosure system over time purportedly to
format to reflect the public's changing needs, the disclosure system would always be a useful tool for comparison shopping by consumers.

To place the quality information in context, the prospective patient would need to see all material information relating to healthcare costs. Once enrolled in a plan that pays providers at a given reimbursement rate, a reasonable patient would want to know whether the payment of this reimbursement rate would result in the receipt of services at a level of quality similar to the level exhibited by the provider's quality data. Accordingly, the provider should disclose the reimbursement rates necessary to have covered the charges incurred in her provision of care, broken down by the percentage of cases that she has treated within the recent past that could have been covered by each reimbursement rate. If an inordinately large number of cases treated by the provider required a high reimbursement rate to fully cover the costs of receiving care, a prospective patient would conclude that the level of quality of care traditionally rendered by the provider was contingent upon the use of expensive resources that fall outside of the intended scope of coverage of lower reimbursement levels. If the patient enrolls in a lower reimbursement level, she might choose another provider, or she might decide to pay "out of pocket" the portion of care for which insurance payment would not be sufficient. Once the prospective patient has access to this cost and quality information, she can determine which provider will best suit her needs and expectations.

support market efficiency through increasing the availability of material information).

163 See Louise Kertesz, What Does it All Mean? Making Sense of Health Plan Data, MOD. HEALTHCARE, Apr. 20, 1998, at 98, 106 (summarizing the results of one survey that indicated that consumers want both price and outcomes data to help them with decisions in selecting providers); cf. 17 C.F.R. § 229.201(a)(1) (1999) (requiring the disclosure of securities prices over the past two years to investors).

164 See supra Part IIIA (proposing that insurance enrollment involve a patient choosing one of several standardized levels corresponding to a reimbursement rate to be paid to providers when they receive care).

165 See supra Part IIIA (asserting that when patients decide at the time of treatment that they want care not covered by their reimbursement level, they should have the right either to bear the costs of care exceeding the reimbursements to which they are entitled or to find alternate sources of financing).
To bolster the reliability of this information, there would need to be a requirement that the information be audited.\footnote{See President's Advisory Commission, supra note 29, at 75 (suggesting external audits). Although NCQA is requiring audits of quality data it receives, it does not appear that JCAHO or the AMA have similar plans. See NCQA Redefines Evaluation Process with Standards that Focus on Results, supra note 151, at 593 (describing NCQA's quality data project); Jaklevic, supra note 151, at 42 (discussing the AMA's program); Moore & Morrissey, supra note 151, at 89 (examining JCAHO's initiative).} Auditors would need to remain independent to avoid the appearance of impropriety, thereby establishing trust with consumers.\footnote{Cf. supra note 138 and accompanying text (explaining that auditors working with securities-related financial disclosures are required to be independent).} To further ensure the reliability of any disclosed price and quality data, auditors could be required to certify the information they have reviewed, which would result in their incurring the risk of liability.\footnote{Cf. supra text accompanying notes 136–41 (stating that the risk of liability to parties certifying a prospectus increases the reliability of the information contained within the prospectus).} Furthermore, auditors should be subject to rules established by an equivalent to the AICPA with respect to generally accepted auditing standards for health care data.\footnote{NCQA has already begun this initiative. See NCQA Bolsters HEDIS with Uniform Auditing Standards, Managed Care Week, April 14, 1997, available in 1997 WL 8048466 (noting the release of NCQA's new auditing standards).} Through this system of checks and balances, prospective patients could feel more secure in their ability to choose a provider matching their desired price and quality criteria.

Once this price and quality information has been accumulated and verified, it would need to be compiled and distributed. Unlike providers, insurers would know the identity of prospective patients, irrespective of whether they are currently undergoing medical treatment. Therefore, insurers should be responsible for the compilation and distribution of information to their enrollees.\footnote{See President's Advisory Commission, supra note 29, at 75 (stating that health care quality information should be widely available). In fulfilling this role, insurers can model their practices upon the operations of securities underwriters. These firms are responsible for communicating with prospective securities purchasers on behalf of issuers. See Stephen P. Ferris et al., An Analysis and Recommendation for Prestigious Underwriter Participation in IPOs, 17 J. Corp. L. 581, 583 (1992) (describing the tasks a securities underwriter performs).} The information could be compiled in any of several formats.\footnote{See President's Advisory Commission, supra note 29, at 75 (suggesting that "multiple modes" be used for presenting health care quality information).} A printed compilation of information could be distrib-
uted periodically to enrollees, and for those who might not comprehend the import of this information, insurers could have interactive databases available at their offices or on the Internet that would explain the meaning of this data. The document would be divided into many small sections, each containing all the key price and quality data for each provider about whom an enrollee would want information. Thus, the insurer would likely provide information about primary care physicians that are located in the enrollee's town or zip code, and it would likely provide information covering a somewhat larger territory for secondary and tertiary care providers. Before conveying this information, the insurer should be required to carefully review the manner in which providers propose to have their information presented. All information should be clearly and dispassionately presented, in a manner devoid of marketing tactics, to ensure that enrollees use the information to make rational choices regarding providers and not emotional ones. With this user-friendly document, the prospective patient could ascertain that she would receive care at a level of quality she could have anticipated when making her decision about the amount she was willing to pay for her insurance. Because the nature of her health care services thus would correspond with the enrollment choice she made, it is likely that she would experience increased satisfaction with the health care system.

172 This could work similarly to the use of prospectuses and annual reports in the securities industry. See supra Part IV.A (discussing the use of prospectuses in selling securities); see also 3 LARRY D. SODERQUIST, SECURITIES REGULATION 101-02 (1990) (discussing the criticisms of the process of compiling a prospectus).

173 See Cleary & Edgman-Levitan, supra note 151, at 1610 (commenting that information needs vary with different population groups); see also Kertesz, supra note 162, at 100-02 (discussing how interactive information relating to health care quality data is already available on-line).

174 See Jack Zwanziger et al., Hospitals and Antitrust: Defining Markets, Setting Standards, 19 J. HEALTH POL., POL'Y & L. 423, 432 (1994) (stating that patients are more willing to travel for specialized services than they are to receive more general services).

175 See Rice, supra note 9, at 394 (pointing out that marketing can change consumer tastes, which often leads consumers to make choices that do not maximize their welfare). Securities laws similarly prohibit any emotional appeals to prospective investors to encourage consumption. See Publication of Information Prior to or After the Effective Date of a Registration Statement, Securities Act Release No. 33-3844, at *3 (Oct. 8, 1957), available in 1957 WL 3605 (S.E.C.) (clarifying that it is unlawful to stimulate the securities market through publicity prior to filing a registration statement).
C. Reforms Required to Implement the Disclosure System

1. Reforms Relating to the Implementation of a Disclosure System

As the present health care environment does not promote disclosure of material, reliable price and quality information, the roles of the different actors within health care need to be redefined to allow this information to reach consumers. Employers are presently the main source of information for most Americans with respect to health care price and quality, however, they often do not convey quality information to their enrollees. Accordingly, employers should not be permitted to remain the conduits of information any longer. Insurers should replace employers as the source of health care information. This new role would supersede various activities in which insurers (especially those operating in managed care environments) presently engage, such as using leverage over providers to extract the lowest possible price from them for their services. Under a disclosure system, the distribution of information about the price and quality of providers' services to the entire consumer market would lead to competition among providers to offer the highest quality of care at the lowest cost.

Within this proposed system, the function of the Department of Health and Human Service's Office of the Inspector General (the "DHHS OIG") would also need to undergo dramatic change. Since providers would be responsible for incorporating informa-

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176 See Kertesz, supra note 163, at 103 (describing the experiences of Medstat Group and J.D. Power & Associates, who sold health plan and provider report cards to employers but found that most employers did not forward them to employees).
177 See supra Part IV.B (suggesting that insurers should assume this role).
179 See PRESIDENT'S ADVISORY COMMISSION, supra note 29, at 75 (stating that rewarding providers "that demonstrate better performance and higher quality" will lead to more competition); see also, e.g., Frank Jossi, Money Matters: A BHCAG Update from the Twin Cities, BUS. & HEALTH, Apr. 1998, at 41, 51 (describing how disclosure of price and quality information in the competitive Minneapolis market led to an increase in enrollment for one low cost, high quality physician group); cf. supra note 142 and accompanying text (explaining that disclosure in the securities market has meant that investors can accurately compare stocks to each other to determine their value).
tion about the price and quality of the services of other providers treating the patients referred by the initial provider. The market would create strong disincentives against abusive activities, such as kickbacks and self-referrals, unless such practices would not adversely affect the provider's price and quality results. Thus, the DHHS OIG would no longer need to devote its resources to the enforcement of the anti-kickback or self-referral laws, which would largely become obsolete. Assuming a role similar to that of the SEC, the DHHS OIG could review documents to be disseminated to the public relating to health care price and quality information to determine if they appear incomplete or misleading. Further, it could monitor pronouncements issued by the equivalents of FASB and the AICPA to ensure that their rules comport with disclosure principles. It could also lead the effort in further determining the types of information that the public would consider material in making health care choices. By reforming the roles of these parties to promote disclosure, the system would ensure that consumers could make informed decisions with respect to their health care delivery.

2. Reforms Relating to Legal Liability Arising Within the Disclosure System

Similar to liability principles found in the securities laws, a structure of legal liability would need to be created to encourage

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180 See supra note 158 and accompanying text (suggesting this disclosure mechanism).

181 See supra note 146 and accompanying text (pointing to these practices as evidence that the system is vulnerable to abuse).


184 See supra note 161 (discussing the Health Care QUEST Act legislation, which proposes an organization—possibly one that would be a public-private partnership—that reports to two governmental agencies on quality indicators); Etheredge, supra note 161, at 25 (advocating a public-private collaborative effort in the area of health care information disclosure similar in structure to the SEC-FASB model); cf. supra notes 137–42 and accompanying text (discussing the interrelationship among the SEC, FASB, and the AICPA).

185 See Etheredge, supra note 161, at 23 (suggesting that the SEC equivalent be responsible for establishing health care information disclosure requirements); cf. Part IV.A (noting that securities disclosure laws have developed over time).
the completeness and accuracy of the health care price and quality information provided to consumers. Providers, the entities who collect and prepare price and quality data, and the auditors reviewing the data should all be required to certify that they have used due care in performing their tasks.\(^{186}\) If it is shown that they used less than due care, they should be liable for their actions.\(^{187}\) The DHHS OIG should be able to file suit against any party whose actions did not meet the due care standard and collect set penalties that vary with the degree of egregiousness of the conduct.\(^{188}\) Patients should also have the right to sue either individually or as a class. If they win a lawsuit establishing that they either received material misinformation or failed to receive material information due to the misfeasance of the parties that prepared the disclosure, should be entitled to damages. Courts should award plaintiff patients the fees paid to the provider in rendering medical care to the patient or patients, irrespective of whether there had been any adverse outcomes resulting from the provider’s treatment.\(^{189}\) Notwithstanding this recovery of funds, the damage award for the distribution of misinformation should not act as a bar against any separate malpractice action against


\(^{187}\) Cf. 15 U.S.C. § 77k(b)(3) (1994) (shielding accountants and other professionals, except for the issuer, from liability for untrue statements or omissions of material fact only if, after reasonable investigation, such party had reasonable grounds to believe that the statements in the registration statement were true and there were no omissions).

\(^{188}\) See Etheredge, supra note 161, at 23 (suggesting that the SEC equivalent in the health care industry should have the right to investigate and impose sanctions); cf. 15 U.S.C. § 77t (1994 & Supp. I. 1995) (granting the SEC the right to enforce the securities laws and setting out a penalty schedule).

\(^{189}\) Cf. 15 U.S.C. § 77k(a) (1994) (granting the right to sue to anyone acquiring a security when it is subsequently discovered that the registration statement contained an untrue statement or omission of material fact); 15 U.S.C. § 77k(e) (1994) (allowing recovery of the difference between the amount paid for the security and the value of the security at the time suit is brought). Though the securities laws limit recovery to the difference between the purchase price and the value of the security upon the disclosure of the concealed information, damages within the health care industry arguably would not have these gradations. Whereas a prospective investor might still have bought the security, albeit at a lower price, even if she knew the material information affecting the security’s value, the prospective patient would probably not have used the physician’s services at all but for the disclosed price and quality results that subsequently turned out to be materially inaccurate. Thus, a total disgorgement of the physician’s fees would seem appropriate.
the provider of substandard treatment. By imposing these stringent liability measures on the parties responsible for the disclosure, patients can be assured that these parties will prepare the information with the degree of vigilance necessary to allow the patient to confidently rely on it.

CONCLUSION

This Article has suggested that effectively responding to the rampant dissatisfaction with the present state of American health care entails providing price and quality choices with respect to medical care that are not currently available. Consumer choice can be enhanced by establishing standardized levels of insurance that vary in terms of their costs and anticipated levels of efficacy of care. By choosing a level of care for which they are willing to pay, consumers could be provided with adequate disclosure about material provider price and quality data. Such disclosure would allow them to confirm that they are receiving the care they expected to receive for the price they paid. This system would increase consumer satisfaction with the health care system at several different levels. Most directly, consumer demand would guide the allocation of resources.\(^{190}\) Since the provision of services would be dictated by consumer tastes and preferences, providers would no longer have the ability to overutilize or underutilize health care inputs.\(^{191}\) This system protects against overutilization by holding the provider financially liable, in most cases, for her costs of care in excess of the reimbursement rate she is to receive from the insurer.\(^{192}\) Not limited to overutilization of the provider's services alone, this system discourages the provider from causing the services of other providers to be overutilized. This system would mandate that the provider aggregate price and quality information with respect to the services administered by all other providers to her patients where she has

\(^{190}\) See supra Part I.A (stating that demand-driven allocation of services is a benefit derived from a well-functioning market).

\(^{191}\) See supra Part II (describing how the health care system has vacillated between these two extremes).

\(^{192}\) See RODWIN, supra note 6, at 15 (discussing the incentives created by a DRG system); see also supra Part III.A (suggesting the implementation of this payment system); supra note 147 and accompanying text (noting that overutilization has been a problem confronting the health care industry).
referred her patients to these providers. Because patients would refrain from using the services of a provider whose aggregated outcomes demonstrated low quality or high prices, this disclosure would act as a prophylactic against practices like accepting kickbacks or making self-referrals. This system would also protect against underutilization because providers would not try to minimize the amount of services they provide at a given reimbursement rate where such restraint would lead to lower quality results subject to disclosure. Further, unlike providers presently working in managed care environments, providers under this system, would not have an incentive to overcompensate for any uncertainty in receiving reimbursement for their services by unduly limiting the range of services they provide to patients. Rather, they would have complete access to all relevant reimbursement information relating to the patient.

This system would have a particularly salutary effect on new, unproven technology. While allowing technological advances to penetrate into the system, such advances would initially be financed only by those health care enrollees willing to

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193 See supra note 158 and accompanying text (suggesting this mechanism for enhancing disclosure).

194 See supra note 146 and accompanying text (noting that these practices adversely affect the present health care system); see also 42 U.S.C. § 1320a-7b (1994 & Supp. III 1997) (prohibiting kickbacks in Medicaid and Medicare payments); 42 U.S.C. § 1395nn (1994) (prohibiting physicians from referring to those with whom they have a financial relationship).

195 See supra Part IV.B (mandating disclosure of this information under the proposed choice-based system).

196 The uncertainty involved in receipt of payment arises due to MCO utilization review practices. See supra note 51 and accompanying text (noting that HMO's use utilization review to contain costs by denying payment for services deemed medically unnecessary). Though provider reimbursements are subject to utilization review, providers often are not privy to the methodology used in making utilization review decisions. See External Appeal of UR Decisions Seems Headed for Enactment in Virginia, 4 Health L. Rep. (BNA) 227 (Feb. 16, 1995), available in WESTLAW, 4 BHLR 7 d3 (stating that companies using utilization review regard their criteria as proprietary and often do not share it even with physicians). Thus, besides the direct cost containment effect that comes from denial of payments for services the MCO deems unnecessary, utilization review also has an indirect effect of incentivizing providers to avoid providing services where reimbursement is not certain.

197 See supra Part III.A (suggesting that there be standardized reimbursement rates dependent upon the level of care chosen by the patient and upon the DRG of the patient as determined at the time of treatment).
pay for unproven, experimental treatment regimens. Over time, access would increase to those high-tech practices that prove to be both efficacious and cost efficient. By controlling the allocation of resources in this way, health care consumers could be certain that their health care system would always respond to their continuing needs and wishes.

In addition to preventing the use of resources other than in accordance with consumer dictates, this choice-based system would ensure that resources of little or no value would not be used at all. Under this system, independent physician boards would determine what practices are considered appropriate to achieve the expected level of efficacy at each reimbursement level for each DRG. As a practitioner would have access to this information, she would have an incentive to conform her administration of care to these established practices unless she had good reason to believe an alternative course would achieve better results for the same or less cost. Thus, practices of little or no value would be avoided. Similarly, practitioners whose charges were not justified by their results would find that their services were not in demand. Prospective patients would be able to compare price and quality results of different providers and would avoid those of little value. These providers would either im-

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198 See supra notes 65-67 and accompanying text (suggesting the creation of a comprehensive reimbursement level covering all possible treatments). Although initial access to new technologies would be limited, the alternative is better than the present managed care environment, that focuses on costs to such an extent that it jeopardizes the introduction of new, beneficial technologies. See David Wessel, Health-Cost Trims Hold Inflation Down, WALL ST. J., June 30, 1997, at A1.

199 Cf. W. Michael Cox, The Low Cost of Living, WALL ST. J., Apr. 9, 1998, at A22 (noting how the cost of new technologies has decreased over time).

200 See supra text accompanying note 21 (stating that in a perfect economy, there is no wasted production).

201 See supra Part III.A (discussing the mechanics of implementing a choice-based system).

202 See id. (suggesting that a provider have access to this information but allowing for variation in practice); see also supra Part IV.B (describing how the results of these treatment sessions would be disclosed). Clinical guidelines have often been shown to be superior to a provider's individual judgment. See, e.g., J. Duncan Moore Jr., Teamwork Pays Off, MOD. HEALTHCARE, May 11, 1998, at 28, 28 (describing how one study of the use of best-practices guidelines for coronary artery bypass grafts in Pennsylvania showed results of reduced costs and improved quality).

203 See Part IV.B (describing proposed disclosure mechanisms).
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prove the quality of their care or leave the industry. Through these disincentives against implementing treatment regimens of low value, and against engaging the services of overpriced providers, a choice-based system could minimize the costs of care without sacrificing quality, thereby further maximizing consumer satisfaction with the health care system.

Not only would this system prevent the use of wasteful health care inputs, it would ensure that the inputs that were employed continued to be used with increasing efficiency. Because price and quality results would be shared with prospective patients, providers would continually strive to achieve higher quality without increasing costs. This would lead them to seek innovative treatment regimens to maximize quality at a given cost. As these treatment regimens would become the standard as incorporated by the independent physician boards in determining reimbursement rates after their efficacy had become certain, there would be a constant need to improve practices to continue to offer care of higher quality and lower cost than the standard. Thus, by implementing this choice-based system, the health care industry would continue to grow more efficient over time, and result in increasing degrees of consumer satisfaction.

Despite all the benefits that could accrue through this system, many might question whether such a system would be fair. There are many who believe that there should be some degree of equality in the provision of health care. Arguably, the differences between the present system and the system proposed herein are not as great as they might seem. Even now, the afflu-

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204 Cf. David Nather, Managed Care Debate Aimed at Public, but Close Look at Polls Shows Mixed Signals, 6 HEALTH CARE POL'Y REP. (BNA) 1095 (July 6, 1998), available in WESTLAW, 6 HCP 1095 (quoting one congressional aide as stating that disclosure requirements for health plans would put bad actors out of business).

205 See supra notes 22-24 and accompanying text (observing that innovation is encouraged in well-functioning markets).

206 See supra note 179 and accompanying text (asserting that price and quality competition would be enhanced under this proposed system).

207 Cf. Havighurst, supra note 73, at 116–17 (suggesting that society allow for competing guidelines to get the best value out of health care).

208 See supra note 74 and accompanying text (positing that there should be an exchange between practitioners in the field and the independent physician boards).

209 Cf. Rice, supra note 9, at 391 (commenting that since people are concerned about the well being of others, a redistribution mechanism would increase each person’s utility by assuaging this concern, thereby increasing market efficiency).
ent can in some cases afford to pay for medical care that others cannot buy, such as services not deemed to be medically necessary and thus not reimbursable by an insurer. To the degree that the public wishes to appease its equitable sensibilities, it can act through the political process. If, under either the present system or a choice-based system, the American people strongly wish to grant the necessary health care financing to allow unlimited access to medical resources to certain classes of individuals, such as the gravely ill, it can do so through the government. The political process can also help alleviate the problem of providing health care to the poor, both those on Medicaid and those who are presently uninsured due to an inability to pay for health insurance. Yet it is suggested that, in these instances, granting choice among different uses of the money to be distributed to this population could maximize the satisfaction these people attain in purchasing health care. Similar to what has been proposed for Medicare, vouchers could be distributed for whatever amount is deemed equitable by the American public. These vouchers could be used for some combination of health insurance, MSAs, and cash. Irrespective of how any such redistributive mechanisms are to operate, their success could be enhanced by their implementation in a system that has already maximized public benefit through the fostering of price and quality choices. That is, before any equitable redistribution occurs, it is better first to maximize the wealth within the system, thereby increasing the size of the wealth of each party entitled to a share of it after any subsequent reallocation. In this way,

210 See Albert R. Hunt, Public is Split on How to Pay for Access, WALL ST. J., June 25, 1998, at A10 (noting that one survey found that at least two-thirds of all individuals are in favor of the government’s guaranteeing access to the best health care technology available).

211 See id. (finding that the results of one survey indicate overwhelming support for the notion that everyone should have access to health care).

212 See Enthoven & Singer, supra note 10, at 28 (asserting that a voucher system would be necessary to achieve universal or near-universal coverage).

213 See supra Part III.B (discussing this possibility within the context of Medicare). Some might argue that it is unrealistic to expect individuals facing economic hardship to use the vouchers for any other purpose than to redeem them for cash. Though counter to the principles inherent in a choice-based system, the cash redemption option could be eliminated to guarantee that the vouchers were used for medical purposes only, making the proposal more politically acceptable.
the political process could benefit from the efficiencies created by a choice-based system.

Not limited to addressing questions of equity, the political system would also need to champion many of the mechanisms geared toward improving efficiency discussed in this Article before they could be applied to the health care industry. In considering whether to act upon the choice-based suggestions contained herein, legislators would need to evaluate the impact of these suggestions on different actors within the health care industry, many of whom are heavily involved in lobbying activities. MCO's would fear that a choice-based system would eliminate their role entirely. Their success has largely been driven by their ability to convince employers that they can keep costs down by reducing the provision of supposedly unnecessary care, and by negotiating favorable rates with providers. Although MCO's would no longer carry out these functions under this choice-based system, they could continue to profit from their expertise in cost management. Under the new system, MCO's could offer to sell providers guidelines that surpass the ones promulgated by the independent physician boards in delivering high quality care at low costs. Thus, the most desirable attribute of MCO's could continue even under the new system.

Providers would not likely be unified in their reaction to any choice-based system. Those who know they provide high quality, low cost services would clearly be in favor of legislation that would lead to their ability to publicize their superiority. Providers who are less certain about where they stand relative to their

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214 See POLINSKY, supra note 11, at 9 (asserting that, where income can be costlessly redistributed, it is better to maximize efficiency before engaging in any redistribution of wealth).

215 See, e.g., Eric Weissenstein, Donations Heating Up, MOD. HEALTHCARE, July 13, 1998 at 33, 33 (observing that in the first half of 1998, over $4 million was contributed to political candidates by various health care provider associations and by associations representing insurers).

216 See Anders & Winslow, supra note 2, at A8 (stating that the financial problems of HMO's can be linked, in part, to their restriction of consumers' choices).

217 See supra Part IIIA (describing how MCO's would no longer need to fill these roles in a choice-based system).

218 See Havighurst, supra note 73, at 88 (explaining the benefits of using competing guidelines).

219 See Anders & Winslow, supra note 2, at A1 (noting that MCO's had broad support when they appeared to be capable of lowering costs while improving quality).
competition would be less supportive of any legislation in this area. It is, however, possible to garner the support of the entire provider community for this legislation by highlighting that it would largely remove the influences of MCO’s and employers in the provision of care—issues that have proved important for providers.220

Though employers face a diminished role in the health care system, it is unlikely they would oppose any advances towards a choice-based system. Employers would immediately achieve savings in the area of human resources, and they would experience permanent relief from further assaults to their bottom lines due to rising health care costs. Furthermore, while employers may remain indifferent, labor unions would likely launch strong criticism against any choice-based system. They have fought hard for control over health benefits, and thus would not easily accept a return to full taxability of these benefits.221 Their concerns could, however, be deflated by enacting the choice-based system in a tax neutral fashion such that taxpayers would be compensated for the taxes levied on health care benefits by receiving a comparable reduction in overall income taxes. In this way, the proposed system could deflect criticism from both the unions and the workers they represent.

Since the operations of DHHS would also undergo change, it is conceivable that it too would attempt to block the enactment of legislation resulting in choice-based health care. Although it would no longer need to set provider Medicare rates or enforce laws preventing overutilization of medical services provided under government programs,222 it would find that its power base was significantly increased by its authority over provider disclosures of price and quality data.223 Unlike the regulation of Medicare and Medicaid, the regulation of disclosure documents con-

220 See Anders & Winslow, supra note 2, at A8 (reporting that the AMA has encouraged its members to contact legislators about MCO abuses); AMA Pushes Expanded Health Plan Choice, BUS. & HEALTH, July 1998, at 10, 10 (stating that the AMA has expressed its support of tax parity for individuals who purchase health care outside of the employment setting to discourage employer interference in the provision of health care).

221 See STARR, supra note 31, at 310-20 (describing the rise of unions to a position of prominence in the health care arena).

222 See supra Parts III.B, IV.C (suggesting these changes).

223 See Part IV.C (proposing that the DHHS OIG receive SEC-like authority).
templated herein would include disclosure statements relating to the care provided to all patients. This would broaden DHHS's authority to cover, for the first time, the provision of health care services to the entire American public. Whereas all of these parties would experience mixed fortunes from a choice-based system, only consumers would experience an unqualified, significant benefit from this system. Consumers, however, are also the least organized group in terms of political power. To truly succeed at effecting change, consumer dissatisfaction must be channeled through consumer action groups. These groups must strongly voice their concerns over the lack of ability of consumers to make informed choices with respect to their health care. Since, to some extent, consumer voices are beginning to be heard, the changes proposed in this Article should serve as a basis for ensuing discussions relating to the next logical step in the evolution of the health care industry.

224 On the federal level, this system would offer benefits not attainable by enacting similar changes at the state level. Cf. Enthoven & Singer, supra note 10, at 32 (suggesting that a national policy dealing with managed care would promote regulatory coherence and internal consistency).

225 See RODWIN, supra note 6, at 247 (observing that organized advocacy has often played an instrumental role in affecting desired changes).