Consumer Protection in a Managed Care World: Should Consumers Call 911

David A. Hyman
CONSUMER PROTECTION IN A MANAGED CARE WORLD: SHOULD CONSUMERS CALL 911?

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"In some ways, it's less frustrating for us to take care of homeless people than H.M.O. members. At least, we can do what we think is right for them, as opposed to trying to convince an H.M.O. over the phone of what's the right thing to do."1

I. Introduction

Once upon a time, managed care was popular. Admittedly, writings that begin with the words "once upon a time" are usually classified as fairy tales.2 Until quite recently, however, managed care actually was popular.3 Things change; in the last three years, the reputation of managed

* Associate Professor, University of Maryland School of Law. In commenting on an earlier article, William Frazier, Associate General Counsel of Rush-Prudential Health Plans, suggested that false burglar alarms presented an interesting model for the issues created by regulating access to emergency care. The expansion of his suggestion into a full-blown narrative was my own doing. Bill Brewbaker provided helpful comments. As always, all errors of commission or omission are mine alone.


2. But see Jeffrey S. Kinsler, Politically Incorrect, 48 SMU L. REV. 411, 411 n.2 (1995) (noting that phrase "fairy tales" is politically incorrect because it reflects heterosexual bias; "bedtime stories" is politically correct terminology).

3. To be sure, if the number of Americans enrolled in managed care organizations (MCOs) is any indication, managed care remains extraordinarily popular. See Karen Davis & Cathy Schoen, Managed Care, Choice, and Patient Satisfaction (visited Mar. 1, 1998) [http://www.cmwf.org/health_care/satis.html] ("Based on preliminary data from the 1997 Kaiser/Commonwealth National Health Insurance Survey . . . Managed care plans dominate employment-based coverage. Altogether, 71 percent of employed, insured working families under age 65 are in managed care plans."). Another set of commentators noted that [t]his year, for the first time, managed care attracted the majority of Americans. More sign up every day. Managed care now provides coverage for 77 percent of Americans and their dependents who are insured through their employers according to Mercer/Foster Higgins employer survey data. In addition, 80,000 elderly Americans each month are switching to Medicare HMOs, largely because of the cost savings they offer.

Susan Brink & Nancy Shute, Are HMOs the Right Prescription?, U.S. NEWS & WORLD REP., Oct. 13, 1997, at 60. Managed care executives also trumpet the results of their consumer surveys, which invariably reflect high levels of satisfaction among their enrollees. See Michael E. Herbert, A For-Profit Health Plan's Experience and Strategy, 17 HEALTH AFF. 121, 121 (1997) (noting that "sophisticated patient satisfaction surveys indicate that . . . the overwhelming majority of members are satis-

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care has been severely tarnished by a rising chorus of complaints.\(^4\)

Public hostility to managed care was intensified by the efforts of the modern equivalents of the Four Horsemen of the Apocalypse: the media, academics, lawyers and legislators.\(^5\) The media provided hundreds of anecdotes about the misdeeds of managed care and editorials bemoaning the changes in the medical marketplace.\(^6\) Academics produced a host of anecdotes with the quality of care they are receiving in HMOs\(^\)\). The general assessment of managed care is considerably less favorable.

4. See Louise Kertesz, Backlash Continues: Survey Finds Managed Care Is Still the Bad Guy in Many Americans' Eyes, MOD. HEALTHCARE, Nov. 10, 1997, at 33 ("People seem to generalize from anecdotal reports in the news about problems with managed care. When asked about specific examples taken from news stories about the problems some people have reported with managed care, the public's perception is that these are fairly common occurrences."); Maggie Mahar, Time for a Checkup, BARRON'S, Mar. 4, 1996, at 29, 30 ("As if smelling blood in the water, newspapers and magazines have turned from cheerful if boring tales of HMO's ability to contain costs to horror stories about patients who requested a particular procedure, were turned down by HMO administrators, and subsequently died.").

One commentator observed that

[p]ractically everybody covered by a managed-care health insurance plan has some story about a suffered indignity, petty or grand, foisted on him or her by a callous or ignorant health insurer. ... Even if one's annoyance is trivial, it makes a person inclined to nod one's head vigorously when hearing about the major-league horrors HMOs are alleged to inflict on helpless citizens. And one hears it a lot these days. Over the past several months, we have had newsmagazine covers and presidential pronouncements replete with anecdotal horror stories about treatments denied and 'gag rules' imposed by HMOs on their physicians to keep patients in the dark about the best treatment available to them.... In the time-honored journalistic tradition of championing the average guy against the rapacious big-money interests, it has become a mainstay for news editors to order stories on outrages among HMOs. Reading the stories and hearing the speeches, it is easy to believe that HMOs are all run by greedy and rapacious sadists concerned more about squeezing out an extra dollar of profit than providing basic aid and comfort to afflicted policyholders. And lots of distinguished people, including not just politicians but also physicians and hospital administrators, are saying just that.

Norman Ornstein, HMO's Rightful Credo: No Pain, No Gain, USA TODAY, Mar. 24, 1997, at 15A.

5. But see Revelations 6:1-4 (noting that Four Horsemen of Apocalypse are Conquest, War, Famine and Death).

articles about the perils of managed care. Lawyers filed claims seeking staggering sums for cost-cutting behavior that they found overly aggressive, and at least some juries agreed with them. Finally, legislators and regulators proposed and enacted a wide array of so-called "consumer protections."

Television has also exploited the dramatic potential of managed care. See Burkhard Bilger, TV's Powerful Doctor Shows vs. the H.M.O., N.Y. TIMES, Dec. 22, 1996, at H41 (noting that television dramas use MCOs to "play the same role that Russians and Arabs used to play in movies: dark forces against which the forces of light must battle."); Barbara D. Phillips, He's No Giuliani, WALL ST. J., Oct. 6, 1997, at A20 ("The big HMO and its employees are depicted as greedy at best, evil at worst—white-collar gangsters deserving of whatever federal threats and punishments can be brought to bear.").


8. See David Leon Moore, Ethics Pinched by the System, Lawyer Says, USA TODAY, Jan. 22, 1996, at D1 (noting that California jury awarded $89 million, including $77 million in punitive damages for denial of coverage of bone marrow transplant for advanced breast cancer); Roger Parloff, The HMO Foes, Am. Law., July-Aug. 1996, at 80 (noting that some patients have won lawsuits against HMOs for their refusal to pay for costly lifesaving treatments); see also Barry R. Furrow, Managed Care Organizations and Patient Injury: Rethinking Liability, 31 GEORGIA L. REV. 419, 425 (1997) (arguing that judicious use of tort litigation can improve the quality of managed care); Harvey S. Wachsmant, Letter to Editor, Reforms Must Target HMOs and Their CEOs, WALL ST. J., Nov. 7, 1997, at A19 ("The one [consumer] reform that would truly make a difference would be to hold managed-care companies and their executives accountable when their actions and policies destroy people's lives."); Ellen Wertheimer, Ockham's Scalpel: A Return to a Reasonableness Standard, 43 VILL. L. Rev. 321 (1998) (arguing that there is nothing with managed care that passel of plaintiff's lawyers cannot fix).

9. See Thomas Bodenheimer, The HMO Backlash—Righteous or Reactionary?, 335 New Eng. J. Med. 1601, 1601 (1996) ("In 1996 alone, 1000 pieces of legislation attempting to regulate or weaken HMOs were introduced in state legislatures, and 56 laws were passed in 35 states."); Fred J. Hellinger, The Expanding Scope of State Legislation, 276 JAMA 1065, 1066 (1996) (noting growing enthusiasm for regulation of managed care); Jerome P. Kassirer, Managing Managed Care's Tarnished Image, 337 New Eng. J. Med. 338, 338 (1997) ("[A]lthough a few thousand bills to control health-plan practices have been introduced in 39 states, approximately 100 of these laws have been introduced in Congress."); Tracy E. Miller, Managed Care Regulation: In the Laboratory of the States, 278 JAMA 1102, 1102 (1997) (describing state regulatory initiatives); Marc A. Rodwin, 32 Hous. L. Rev. 1319, 1335-44 (1996) (describing recent proposals to protect consumers from managed care); Marilyn Werber Serafini, Reining in the HMOs, Nat'l J., Oct. 26, 1996, at 2280 (describing state legislative initiatives against managed care); see also Brink & Shute, supra note 3, at 60 ("This year states passed a record 182 laws on managed care, up from 100 in
The conventional wisdom is that each of these developments has its place in ensuring the protection of those enrolled in managed care plans. This Article argues that at least when it comes to legislation, consumer protection is at best an incidental (and at worst a highly unlikely) by-product of much of this effort. Designing effective consumer protections is difficult under the best of circumstances (readily identifiable villains, problems soluble through straightforward structural responses that create minimal collateral consequences and monitoring expenses, and ample funds for enforcement). Unfortunately, the circumstances under which managed care is regulated are far from this ideal. Predictably enough, many of the resulting consumer protection laws either induce worse distortions than the problems they purport to solve or the “reforms” have been hijacked to serve the economic interests of the health care providers who were losing market share, autonomy and income to managed care. Even if these efforts actually protected consumers, there are no free lunches. The costs are reflected either in increased premi-


10. Whether the efforts of the media, academics and tort lawyers have had a net beneficial impact is beyond the scope of this Article.

11. See William Safire, *On Language; Words out in the Cold*, *N.Y. Times*, Feb. 14, 1998, at 6:14 (tracing origin of phrase “there ain’t no such thing as a free lunch”). The phrase and the corresponding acronym (“TANSTAAFL”) originated in the
ums or decreased access to other medical services, and ex ante, it is unlikely that consumers actually desire that result.

Part II surveys the complaints that have been made about managed care. Part III provides a brief overview of the consumer protections that have been proposed or enacted in the last few years. Part IV focuses on a particularly benign-sounding "consumer protection," which seeks to ensure access to emergency medical services for those enrolled in managed care, in order to make plain the implications, trade-offs and potential for rent-seeking associated with such legislation. Part V provides a narrative perspective on the issues. Parts VI and VII summarize the implications of the analysis and offer some conclusions.

II. COMPLAINTS ABOUT MANAGED CARE

In a relatively short time, managed care has captured an impressive share of the U.S. health care market. The basic premise of managed care is that high quality health care can be delivered at reasonable cost by coordinating the behavior of providers or insurers and patients. The conventional formulation is that managed care is cheaper and better than fee-for-service medicine because it reduces the incidence of wasteful and inap

19th century, but was popularized by economist Milton Friedman, who published a book with that title in 1975. Id. In 1977, Friedman told members of the Knesset Finance Committee in Jerusalem: "There is no such thing as a free lunch. That is the sum of my economic theory. The rest is elaboration." Richard Lederer, On Language: Hunted Words, N.Y. Times, Sept. 3, 1989, at 6:14.

The best known corollary to the "no free lunch" rule was provided by a one-time colleague of Friedman, George Stigler: "There may be no such thing as a free lunch, but there are a lot of people eating them." An equally pointed observation, commonly attributed to Thomas Sowell, is that "although there may be no such thing as a free lunch, that doesn't keep politicians from sending out engraved invitations."

12. For a discussion of the varied complaints which have been made about managed care, see infra notes 17-31 and accompanying text.

13. For a discussion of state and federal legislation created in response to complaints about managed care, see infra notes 32-56 and accompanying text.

14. For a discussion of a case study of consumer protection, see infra notes 57-127 and accompanying text.

15. For a discussion of managed care issues from a narrative context, see infra notes 128-134 and accompanying text.

16. For a discussion of the implications of consumer protection for the cost and quality of health care, see infra notes 135-52 and accompanying text. For the conclusion of this Article, see infra notes 153-78 and accompanying text.

propriate care, lowers the risk of iatrogenic harm, emphasizes preventative care and healthy living and integrates the confusing world of health care into a seamless web of services. Each managed care organization (MCO) uses its own mix of carrots and sticks to accomplish these objectives, including required pre-authorization, restricted access to specialists, panels of authorized providers, higher copayments (and sometimes denial of coverage) for out-of-network care, capitation, bonuses, practice guidelines, retrospective denials of coverage, restricted formularies and limitations on benefits. In global terms, MCOs offer a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles and copayments than traditional indemnity insurance.

Despite the pleasant picture suggested by the preceding paragraph, complaints about managed care have become legion. The general assessment was summed up nicely by an irate patient: "[T]he H.M.O. said I wouldn't have bills, and that's great, but what I do have instead is tsoris." Specific complaints vary considerably, depending on who is asked. Those who have sought assistance for psychiatric problems and substance abuse complain that MCOs emphasize short-term treatment and shred patient confidentiality. Women complain about restricted access to gynecologists, "drive-through" deliveries and "drive-through" mastectomies. Patients with difficult illnesses fight new H.M.O.'s to get help.


21. See David A. Hyman, Drive-Thru Deliveries: Is Consumer Protection Just What
tients who require specialized care or ongoing treatment for chronic illnesses complain about the knowledge and ability of the MCOs' specialists and restricted access to expensive medications. People requiring cutting-edge treatments complain that MCOs refuse to authorize reimbursement. Advocates for the poor complain that MCOs are not truly committed to providing care to such patients. People opposed to euth-

22. Milt Freudenheim, Many H.M.O.'s Easing Rules On Seeking Specialists' Care, N.Y. TIMES, Feb. 2, 1997, at A1 (“They are known as gatekeepers, and they are what many Americans dislike most about their health maintenance organizations. They are the primary-care doctors who must say yes before a patient can see a specialist.”); Robert Pear, Expense Means Many Can’t Get Drugs for AIDS, N.Y. TIMES, Feb. 16, 1997, at A1 (“Even though new drugs show great promise in combating AIDS, many patients are finding that they cannot easily get the costly medicines because of restrictions imposed by health maintenance organizations . . . . Some H.M.O.’s say they limit pharmacy benefits to a specified amount . . . [which] is far less than the cost of the drug combinations often recommended by doctors.”); Elisabeth Rosenthal, Managed Care Has Trouble Treating AIDS, Patients Say, N.Y. TIMES, Jan. 15, 1996, at A1 (chronicling AIDS patients' complaints about managed care); Diana K. Sugg, Hopkins to Offer HMO for AIDS; Program, Among First in Nation, Aims to Pair Efficiency and Quality, BALTIMORE SUN, Jan. 17, 1996, at B1 (“People with AIDS typically dislike managed care. Patients and advocacy groups complain of primary care physicians unaware of the latest findings and fumbling through treatment.”).


24. See, e.g., Anna-Katrina S. Christakis, Comment, Emergency Room Gatekeeping: A New Twist on Patient Dumping, 1997 Wis. L. Rev. 295, 319-20 (noting bureaucratic managed care approach can alienate poor patients); David R. Olmos, A Medi-Cal Matter; HMOs Are Aggressively Trying to Sign Up the Indigent; Critics Worry That Oversight of Recruitment Tactics May Be Inadequate, L.A. TIMES, July 21, 1996, at D1
nasia or physician-assisted suicide complain that MCOs will put pressure on doctors to kill their patients. 25

Health care providers have their own complaints. Clinicians complain about the loss of income and professional autonomy, slow payment, and "gag clauses," which keep them from telling their patients about quality issues and available (but uncovered) treatments. 26 Academic health

(“When a big HMO wanted to sponsor health fairs at a Boyle Heights elementary school, educators faced a quandary. Was the private company, Foundation Health, sincerely interested in improving the health of poor children and their families? Or was it just trying to drum up business?”); see also Note, The Impact of Managed Care on Doctors Who Serve Poor and Minority Patients, 108 Harv. L. Rev. 1625, 1625-26 (1995) (arguing managed care will undermine safety-net institutions that have traditionally provided care to the poor and uninsured).

25. See, e.g., John R. Corboy, Correspondence, 336 New. Eng. J. Med. 439, 439 (“How will the managed-care physician, whose income depends on lowering the costs of medical care, react when a patient who is depressed and seriously ill, but maybe not terminally so, asks for help with suicide? Will the physician be able to resist the lure of the enhanced income that accompanies the hastened death of the patient?”); Leon R. Kass & Nelson Lund, Physician-Assisted Suicide, Medical Ethics, and the Future of the Medical Profession, 35 Duq. L. Rev. 395, 406 (1996) (“In this new medico-economic climate, with for-profit hospital corporations and HMOs, the removal of the ban against physician-assisted suicide becomes even more dangerous: a quick death will often be the most cost-effective ‘therapeutic option’ and will therefore be ever more frequently employed . . . .”); Susan M. Wolf, Physician-Assisted Suicide in the Context of Managed Care, 35 Duq. L. Rev. 455, 479 (1996) (arguing that enthusiasts of physician-assisted suicide do not understand context in which treatment takes place and stating that “[t]o ignore the problems posed by the growing prevalence of managed care is a mistake. In the name of supposed individual rights, it blesses a practice of assisted suicide driven by financial incentives and the needs of health care organizations.”).

Even those who are keen on physician-assisted suicide recognize the problem. See George J. Annas, Correspondence, 336 New Eng. J. Med. 441, 441 (1997) (“Since assisted suicide will always be the cheapest ‘treatment,’ and since it will cure literally every disease, declaring it a constitutional right could make promoting it as a new choice irresistible to those for-profit managed care companies that are more dedicated to enhancing their bottom lines than caring for their patients.”).

center administrators and researchers complain that America’s future physicians cannot be trained and clinical research cannot be conducted on the amounts MCOs are paying for inpatient care.27 Hospitals, nurses and independent pharmacists complain about their tenuous position in the newly competitive health care marketplace.28 Everyone complains about the administrative and marketing overhead, the appeals process and the excessive profits of MCOs.29 Guidance on “managing” managed care is now available from a wide variety of sources.30 Even judicial opinions have

laws of supply and demand and that market will solve problems).

27. See John K. Iglehart, Health Policy Report: Rapid Changes for Academic Medical Centers, 331 NEW ENG. J. MED. 1391, 1393-94 (1994) (describing adverse consequences for academic medical centers as a result of growth of managed care); Jerome P. Kassirer, Academic Medical Centers Under Siege, 331 NEW ENG. J. MED. 1370, 1371 (1994) (same); Joan Beck, Medical Research Succumbing to Managed Care, BALTIMORE SUN, July 24, 1997, at 15A (describing faltering clinical research as result of managed care); Ron Winslow, Heart Research Hurt by Funding Cuts, Managed Care Growth, Scientists Say, WALL ST. J., July 15, 1996, at B4 (arguing that growth of managed care and lack of public financing for research and teaching has resulted in less research and consolidation of health care system).

28. Peter Buerhaus & Douglas Staiger, Managed Care and the Nurse Workforce, 276 JAMA 1487, 1487 (1996) (discussing widely held perception that spread of managed care has caused increase in nurse workloads, decrease in credentials of those providing care and overall decline in quality of patient care); Esther B. Fein, Cost-Cutting by Hospitals to Accelerate, N.Y. TIMES, July 3, 1996, at B1 (noting that hospitals are restructuring their operations in response to low levels of reimbursement); Abby Goodnough, Small Pharmacies Squeezed by the Health Care Revolution, N.Y. TIMES, Jan. 28, 1996, at 15N]6 (noting that small pharmacies are squeezed by MCOs and drug companies); Julie Miller, Pharmacies in A Struggle for Survival, N.Y. TIMES, Dec. 5, 1995, at 13CNI (same); Elisabeth Rosenthal, Once in Big Demand, Nurses Are Target for Hospital Cuts, N.Y. TIMES, Aug. 19, 1996, at B1 (describing how hospitals are firing nurses in response to low reimbursement from MCOs and nurses’ complaints about effect of such practices on quality of care).

29. See Philip M. Nudelman & Linda M. Andrews, The “Value Added” of Not-for-Profit Health Plans, 334 NEW ENG. J. MED. 1057, 1058 (1996) (criticizing for-profit HMOs for spending 20%-30% on administration, marketing and dividends, leaving much less to be spent on health care needs of community); Church, supra note 9, at 33-35 (cataloguing complaints); Ron Winslow, HMO Juggernaut: U.S. Healthcare Costs, Grows Rapidly and Irks Some Doctors, WALL ST. J., Sept. 6, 1994, at A1 (noting that president of U.S. Healthcare made $21.2 million while doctors are being squeezed). But see Malik M. Hasen, Let’s End the Nonprofit Charade, 334 NEW ENG. J. MED. 1055, 1055 (1996) (arguing that critics of for-profit health care are all wet); David A. Hyman, The Comundrum of Charitability: Reassessing Tax Exemption for Hospitals, 15 AM. J. L. & MED. 327, 357-80 (1990) [hereinafter Hyman, Comundrum of Charitability] (reviewing arguments for and against nonprofit hospitals); David A. Hyman, Hospital Conversions: Fact Fantasy and Regulatory Follies, 23 J. CORP. L. (forthcoming 1998) (manuscript at 4-11, on file with author) (noting that argument that nonprofit hospitals are especially virtuous is problematic at best); David J. Fine, Adam Smith, George Orwell, and the Contemporary Hospital, 12 FRONTIERS HEALTH SERV. MGMT. 43, 44 (1996) (“The management and governance values necessary for success in the managed care-oriented marketplace produce a trend line that is bringing the critical success factors of tax-paying and tax-exempt institutions closer together. They may well soon be indistinguishable.”).

30. See, e.g., Karen Cheney, How to Be a Managed Care Winner, MONEY, July 1997, at 122 (collecting advice on how to deal with managed care plans); Tessa
taken note of the changes in the medical marketplace.  

III. THE CONSUMER PROTECTION RESPONSE TO MANAGED CARE

Although some MCOs recognized that there was public dissatisfaction with their operations, they proved remarkably ineffective in defending their policies and procedures. Among other strategies, MCOs responded with denials that the specified conduct was occurring, surveys indicating high levels of satisfaction among their customers, defenses of certain practices, and for some issues, grudging capitulation. After several losses in the public relations war, the managed care trade organization announced the adoption of nonbinding guidelines intended to

DeCarlo, Making Managed Care Work for You, GLAMOUR, Sept. 1996, at 286 (same); Michael S. Z. Gurland & Eugene R. Anderson, How to Make Your H.M.O. Blink, N.Y. TIMES, Aug. 17, 1997, at 3:15 (same); Perri Klass, Managing Managed Care, N.Y. TIMES, Oct. 5, 1997, at 6:72 (cataloguing suggestions for improving managed care); see also Vikram Khanna, Managed Care Made Easy: Survival in the HMO Era (1997) (“Managed Care Made Easy will help you understand and deal with all the angles in managed care, from restrictions on the kinds of prescription drugs you can use, to the limited lists of doctors and hospitals you can choose from.”).

31. See, e.g., Blue Cross & Blue Shield of Wisconsin v. Marshfield Clinic, 265 F.3d 1406, 1410 (7th Cir. 1994) (“From a short-term financial standpoint the HMO’s incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and as cheaply as possible.”); Federal Trade Commission v. Butterworth, 946 F. Supp. 1285, 1302 (D. Mich. 1996), aff’d without written opinion, 121 F.3d 708 (6th Cir. 1997) (“In the real world, hospitals are in the business of saving lives, and managed care organizations are in the business of saving dollars.”).

32. See Kassirer, supra note 9, at 338. Dr. Kassirer has noted a range of responses by managed care organizations:

Some in the managed-care industry have blamed their bad reputation on their own failings: they say that they have not tried hard enough to explain how they add value, that they have not been aggressive enough in responding to criticism, and that they have not taken time to talk to local reporters. Some have blamed the press, claiming that journalists are confused about the differences between HMOs, hospitals, and physician groups and that they are not interested in writing about managed care’s success. Some even claim there has been an organized effort by other health care players to attack managed care. Still others would have us believe that their image problem is only semantic.

Id.

33. See, e.g., Laura Johannes, Managed-Care Group Softens View on Hospital Stays After Mastectomies, WALL ST. J., Nov. 14, 1996 at B6 (noting that MCO trade organization adopted policy urging its members not to deny hospital stays following mastectomies; new policy “aimed at defusing rising criticism of health maintenance organizations that have been making unpopular coverage decisions in their efforts to control costs”); Johannes, supra note 21, at B8 (noting that MCO reversed outpatient mastectomy policy “largely in recognition of the ‘emotional issues’ involved in the surgery. ‘Some battles just aren’t worth fighting.’”); David R. Olmos & Shari Roan, HMO “Gag Clauses” on Doctors Spur Protest, L.A. TIMES, April 14, 1996, at A1 (noting that MCOs denied that there was any such thing as a gag clause, but “some major health plans have scrambled to remove the controversial language from physician contracts.”).
ensure that MCOs were “putting patients first.”  

Legislators have rushed to respond to the complaints outlined above. A deluge of bills, laws and regulations resulted. The “motherhood and apple pie” nature of such legislation is neatly demonstrated by the titles of a number of these initiatives; who could in good conscience oppose the Hippocratic Oath and Patient Protection Act, the Health Insurance Bill of Rights Act, the Patient Right to Know Act or the Patient Access to Responsible Care Act? The desire to “do something” about the excesses of managed care is bipartisan; even conservative Republicans are “castigating private enterprise in tones that would make Ralph Nader proud.”

34. See American Ass'n of Health Plans, Putting Patients First (visited Mar. 1, 1998) <http://www.aahp.org/services/_initiatives/patients_first/putting_patients_first.htm> (discussing “Putting Patients First, [which is] a comprehensive, long-term initiative . . . designed to improve communication with patients and physicians and streamline administrative procedures”); Ron Winslow, Medicine: Managed Care Acts to Mollify Clients, Doctors, WALL ST. J., Dec. 17, 1996, at B1 (discussing MCOs’ strategy). For a more extensive description of the philosophy behind the “Putting Patients First” initiative, along with a variety of more and less skeptical responses, see Bruce E. Bradley, Putting Patients First Helps Business, 16 HEALTH AFF. 121, 121 (1997) (arguing AAHP initiative is good business); Clark C. Havighurst, “Putting Patients First: Promise or Smoke Screen?,” 16 HEALTH AFF. 123, 123 (1997) (criticizing AAHP initiative because it precludes coverage diversity and increases cost of coverage); William F. Jessee, Reed V. Tuckson & Linda L. Emanuel, Going Beyond a “Philosophy of Care,” 16 HEALTH AFF. 126, 126 (1997) (noting alternative strategies for improving quality of health care); David A. Jones, Putting Patients First: A Philosophy in Practice, 16 HEALTH AFF. 115, 115 (1997) (describing AAHP initiative); Peter V. Lee, The True Test of Whether Health Plans Put Patients First, 16 HEALTH AFF. 129, 129 (1997) (criticizing AAHP initiative for ignoring main problems with managed care); see also Kassirer, supra note 9, at 338 (“Putting Patients First may be a laudable start at setting industry norms, but the paucity of clear, strong standards and the absence of rigorous enforcement methods leave one with the impression that the emphasis on patient protection is not entirely sincere.”).

35. See Robert Pear, Three Big Health Plans Join in Call for National Standards, N.Y. TIMES, Sept. 25, 1997, at A1 (“Three big health maintenance organizations joined two consumer groups today in calling for more regulation of managed health care, saying all health plans should be subject to ‘legally enforceable national standards.’”).

36. For a discussion of the range of proposed and enacted legislation, see supra note 9 and accompanying text.


41. See Romesh Ratnesar, Bad Medicine, NEW REPUBLIC July 7, 1997, at 10 (“Something was strange about this Capitol Hill press conference. Here were Republican Senator Alfonse D’Amato and Republican Congressman Charlie Norwood introducing ‘The Patient Access to Responsible Care Act,’ and castigating private enterprise in tones that would make Ralph Nader proud.”); see also Freudenheim, Baby Boomers, supra note 9, at C2 (“Senators and Congressmen in both parties are backing federal laws, including a proposal that would make it
In short order, a clear majority of the states adopted some version of consumer protection legislation. Ballot initiatives in California and Oregon that would have placed significant restrictions on managed care were defeated in 1996. The National Association of Insurance Commission-

[Text continues with references and analysis of state legislation and ERISA preemption issues.]
ers has developed model legislation for regulating MCOs. The states remain a hotbed of consumer protection regulation and legislation. Congress and the executive branch of the federal government have been busy in the area as well. The President’s Advisory Commission on Consumer Protection and Quality in the Health Care System (“President’s Commission”) has just completed drafting a “bill of rights” for patients, which President Clinton has enthusiastically endorsed.

44. See NAIC Adopts Model Laws on Quality, Credentialing, MANAGED CARE WK., June 10, 1996 (outlining NAIC’s model legislation). For a more general perspective on the NAIC’s role, see Iglehart, supra note 42, at 36.

45. For a discussion of consumer protection legislation, see supra note 9 and accompanying text.


At least one important group (congressional staffers) are convinced that such legislation is urgently required. See Congress Feels Pressure Mounting for Managed Care Reform (visited Mar. 1, 1998) <http://home.patientaccess.com/pac/wirthlin.html> (reporting survey of congressional staffers finding overwhelming support for federal regulation of managed care). The executive branch is of like mind, and has proposed its own reforms. See Medicare and Medicaid Programs, Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 42 C.F.R. pt. 417, 434 (1996) (prohibiting certain incentive payments); Robert Pear, Clinton Prohibits H.M.O. Limit on Advice to Medicaid Patients, N.Y. TIMES, Feb. 21, 1997, at A22 (noting new prohibition on gag clauses); Robert Pear, U.S. Issues Rules for HMO’s in an Effort to Protect Patients, N.Y. TIMES, Mar. 27, 1996, at B8 (describing rules enacted to protect patients by restricting managed care incentives to doctors). The Health Care Financing Administration’s final regulations, which would have prohibited certain incentive payments to physicians, were withdrawn almost immediately after they were issued. See Robert Pear, U.S. Shelves Plan to Limit Rewards to H.M.O. Doctors, N.Y. TIMES, July 8, 1996, at A1.


The title of the Commission, the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry, is worthy of note because it does not reflect any acknowledgment of the economic implications of consumer protection or quality. The charter of the President’s Commission does indicate that one of its functions is to “recommend measures as may be necessary to promote and assure health care quality and value,” but the debates of the Commissioners generally excluded discussion of economic matters. Id. The Bill of Rights and Responsibilities issued by the President’s Commission also reflects in its guiding principles that “[c]osts matter,” but “[q]uality comes first.” See President’s Advisory Comm’n on Consumer Protection and Quality in the Health Care Indus., Chapter Eight: Consumer Responsibilities (visited Mar. 1, 1998) <http://www.hcqual-
A complete review of these efforts would be outdated well before this article appeared. Accordingly, this Article provides an abbreviated overview of regulatory activity in the area, but makes no attempt to be comprehensive. For analytical purposes, regulation of managed care can be usefully divided into two broad categories: provisions that affect the relationship between health care providers and MCOs ("Type I"), and provisions that affect the relationship between health care providers or insurers and patients, including the scope of covered services ("Type II").

A. Type I Legislation (Health Care Provider/MCO Nexus)

The paradigm of Type I legislation is an "any willing provider" statute. Although there are a number of variants ("freedom of choice," "mandatory admittance," "due process" and "essential community provider"), all such statutes constrain the ability of MCOs to freely enter into (and exit from) contracts with health care providers. Because selective contracting with providers is one of the core principles of managed care, such statutes are understandably viewed as antimanaged care.

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extreme versions of Type I legislation include prohibitions on "gag" and "hold-harmless" clauses, and restrictions on the use of various systems of compensation, including bonuses, hold-backs and capitation.

Although many of the states have adopted some form of Type I legislation, enthusiasm for global any willing provider provisions has waned. Due process provisions, however, remain popular, as do prohibitions on gag clauses and restrictions on the use of compensation mechanisms that create an incentive for the withholding of necessary care. At the federal level, gag clauses and inappropriate incentive mechanisms were prohibited in the Medicare managed care market, but more global legislation has been repeatedly stalled.

B. Type II (Health Care Provider or Insurer/Patient Nexus)

"Type II" legislation includes a diverse group of consumer protections, such as direct access to specialists, provider disclosure of compensation arrangements, mandated coverage of certain treatments (for example, forty-eight-hour stay postpartum and emergency department (ED) services where a prudent layperson would have sought such care) and expedited external appeals of all claim denials. Each of these issues has attracted a following at the state level. At the federal level, a prohibition on drive-through deliveries was adopted with overwhelming bipartisan support, but broader legislation has been stalled.

52. At least some of the explanation for this decline in broad any willing provider legislation has been the tendency of courts to find that such legislation is preempted by ERISA. See, e.g., CIGNA Healthplan v. Louisiana ex rel. Ieyoub, 82 F.3d 642, 650 (5th Cir. 1996) (holding Louisiana's any willing provider statute preempted by ERISA); Prudential Ins. Co. v. National Park Med. Ctr. Inc., 964 F. Supp. 1285, 1299 (E.D. Ark. 1997) (holding Arkansas' any willing provider statute preempted); Blue Cross & Blue Shield of Atlanta v. Nielsen, 917 F. Supp. 1532, 1537 (1996) (holding Alabama's any willing provider statute preempted).


53. See Miller, supra note 9, at 1103-07 (discussing restrictions on financial incentives, gag clauses and provisions to ensure continuity of care).

54. For a discussion of the current status of consumer protection legislation, see supra notes 9, 42 and 47 and accompanying text.

55. One should distinguish between consumer protections aimed at the patient-provider relationship (Type IIA) and consumer protections aimed at the patient-insurer relationship (Type IIB). In many instances, managed care has effectively combined the provider and insurer function, and thus these issues are treated together for purposes of this article. However, no implication is intended, nor should any be drawn with regard to other issues, such as whether the coverage decisions of the insurer constitute the unlicensed practice of medicine, or whether the medical director of an insurer is subject to discipline by the state medical licensing board.
and state levels, there has been a distinct movement away from issue-specific Type I and Type II legislation toward more global statutory frameworks.\textsuperscript{56}

IV. A Case Study of Consumer Protection: Emergency Medicine and Managed Care

Both Type I and Type II legislation are quite remarkable because the doctor-patient relationship has historically been subject to little or no direct regulation. To the extent that there was any regulatory oversight, the state controlled who could practice medicine and, to a considerably lesser extent, the scope of their authority. There was little occasion to regulate the doctor-insurer and patient-insurer relationship. The general assessment was that statutory micromanagement was unlikely to lead to optimal results, and patients were safe—or at least safe enough in the hands of their health care providers. A substantial incidence of problems did little to dampen this assessment—at least until the arrival of managed care.\textsuperscript{57}

However, as Part III reflects, the last few years have seen an extraordinary outpouring of such consumer protection legislation.

The standard explanation of these developments is that they represent an understandable and reasonable response by state and federal legislators to the complaints outlined in Part II. Consumers must be protected, and the managed care industry has shown no indications it can police its own ranks. In response, there is now a clear and popular "impulse toward regulation"—preferably at the federal level.\textsuperscript{58}

This optimistic picture glosses over some critical issues. First, the proponents of consumer protection lack a consistent theory explaining and justifying their efforts.\textsuperscript{59} Absent such a theory, one is left with only gut

\textsuperscript{56} See, e.g., Miller, supra note 9, at 1102 ("In 1995-1996, state governments started to take a more comprehensive approach, establishing policies on a wide array of issues"). Even the proponents of consumer protection have indicated their unwillingness to continue legislating by body part. \textit{See Equal Time: Advantages and Disadvantages of HMOs and Ways to Reform the Health-Care System} (CNBC television broadcast, Mar. 14, 1997) (transcript on file with author) (comments of Ron Pollack, President of Families USA) ("Now I don't think that the best way to do this is piece by piece, limb by limb, procedure by procedure. And we've been doing a—a bit of that. I think we need to do something more basic than that.").

\textsuperscript{57} \textit{See} Mary Anne Bobinski, \textit{Autonomy and Privacy: Protecting Patients from Their Physicians}, 55 U. Pitt. L. Rev. 291, 291-92 (1994) (cataloguing problems); \textit{see also} M.D. Smith, \textit{Managed Care and the Poor}, 5 \textit{J. Health Care Poor Underserve} 147, 147 (1994) (observing that "nothing is worse than fee-for-service").

\textsuperscript{58} Donald W. Moran, \textit{Federal Regulation of Managed Care: An Impulse in Search of a Theory}, 16 \textit{Health Aff.} 7, 8 (1997).

\textsuperscript{59} \textit{See id.} As Mr. Moran has noted, [a]lthough forceful arguments have been made to support specific regulatory interventions, no advocate of federal regulation has laid out a framework that permits us to see where federal regulation of the health benefits industry may ultimately lead. This state of affairs is unusual. Advocates of regulation in most industries bend over backward to justify regulatory interventions by appealing to a comprehensive theory of
instincts, bad anecdotes and popular appeal to assess the merits of the proposed reforms. The combination of these elements can easily result in misdirected regulatory initiatives. 60 Second, many of the problems that have been identified are far more complex than has been commonly acknowledged. 61 Third, the proposed reforms suffer from their own inadequacies, even without factoring in the (usually carefully ignored) economic implications. 62 Finally, the drafting of consumer protection initiatives is readily hijacked by providers, who have their own interests at heart. 63

regulation. The rationale typically proceeds from a diagnosis of 'market failure'—that is, that the unfettered free market, left to its own devices, would produce socially suboptimal results because of specific structural flaws in the way the market works. The regulatory regime being advanced is then typically characterized as the lowest-cost intervention in the marketplace sufficient to remedy the identified defects and produce results closer to the desired optimal outcome.

Id. 60. See Jerome Kassirer, Practicing Medicine Without a License—The New Intrusions by Congress, 336 New Eng. J. Med. 1747, 1747 (1997) [hereinafter Kassirer, Practicing Medicine]. Dr. Kassirer commented that Congress is not the appropriate forum for making complex medical decisions . . . the data on which many important medical decisions are based are often contradictory and still in evolution. Legislators do not have the context nor the capacity to weigh medical evidence adequately. . . . Not only are complexity, lack of context, and expertise an issue, but legislators frequently respond politically to the emotional appeals of their constituents. (How could health-maintenance organizations insist on sending tired-out moms home in 24 hours? How could insurance companies deny lifesaving mammography to women? How could a grisly abortion method be condoned?) This is decision making by emotional and opportunistic consensus, not by studied, thoughtful reasoning, based on evidence.

Id. Not surprisingly, these circumstances result in bad legislation. See Kassirer, supra note 9, at 338 (“The potential impact of this legislation varies widely; some bills would protect the public, some could go too far in requiring benefits and potentially cripple the health insurance industry, and some would abrogate physicians' authority to practice medicine”).

61. For example, mandated post-partum coverage and mammography screening are politically popular, but the editor of the New England Journal of Medicine noted that

[r]equiring health plans to pay for up to 48 hours of hospital care makes little sense when there is meager evidence of actual benefit in prolonging the stay for the new mother and baby. Offering firm recommendations for mammography for women in their forties is irrational when the profession itself is conflicted and confused about the procedure's value.

Kassirer, Practicing Medicine, supra note 60, at 1747.

62. See Moran, supra note 58, at 20 (“The dilemma for public policy is that the sort of regulatory tools we have do not match up well against the essence of the problem that any meaningful policy needs to address.”).

63. See David A. Hyman, Consumer Protection (?), Managed Care, and the Emergency Department, in Achieving Quality in Managed Care: The Role of Law 57, 65 (1997); Robert L. Roth, Anti-Managed Care Laws: Patient Protection or Provider Self-Interest, in Health Law Handbook 163, 163-66 (1997). Those who wonder whether the debate is about consumer protection or provider protection and
Such arguments can be made on a purely theoretical plane, but an example provides concrete evidence on these points. Consider access to emergency care, which has become a flash-point issue for discontent about managed care. Almost any discussion of consumer protection and managed care results in some anecdotes about a terrible outcome that could have been averted had the MCO only authorized a visit to the ED, or people who were stuck with a large bill for an unauthorized visit to an ED for what they believed was an emergency, but turned out not to be. In re-

profit should examine the reaction to the proposal to capitate specialty care. Capitation shifts financial risk to physicians, but gives them increased control over treatment decisions. Not surprisingly, some physician groups were opposed, and complained that "lower quality care will result." Elisabeth Rosenthal, Reduced H.M.O. Fees Cause Concern About Patient Care, N.Y. TIMES, Nov. 25, 1996, at A1; see also Arnold S. Relman & Uwe Reinhardt, An Exchange on For-Profit Health Care, in FOR-PROFIT ENTERPRISE IN HEALTH CARE 209, 211-12 (Bradford H. Gray ed., 1986). Reinhardt cuttingly observed that

[s]urely you will agree that it has been one of American medicine's more hallowed tenets that piece-rate compensation is the sine qua non of high quality medical care. Think about this tenet. We have here a profession that openly professes that its members are unlikely to do their best unless they are rewarded in cold cash for every little ministration rendered their patients. If an economist made that assertion, one might write it off as one more of that profession's kooky beliefs. But physicians are saying it!

Id.

64. See Loren A. Johnson & Robert W. Derlet, Conflicts Between Managed Care Organizations and Emergency Departments in California, 164 W. J. MED. 137, 137-40 (1996) (discussing MCOs' practice of restricting use of EDs by their enrollees, refusing to pay for unnecessary treatment and use of varying standards for determining necessary treatment); Harold H. Osborn, Health Maintenance Organizations: Managed Care or Mismanaged Care?, 27 ANNALS EMERGENCY MED. 225, 225-26 (1996) (recounting episode where MCO denied coverage of ED visit and child was subsequently diagnosed with meningitis and stating "[u]nfortunately, this is not an isolated case of (mis)managed care but one of a growing number indicating serious problems with efforts to reorganize our health care system"); Pear, supra note 1, at A1 (noting that MCOs "are increasingly denying claims for care provided in emergency rooms," causing "obstacles to emergency care for . . . patients" and frustrating emergency room doctors "who say [MCO] practices discourage patients from seeking urgently needed care"); Lori Sharn, Ed: Battle of the Bill; Insurers, Patients Often Clash over Who Pays, USA TODAY, Aug. 22, 1995, at 1 (stating that based on analysis of claims handled by Emergency Physicians Billing Service in Oklahoma City, "[s]ome plans deny less than 1% of emergency room claims as non-authorized or non-urgent, while other plans deny 15% or more . . . . Some plans are denying two to three times as many claims as other plans at the same hospital"). The problem is complicated by the fact that each H.M.O. seems to have its own way of handling emergencies. Large plans like Kaiser Permanente provide a full range of 24-hour emergency services at their own clinics and hospitals. Some H.M.O.'s have nurses to advise patients over the telephone. Some H.M.O. doctors take phone calls from patients at night. Some leave answering-machine messages telling patients to go to hospital emergency rooms if they cannot wait until office hours.

Pear, supra note 1, at A1.

65. See Serafini, supra note 9, at 2280-83 (discussing anecdotes of patients refusing to be seen in ED if they thought visit would not be covered by their MCO); Church, supra note 9, at 32 (noting "recent addition" to litany of horror stories
about managed care is when "a patient rushes to an emergency room with what feels like a heart attack but turns out to be only gas pains—and gets zapped with a huge bill because his HMO will reimburse only for a 'real' emergency"). In a few isolated cases, anecdotes about claim denials when there was a true emergency have been offered. See Gregory L. Henry, Require HMO's to Provide Emergency Care, N.Y. Times, Dec. 30, 1995, at A26 ("In one case, a claim filed on behalf of a Detroit woman who died of sudden cardiac arrest was denied because she did not call for permission before seeking emergency care."). The overwhelming majority of anecdotes about coverage denial, however, involve the two variations in the text.

66. See, e.g., ARIZ. REV. STAT. ANN. §§ 20-821, -923, -1068, -1137, -2801 to -2804 (West Supp. 1996) (regulating medical service corporations); ARK. CODE ANN. § 20-9-309 (Michie Supp. 1996) (creating Emergency Medical Care Act, which ensures that necessary emergency care be provided in timely manner, regardless of patients' ability to pay); CAL. HEALTH & SAFETY CODE § 1371.4 (Deering Supp. 1996) (enumerating requirements that MCOs must comply with, including providing 24-hour access for enrollees to obtain authorization for treatment, reimbursement for emergency services and care and authority to deny payment under certain circumstances); FLA. STAT. ANN. § 641.513 (West Supp. 1997) (prohibiting MCOs from, among other things, requiring prior authorization for emergency care and indicating that emergencies are covered only if care is secured within a set time); GA. CODE ANN. §§ 31-11-80 to -82 (1996) (creating emergency services law that imposes duty on hospitals to treat all patients who present themselves, regardless of ability to pay); id. §§ 33-20A-1 to -10, 33-21-1, -13, -18 (enacting Patient Protection Act, which prohibits MCOs from using financial incentive programs "that directly compensate[] a health care provider for ordering or providing less than medically necessary and appropriate care"); LA. REV. STAT. ANN. § 22:2018(D)(1) (West 1995) (governing terms of contracts between MCOs and providers); MD. CODE ANN., HEALTH-GEN. II §§ 19-705.1(b), -712.5, -716 (Supp. 1996) (setting forth minimum standard of quality care to be provided by MCOs to their members); VA. CODE ANN. § 38.2-4300 (Michie Supp. 1996) (defining requirements placed on MCOs); W. VA. CODE § 33-25A-8d (Supp. 1996) (requiring that all those covered by act shall "provide as benefits to all subscribers and members coverage for emergency services").

Some states have addressed the issue through regulations. See MINN. R. 4685.1010 (1996) (setting forth requirements for availability and accessibility of health care services); 25 TEX. ADMIN. CODE §§ 119.51, 52 (West 1996) (stating that MCOs shall provide accessible physician coverage to enrollees 24 hours per day); id. § 3.3704 (prohibiting health insurance policies from requiring that service be rendered by particular health care provider).

A number of state legislatures have also proposed bills on the issue. See, e.g., H.B. 1122, 61st Leg., 1st Sess. (Colo. 1997) (enacting "consumer protection standards for the operation of managed care plans"); H.B. 6883, 1997 Leg., 1st Sess. (Conn. 1997) (requiring MCOs to, among other things, report to state regarding complaints for denials of coverage); S. 209, 144th Leg., 1st Sess. (Ga. 1997) (amending law relating to emergency medicine "so as to provide that no insurer . . . may deny coverage of certain emergency procedures"); S. 984, 19th Leg., 1st Sess. (Haw. 1997) (enacting law governing health insurance providers); S. 1150, 54th Leg., 1st Sess. (Idaho 1997) (same); H.B. 626, 90th Leg., 1st Sess. (Ill. 1997) (same); S. 204, 77th Leg., 1st Sess. (Kan. 1997) (amending law governing health insurance providers); H.B. 2206, 1997 Leg., 1st Sess. (La. 1997) (amending emergency law to prohibit "pre-certification [requirement] for an emergency medical condition"); S. 960, 80th Leg., 1st Sess. (Minn. 1997) (enacting law providing for patient protection with regard to health insurance providers); H.B. 395, 89th Leg., 1st Sess. (Mo. 1997) (same); S. 365, 55th Leg., 1st Sess. (Mont. 1997) ("An
Medicare and Medicaid populations, and Congress is considering various bills that would extend these protections to the rest of the population.67 The President's Commission has made it clear that a consumer's "bill of rights" would include a provision on this issue.68 The Physician Payment Review Commission and the National Center for Quality Assurance came


[c]onsumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing their health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

To ensure this right:

• Health plans should educate their members about the availability, location, and appropriate use of emergency and other medical services; cost-sharing provisions for emergency services; and the availability of care outside an emergency department.

• Health plans using a defined network of providers should cover emergency department screening and stabilization services both in network and out of network without prior authorization for use consistent with the prudent layperson standard. Non-network providers and facilities should not bill patients for any charges in excess of health plans' routine payment arrangements.

• Emergency department personnel should contact a patient's primary care provider or health plan, as appropriate, as quickly as possible to discuss follow-up and post-stabilization care and promote continuity of care.

Id.
to the same conclusion. 69 Academic commentators and editorial writers have hailed these initiatives. 70 Even the managed care industry has effectively conceded the fight. 71 Unfortunately, the resulting reforms make plain the difficulties facing those who would craft a legislative response to such problems. A full appreciation of the complexities of this issue requires some background on ED utilization, the Emergency Medical Treatment and Active Labor Act ("EMTALA") 72 and cost-quality trade-offs in the health insurance market.

A. ED Overview

EDs, which range in sophistication, staffing and resources, are a major component of the American health care system. For uninsured Americans and those covered by Medicaid, the ED has historically been the primary means of access to health care. For insured Americans, the ED provides around-the-clock access to sophisticated diagnostic and treatment


70. See, e.g., Too Many HMOs Stint on Emergency-Room Care, USA TODAY, Apr. 9, 1997, at 10A ("Few health mandates, especially those that second-guess health-care professionals, make sense. But requiring an industry to do its job—in this case, to care for and cover people in need of medical attention—is neither picayune nor meddlesome. It is the right thing—the best thing—to do.").

Academic commentary has been equally favorable. See Diane E. Hoffman, Emergency Care and Managed Care—A Dangerous Combination, 72 WASH. L. REV. 315, 406-07 (1997); Christopher J. Young, Emergency! Says Who? Analysis of the Legal Issues Concerning Managed Care and Emergency Medical Services, 13 J. CONTEMP HEALTH L. & POL’Y 553, 554 (1997). Dissenting notes are rare. See Hyman, supra note 63, at 59; John C. Goodman, Government Has No Role, USA TODAY, Apr. 9, 1997, at 10A ("The proper role of government is to make sure insurers keep their promises and don’t defraud or cheat us. It should help low-income families pay premiums they can’t pay on their own. Beyond that, the free market should decide.").

71. See Jones, supra note 34, at 119; see also Health Plans Vote to Require Patient-Centered Policies for Membership in AAHP (visited Mar. 1, 1998) <http://www.aahp.org/services/pr_update/patients_first/prinst.html> (discussing "policies . . . to clarify how health plans should cover emergency care.").


73. See Kenneth V. Iserson & Tammy Kaystre, Are Emergency Departments Really a "Safety Net" for the Medically Indigent?, 14 AM. J. EMERGENCY MED. 1, 1 (1996) (describing function of ED as providing treatment for those with threats to life or limb, but also ‘for those individuals whose health needs are less urgent but for whom the ED may be the only entry point into the broader health care system.’") (quoting American College of Emergency Physicians, Emergency Care Guidelines, 20 ANNALS EMERGENCY MED. 1389-95 (1991)); Medicaid Access Group, Access of Medicaid Recipients to Outpatient Care, 330 NEW ENG. J. MED. 1426, 1430 (1994) (noting that many poor people have nowhere else to go other than ED); Robert S. Stern et al., The Emergency Department as a Pathway to Admission for Poor and High-Cost Patients, 266 JAMA 2238, 2238 (1991) ("[P]atients with lower socioeconomic status are more likely than other patients to use the emergency department as their means of access to the hospital.").
options. In 1993, there were ninety-six million visits to EDs, or approximately 360 visits for every 1000 Americans. As Figures 1 and 2 reflect, however, there is considerable regional and small-area variation in the utilization of EDs.

**Figure 1: Visits per 1000 Population**

![Figure 1](image)

**Abbreviations:** NE, Northeast; MA, Mid-Atlantic; SA, South Atlantic; ENC, East North Central; ESC, East South Central; WNC, West North Central; WSC, West South Central; MTN, Mountain; PAC, Pacific.

Regional utilization ranged from 292 ED visits per 1000 people in the Mountain region of the United States to 477 ED visits in the East South Central United States.


75. See Allan S. Detsky, *Regional Variation in Medical Care*, 333 New Eng. J. Med. 589, 590 (1995) (noting that such regional variations are important to patients, payers and providers). Additionally, the rates of individual ED usage varies widely. Although the Medicaid population has attracted the most attention, such variation is observed in other populations as well. See Melissa Brokaw & Adel S. Zaraa, *A Biopsychosocial Profile of the Geriatric Population Who Frequently Visit the Emergency Department*, Ohio Med., July 1991, at 347 (noting that geriatric “frequent fliers” repeatedly use ED services inappropriately); P.J. Cunningham et al., *The Use of Hospital Emergency Departments for Nonurgent Health Problems: A National Perspective*, 52 Med. Care Res. Rev. 453, 458 (1995) (noting factors that correlate with increased inappropriate ED usage, including absence of insurance coverage, eligibility for Medicaid, youth and increased number of available EDs).
At the metropolitan level, annual ED usage in Los Angeles, California and the Minneapolis-St. Paul region of Minnesota was 270 and 210 visits per 1000 people, respectively, although Chicago and Detroit were much closer to the national average.76

In addition, ED utilization is not static. In Tennessee, the movement of the Medicaid population into managed care had an immediate and profound impact on ED utilization.77 As Figure 3 reflects, comparable decreases in ED utilization have been observed in other parts of the country.

76. SOCIETY FOR AMBULATORY CARE PROF’L OF THE AM. HOSP. ASS’N, TRENDLINES, Jan. 1996, at 5 fig.3 (charting ED usage per 1000 population in 1993 for seven cities).

77. See David Brown, Deluged By Medicaid, States Open Wider Umbrellas, WASH. POST, June 9, 1996, at A6 (noting profound drop in rate of ED utilization in Tennessee in one year; rate at which Medicaid patients under age 21 visited hospital EDs cut from 900 visits per 1000 Medicaid patients in 1993 to approximately 500 visits per 1000 TennCare patients in 1994; visits by TennCare patients between ages 21 and 64 dropped by more than one-third). But see Keith Wrenn & Corey M. Slovis, TennCare in the Emergency Department: The First 18 Months, 27 ANNALS EMERGENCY MED. 231, 233 (1996) (noting immediate drop of total ED visits of 25% (40% in pediatric ED visits), but return to normal volume within nine months of institution of TennCare).
Although there is considerable regional and small area variation in ED utilization, one thing does not vary—the fact that many of these ED visits are not for true emergencies. Both prospective and retrospective studies have consistently demonstrated that a majority of visits to the ED are for nonurgent problems. The most extensive prospective study of

78. See e.g., GENERAL ACCOUNTING OFFICE, GAO/HRD-93-4, EMERGENCY DEPARTMENTS UNEVENLY AFFECTED BY GROWTH AND CHANGE IN PATIENT USE 21 (1993) (noting that 43% of visits were nonurgent, 40% were urgent and 17% were emergent in nationwide random sample of 1025 hospitals); LINDA F. McCaig, NO. 245, NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY: 1992 EMERGENCY DEPARTMENT SUMMARY 1 (1993) (stating that in study of ED visits, 55.4% of visits were nonurgent); Marc Afilalo et al., Emergency Department Use and Misuse, 13 J. EMERGENCY MED. 259, 262 (1995) (collecting various studies showing wide but substantial range of nonurgent care in ED); Steven F. Foldes et al., What is an Emergency? The Judgments of Two Physicians, 23 ANNALS EMERGENCY MED. 833, 835 (1994) (presenting table that reflects results of seven earlier studies, which showed emergency rates from 6% to 35%); Robert Steinbrook, The Role of the Emergency Department, 334 New Eng. J. Med. 657, 657 (1996) ("The majority (55.4 percent) [of visits to emergency departments in this country in 1992] were classified as nonurgent."); William C. Stratmann & Ralph Ullman, A Study of Consumer Attitudes About Health Care: The Role of the Emergency Room, 13 Med. Care 1033, 1034 (1975) (noting estimates of nonurgent visits range from one-third to two-thirds of total visits); Robert M. Williams, The Costs of Visits to Emergency Departments, 334 New Eng. J. Med. 642, 643 (1996) (noting that 32% of visits were nonurgent, 26% were semigent and 42% were urgent at six community hospital EDs in Michigan); Gary P. Young et al., Ambulatory Visits to Hospital Emergency Departments: Patterns and Reasons for Use, 276 JAMA 460, 464 (1996) (noting 43% of ambulatory ED patients were classified as nonurgent on prospective triage). But see Don P. Buesching et al., Inappropriate Emergency Department Visits, 14 ANNALS EMERGENCY MED. 672, 672 (1985) (noting that use of ACEP prudent layperson standard resulted in inappropriate visit rate of
the issue appeared in the *Journal of the American Medical Association* in 1996 and presented data from visits to fifty-six hospitals throughout the United States during a single twenty-four-hour period.\(^79\) An intake nurse at each ED made a prospective determination as to whether the symptoms justified a visit to the ED.\(^80\) The study concluded that 49% of the ED visits were inappropriate, and further evaluation demonstrated that the nurse’s prospective determinations were quite accurate, albeit not perfect.\(^81\)

Although many of these visits are unnecessary, they are not cheap. Estimates of the aggregate excess cost for inappropriate ED usage range from five to fourteen billion dollars.\(^82\) High levels of inappropriate ED

\(^79\). See Young et al., *supra* note 78, at 460 (discussing study results).

\(^80\). See id. at 461 (noting “triage nurse elicited the patient’s chief complaint, conducted a brief history, obtained vital signs, and performed a brief, directed examination to determine the urgency of the patient’s condition”).

\(^81\). See id. at 463 (noting that in 5.5% of cases which were identified as nonurgent, patient ultimately required hospitalization, but prospective assessment accurately sorted approximately 97.5% of the patients). Interestingly, patients who were identified as nonurgent and subsequently admitted were more likely to be insured, and 13% had sought care within the previous two days. See id. at 462 (discussing demographics of study group).


The disparity arises from substantially higher average charges in an ED, which a number of studies have found were in the range of three to five times higher than for a comparable outpatient visit. Id. (finding two- to three-fold difference); General Accounting Office, *supra* note 78, at 21 (“[A]verage charges for treatment of a nonurgent condition in an ED were from one to five times the average charge for a Medicaid visit to a clinic or physician’s office in the community.” (footnote omitted)).

Emergency medicine physicians believe the true figure is far lower, especially if one uses marginal cost instead of charges. Williams, *supra* note 78, at 642 (arguing that marginal cost of providing services in ED is not that much higher than in ordinary outpatient clinic; “[t]he true costs of nonurgent care in the emergency department are relatively low” and potential savings from diversion of nonurgent visits may “be much less than is widely believed”). Although questions have arisen regarding whether these results can be applied to EDs generally, one commentator agreed that “the data suggest that much of the purported savings achieved by keeping patients out of the emergency room may never materialize.” Steinbrook, *supra* note 78, at 657-58.

From an economic perspective, it makes sense to use marginal cost instead of charges to score the true cost of inappropriate ED usage—but only if hospitals are actually prepared to charge marginal cost, and there is no excess capacity in the system. Although considerable evidence indicates that neither of these preconditions are satisfied, these points are not widely appreciated. See, e.g., id. (discussing assumptions other studies incorporated and concluding these assumptions limit ability to generalize from findings); see also Arthur L. Kellermann, *Nonurgent Emergency Department Visits: Meeting an Unmet Need*, 271 *JAMA* 1953, 1954 (1994) (“Even
utilization also result in ED overcrowding, which increases costs still further.83 Even modest deductibles and copayments eliminate a substantial percentage of this inappropriate usage.84 Presentation at the ED can also trigger a "clinical cascade," in which the "better safe than sorry" and "cost is no object" default rules can result in substantial expenses, when more cost-effective options are available.85 Finally, continuity, quality and cost-effectiveness of care can also be compromised when the care is provided by an ED—particularly when EDs "treat everyone, no matter how trivial the problem."86

One should not overstate the issues or the potential savings. Total ED if efforts to reduce nonurgent ED visits succeed, it is unlikely that the cost of operating EDs will substantially decline. Most of these costs are fixed because the facilities and staff needed to properly treat emergency patients must be maintained 24 hours a day.

83. See Paul Krochmal & Tamrah A. Riley, Increased Health Care Costs Associated with ED Overcrowding, 12 Am. J. EMERGENCY MED. 265, 265 (1994) (noting that ED overcrowding increases inpatient lengths of stay thereby increasing costs per patient); see also Kevin Grumbach et al., Primary Care and Public Emergency Department Overcrowding, 83 AM. J. PUB. HEALTH 372, 372 (1993) ("[O]vercrowding of hospital emergency departments in the inner city has reached desperate proportions.").

84. See Joe V. Selby et al., Effect of a Copayment on Use of the Emergency Department in a Health Maintenance Organization, 334 NEW ENG. J. MED. 635, 635 (1996) (noting that copayment of $25 to $35 resulted in 14.6% decline in ED visits, with decline disproportionately weighted toward less serious conditions); see also Kevin F. O'Grady et al., The Impact of Cost Sharing on Emergency Department Use, 313 NEW ENG. J. MED. 484, 484 (1985) (noting that patients without cost sharing had significantly higher ED expenses, and disproportionate amount of increased use involved less serious conditions).

In one large study, copayments did not induce delay in seeking necessary care. See David J. Magid et al., Absence of Association Between Insurance Copayments and Delays in Seeking Emergency Care Among Patients with Myocardial Infarction, 336 NEW ENG. J. MED. 1722, 1722 (1997) (finding that, even with copayment, patients were not deterred from seeking treatment). But see Selby, supra, at 640 (warning that results of study "should not be generalized to apply to low-income groups or the elderly, particularly as regards the possibility that imposing a copayment could lead to adverse effects"); Steinbrook, supra note 78, at 657 (noting that although study results of Selby and others showed no adverse effects, significant decline in patients with diagnoses classified as "often an emergency" was troubling because "[b]y any standard, a substantial proportion of patients with these diagnoses should be evaluated in the emergency department").

85. See Martin S. Karpiel, Capitated Contracting for Emergency Services, 50 HEALTHCARE FIN. MGMT. 33, 33 (1996) ("[MCOs] believe emergency services are overutilized and too expensive, and that emergency department physicians are risk averse, order too many ancillary services, and over-admit.").

86. Johnson & Derlet, supra note 64, at 140; see also Robert H. Brook et al., Effectiveness of Nonemergency Care Via an Emergency Room, 78 ANNALS INTERNAL MED. 333, 333 (1973) (concluding quality of care for treatment of gastrointestinal symptoms found acceptable in only 25% of cases evaluated); Kenneth C. Elam et al., How Emergency Physicians Approach Low Back Pain: Choosing Costly Options, 15 J. EMERGENCY MED. 143, 148 (1994) (noting common approaches of physicians in ED to lower back pain—imaging, testing and specialist consultation—were costly, unlikely to be of benefit and may well cause harm to patients). But see Gary P. Young & David Sklar, Health Care Reform and Emergency Medicine, 25 ANNALS EMERGENCY MED. 666, 666 (1995) (arguing that EDs provide quality care for patients).
charges accounted for only two to five percent of the health expenditures of the nation, and unnecessary ED visits account for some lesser fraction. Charges accounted for only two to five percent of the health expenditures of the nation, and unnecessary ED visits account for some lesser fraction. 87

Prospectively sorting out which ED care is inappropriate is frequently difficult. There is considerable interobserver variation in the assessment of whether a patient should have sought care at the ED, even among physicians. 88 There is also the normative question of whether one should identify ED visits as inappropriate if patients have no other locus from which to receive care. 89 However, such visits need to be paid for by someone, and from the perspective of an MCO, a substantial amount of money is on the table if inappropriate ED utilization by its members can be constrained. Not surprisingly, MCOs sought to limit ED utilization by using such mechanisms as mandatory preauthorization, restrictive coverage, selective con-

87. See Hoffman, supra note 70, at 348 (observing that unnecessary ED visits are small percentage of total health expenditures).

88. See Judith C. Brillman et al., Triage: Limitations in Predicting Need for Emergent Care and Hospital Admission, 27 ANNALS EMERGENCY MED. 493, 493 (1996) (noting "great variability among physicians, nurses, and a computer program with regard to triage decisions" and "none of the three performed well in predicting which patients required admission"); Foldes et al., supra note 78, at 836 (discussing disagreement as to what constitutes emergency); James M. Gill et al., Disagreement Among Health Care Professionals About the Urgent Care Needs of Emergency Department Patients, 28 ANNALS EMERGENCY MED. 474, 475 (1996) ("[E]ven when health care professionals use the same criteria to measure urgency for the same patients, disagreement may arise as to what constitutes an urgent problem."); James M. Gill, Nonurgent Use of the Emergency Department: Appropriate or Not?, 24 ANNALS EMERGENCY MED. 953, 953-55 (1994) (discussing variations in determining urgency); Robert A. Lowe & Andrew B. Bindman, Judging Who Needs Emergency Department Care: A Prerequisite for Policy-Making, 15 AM. J. EMERGENCY MED. 133, 133 (1997) ("[S]ome literature suggests that patients, clinicians, payers, and policymakers cannot agree as to what constitutes a true emergency."); Thomas A. Mitchell, Nonurgent Emergency Department Visits—Whose Definition?, 24 ANNALS EMERGENCY MED. 961, 962 (1994) (noting disagreements in determining urgency of patients' needs).

Before one dismisses the entire enterprise, it should be understood that there is considerable disparity of opinion even among ED physicians as to the correct role of the ED. See Afilalo et al., supra note 78, at 263 ("As demonstrated in a recent article and pair of editorials, there is little agreement even about the fundamental mission of emergency medicine."). No one reasons, however, from the fact that there are dissent to many Supreme Court opinions to the claim that one can safely ignore the conclusion reached by the majority.

89. See Kellerman, supra note 82, at 1953-54. As Dr. Kellerman noted, [i]t is fair to label nonurgent visits to the ED 'inappropriate' when many patients have nowhere else to go? Will measures to block or discourage access to walk-in care in the ED prove harmful to patients who cannot readily gain access to care in alternative locations? . . . Instead of considering EDs part of the health care system problem, it could be helpful to consider them part of the solution. For example, EDs are often the primary point of contact for many poor or disadvantaged citizens . . . Although treatment in the ED is expensive because most hospitals increase charges to cover the cost of uncompensated care, per-patient charges for care in the ED could be substantially reduced once universal health insurance becomes a reality.

Id. at 1953-54. For a discussion of why using EDs for nonurgent care is problematic on economic and quality grounds, see supra note 82 and accompanying text.
tracting, high copayments and deductibles and aggressive coverage denials. The results were pronounced; as managed care targeted ED utilization, patient visits to the ED declined in 1994 and again in 1995 for the first time in at least twenty-two years, despite steady increases in the population and the number of the uninsured.

**B. EMTALA**

EMTALA requires hospitals to provide screening and stabilization treatment to all comers, regardless of ability to pay. EMTALA’s legislative history reflects its focus on the plight of the uninsured, but the clear language of the statute also encompassed the insured, and courts have interpreted it accordingly. Attempts to secure authorization from an MCO violate EMTALA if they result in any delay in the delivery of services. Thus, a hospital is required to provide all necessary screening and stabilizing treatment, even if it knows the MCO will refuse to pay for the care because pre-authorization was not (or could not) be properly secured.

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90. *See* Hyman, *supra* note 63, at 62 (noting MCOs admitted they tried to discourage inappropriate ED usage through a variety of means); *see also* Harry Davidson Kett, *Access to Emergency Departments: A Survey of HMO Policies*, 18 ANNALS EMERGENCY MED. 274, 276 (1989) (discussing gate-keeping mechanisms employed by HMOs to contain costs generated in EDs); Hoffman, *supra* note 70, at 331-32 (discussing managed care providers’ denial of ED claims). Unless the condition is life-threatening, patients must obtain prior authorization before seeking emergency care services in 80% of the responding HMOs, and 39% of HMOs limited their members to using the EDs of selected network hospitals. *See* Kerr, *supra*, at 274. Many indemnity insurers have adopted similar provisions. *See* Physician Payment Review Commission, *supra* note 69, at 136 (discussing limits on ED usage).


92. EMTALA imposes a duty on hospitals to evaluate all arriving patients, as well as the duty to stabilize patients with emergency medical conditions. *See* 42 U.S.C. § 1395dd(a) (requiring EDs to provide treatment to “any individual” seeking care with emergency medical condition and noting that duty to treat terminates only when patient is stabilized, appropriately transferred or dead). Noncompliance by hospitals can result in stiff civil penalties, including monetary fines. *See id.* § 1395dd(d) (imposing “a civil money penalty of not more than $50,000 . . . for each such violation”). In addition, EMTALA covers specialty care and “reverse” dumping (the refusal to accept transfers of patients requiring specialty care).

93. *See id.* § 1395dd(a) (stating that “any individual” who presents to hospital is entitled to medical screening regardless of insurance coverage); Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991) (holding that “any individual” means any individual); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 268 (6th Cir. 1990) (same).

94. *See* 42 U.S.C. § 1395dd(h) (“A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual’s method of payment or insurance status.”).

C. Cost-Quality Trade-offs

Insurance is a mechanism for contractual shifting, spreading and allocation of risk. Regulation of the contractual terms is left to the states, unless ERISA preemption applies—in which case there is effectively no substantive regulation. Those risks that are not transferred are self-insured. Coverage which is more generous is also more expensive. Copayments and deductibles help fine-tune the coverage (and deal with the problem of moral hazard) by allowing for a mix of self-insurance and third-party coverage. Not surprisingly, a policy with a substantial copayment and deductible is substantially cheaper than one with first-dollar coverage.

Willingness to purchase insurance is heterogeneous, and greatly affected by the premium. As the premium increases, the policy becomes less affordable for people at the margin. Policy sellers must weigh whether broadening coverage, ensuring more accurate prospective coverage decisions and enhancing internal grievance procedures are worth doing if they price the policy out of the market—or result in a shift in the nature of coverage from that which is most appealing to the covered pool as a whole. Those who would willingly have bought a less elaborate policy must self-insure (become one of the forty million uninsured Americans) once the cost of the minimum product exceeds their willingness or ability to pay. Thus, better protection for some groups or conditions is neces-

96. The implications of the regulatory mismatch created by ERISA, as well as the consequences of the dominance of employer-based health insurance are beyond the scope of this Article. For a brief discussion of this issue, see supra note 43, infra notes 136-38 and accompanying text. For a more thorough discussion of this issue, see generally Hyman, supra note 21.

97. See Ira Mark Ellman & Mark A. Hall, Redefining the Terms of Health Insurance to Accommodate Varying Consumer Risk Preferences, 20 Am. J.L. & Med. 187, 188 (1994) (noting wide differences in coverage preferences, and suggesting health insurance plans should offer range of choices so consumers can pick Cadillac care, Buick care or Chevrolet care); Martin Gottlieb, Picking a Health Plan: A Shot in the Dark, N.Y. Times, Jan. 14, 1996, at 3:1 (“[C]hoosing a health plan is a personal matter, and personal needs vary. While quality . . . might seem the primary consideration, it isn’t always. Young people, who are less concerned about getting sick, usually cast a much harder eye on price. So do poorer people.”); see generally CLARK HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995) (presenting evidence of variable consumer preferences for different levels of health insurance coverage and arguing private contracts can effectively implement such variable preferences).

98. Approximately 15.5% of the U.S. population is currently uninsured. 1997 STATISTICAL ABSTRACT OF THE UNITED STATES tbl. 172. There is considerable state-to-state variation in the percentage of the population that is uninsured. See id. In Wisconsin, only 7.3 percent of the population is uninsured, while in New Mexico, 25.6% of the population is uninsured. See id. In general, southern and southwestern states have the highest percentage of their population uninsured. See id.

The cost of coverage obviously has an impact on the number of the uninsured. In assessing the impact of the Newborns’ and Mothers’ Health Protection Act, the Congressional Budget Office estimated that a uniform increase of 1% in the cost of insurance coverage would result in 200,000 currently insured individu-
sarily purchased at the expense of the rest of the covered pool, and some of them will decline coverage entirely.

D. Conflict

Caught between EMTALA and managed care, hospitals are left in a bad way in dealing with both uninsured and insured patients. Under the old (premanaged care) system, revenues from the insured offset charity care provided to the uninsured. The new (managed care) system has fewer insured patients presenting to the ED, and less reimbursement when an insured patient does present to the ED, to the extent there is any reimbursement at all. EMTALA may obligate hospitals to screen and treat all persons, but MCOs are under no compulsion to pay for such efforts, particularly if contractually required pre-authorization was not obtained. Furthermore, securing such pre-authorization runs a substantial risk of violating EMTALA, even if the MCO maintains an adequate system for providing pre-authorization, which not all MCOs do. In addition, insured patients could sign up for an exceedingly restrictive MCO, but unilaterally present to any ED if they wished to receive care. Thus, EMTALA effects becoming uninsured. As it is, approximately eight million Americans could purchase employer-arranged health insurance, but chose not to do so. See Philip F. Cooper & Barbara Steinberg Schone, More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996, 16 HEALTH AFF. 142, 142 (1997).

Even when individuals purchase health insurance, they have a distinct tendency to purchase the lower-priced spread. The Medicare supplemental insurance market ("Medigap") illustrates the phenomenon nicely. Federal law specifies that insurers can only offer ten standard Medigap policies, lettered A through J, with plan A offering the cheapest and most basic coverage. See David J. Morrow, High Cost of Plugging the Gaps in Medicare, N.Y. TIMES, May 12, 1996, at 3:8 (comparing provisions of 10 available Medigap plans). Plans H, I, and J offer prescription drug benefits. See id. Although Medicare beneficiaries are frequent users of prescription pharmaceuticals, and their advocates invariably suggest Medicare should be expanded to include such coverage, few Medigap patients voluntarily sign up for Plans H through J. See id.

99. See Hyman, Conundrum of Charitability, supra note 30, at 371-72. In an earlier article, the author noted that if the nonprofit hospital views its role as providing health care to those in need, everyone pays the cross-subsidy for charges which they did not incur. Because our society is not willing to pay for universal health insurance, the nonprofit hospital attempts to recover unreimbursed costs from two smaller groups: the citizens that live within the local taxing district and the insurance companies of patients. Id. Although cost-shifting comes in for a bad name, profit-maximizing firms with good information also charge differential rates based on relative demand. The author has met few casual travellers who bemoan the fact that a "stay-over-Saturday" plane ticket costs a fraction of the "in-and-out-on-a-weekday-business-special."

100. See generally Hyman, supra note 95. The financial consequences were predictable. See Jennifer Preston, As Revenues Drop, Hospitals Talk of Forsaking Charity Care, N.Y. TIMES, Apr. 14, 1996, at A1 (noting increasing reluctance of hospitals to provide charity care, as losses have accumulated).

101. For a discussion of the varying mechanisms used by MCOs for preauthorization, see supra note 90 and accompanying text.
tively leaves hospitals at the mercy of free-riding MCOs—and both at the mercy of free-riding patients.\textsuperscript{102}

Hospitals faced the unappetizing prospect of losses on both their insured and uninsured patients, but could not refuse to deal (the usual remedy for expected nonpayment or inadequate payment) because of EMTALA. Virtuous MCOs wanted to keep their members out of EDs unless there was truly an emergency. Less-virtuous MCOs could use the ED as a safety valve for after-hours coverage and could always deny coverage if a true emergency was not diagnosed. Patients who went to the ED wanted their MCO to provide coverage, but premiums would only stay low if MCOs could control the use of high-cost providers (like EDs) by their members.

Patients seemingly had to decide before they went to the ED if they actually had an emergency medical condition—and the wrong decision had negative consequences in both directions. A false-negative decision exposed the patient to a risk of death or disability. A false-positive decision exposed the patient to staggering medical bills. Of course, this problem was not unique to managed care; any insurance plan forces the patient to decide whether to go to the hospital or not—and deciding incorrectly carries some of the same potential for adverse consequences.\textsuperscript{103}

\textsuperscript{102.} See Sham, supra note 64, at A1 (discussing denial of ED claims). Whether MCOs and patients believe they are free-riding is a different question. MCO representatives who comment on the issue insist that they are doing their part to deliver cost-effective health care, and the ED physicians are generalizing from a few unrepresentative anecdotes. See Sham, supra note 64, at A1 (noting MCO argument that “[t]here isn’t a plot against emergency medicine”).

As for patients, few people view the ED as an ideal place to spend a Saturday evening. Certainly, most patients who go to the ED believe they need to be seen there. See David W. Baker et al., Determinants of Emergency Department Use by Ambulatory Patients at an Urban Public Hospital, 25 ANNALS EMERGENCY MED. 311, 313 (1995) (finding 89% of patients believed they needed immediate medical attention, even when they said their condition was not serious, painful or debilitating; only 44% required care within 24 hours according to evaluating physician); Foldes et al., supra note 78, at 837-40 (noting that there is no consensus among providers (internists and ED physicians), let alone among patients and providers about necessity for seeking care at ED); Robert M. Williams, Triage and Emergency Department Services, 27 ANNALS EMERGENCY MED. 506, 507 (1996) (noting that “perception of severity of symptoms varies among individuals and groups, and patients seek care for a multitude of personal, cultural, financial, and social reasons”).

Whether they believe they need to be seen in an ED because it is more convenient than the alternatives, or because they believe they cannot wait is another matter. See Cunningham et al., supra note 75, at 470 (“The main reason most persons use the hospital ED for nonurgent problems has less to do with an absolute lack of access to more appropriate sources of primary care than perhaps with issues of convenience and preference . . . .”); Stratmann & Ullman, supra note 78, at 1042-43 (noting that many people use ED because they believe their problem to be urgent and alternative sources of care are less convenient). Thus, it is not surprising that the decision to actually seek such care depends greatly on the financial implications of that decision. For a discussion of the effect of copayments on ED usage, see supra note 84 and accompanying text.

\textsuperscript{103.} See Helen Lippman, The Games Plans Play with ER Bills, BUSINESS &
Complaints surfaced about retrospective denial of coverage by MCOs, widely differing definitions among MCOs of what constituted an emergency, difficulties with obtaining pre-authorization, coverage only if an actual emergency was diagnosed after the work-up had been performed, and long-distance second-guessing of ED doctors by utilization review nurses.\textsuperscript{104} MCOs denied that a problem existed, although they admitted that they tried to discourage inappropriate ED usage.\textsuperscript{105} Empirical data on the severity of the problem was sketchy at best, but the American College of Emergency Physicians ("ACEP") used a number of horrific anecdotes to argue that access to the ED had to be safeguarded with consumer protection laws.\textsuperscript{106}

In response to these concerns, legislatures quickly enacted laws regulating access to the ED for MCO members. Although these laws and bills differ in their details, they are based on a few simple models.

1. **Prudent Patient or Reasonable Person Standard**

MCOs frequently use different definitions of the circumstances under which they will cover a visit to the ED.\textsuperscript{107} The prudent patient or reasonable person standard

\textsuperscript{104} For discussion of complaints about managed care and emergency care, see supra note 64 and accompanying text.

\textsuperscript{105} For a discussion of discouraging ED usage, see supra note 64 and accompanying text.

\textsuperscript{106} See Gregory Henry, *Emergency Care Under Managed Care: A Fatal Distraction*, HEALTH SYST. REV., Mar.-Apr. 1996, at 55 (providing ACEP's anecdotes). Such anecdotes were also circulated through a variety of other venues. ANDERS, supra note 6, at 132-49 (collecting anecdotes); Hoffman, supra note 70, at 333-34 (collecting anecdotes).

Although these narratives had a major impact, there was no indication of the typicality and prevalence of these problems. Even compelling anecdotes provide an unsound basis for public policy, absent proof of typicality, truthfulness and frequency. See David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L. J. 797 (1998) (arguing case for EMTALA was based on untruthful and atypical anecdotes). The problem of unrepresentative anecdotes is not unique to this issue. In commenting on proposals to make lawyers do more to prevent their clients from committing fraud, Professor Langevoort observed that "[i]n all fairness, of course, we do not know whether a serious problem really exists. The scandals, publicized more through indictments and allegations than legal findings of complicity, are highly salient, vivid bits of information that naturally skew our impressions. We lack actual base-rate data establishing the incidence of complicity, or documentation of the offsetting events when attorney involvement has somehow deterred client misconduct."


\textsuperscript{107} See ANDERS, supra note 6, at 136-37 (discussing use of different standards for authorizing ED visits); Hoffman, supra note 70, at 335 (same); Pear, supra note 32.

http://digitalcommons.law.villanova.edu/vlr/vol43/iss2/3
able person model contractual term eliminates such variation, and requires the MCO to pay for care provided in the ED if a prudent layperson with an average knowledge of medicine and health and experiencing the same symptoms would have gone to the ED—or if a reasonable person would have done so. Three MCOs are on record as supporting this standard, and at least two MCOs already use it to judge whether to cover emergency care.108 The American Association of Health Plans has endorsed the reasonable person standard as well.

This model contractual term has considerable intuitive appeal. After all, why should MCOs pay for unreasonable or imprudent behavior, and why shouldn’t they pay if the behavior was prudent and reasonable? Unfortunately, words like “prudence” and “reasonableness” require the MCO to apply an inherently factual (albeit not wholly subjective) standard, which can always be second-guessed when coverage is denied—but is never second-guessed when coverage is extended. Although this solution appears to finesse the coverage issue, its indeterminacy actually has the potential to cause severe secondary disputes, even if MCOs proceed with the utmost good faith.109 As a general proposition, there are also benefits to diversity of terms, even for coverage of emergency care.110

1, at A1 (“Most HMOs promise to cover emergency medical services, but there is no standard definition of the term. HMOs can define it narrowly and typically reserve the right to deny payment if they conclude, in retrospect, that the conditions treated were not emergencies.”).


109. The dispute as to whether “reasonable” is more restrictive or less restrictive than “prudent layperson,” both with and without the qualifier “with an average knowledge of medicine,” suggests the difficulty of implementing standard—let alone the costs of resolving appeals of adverse decisions. See Hoffman, supra note 70, at 390-93 (debating which standard is stricter); President’s Advisory Comm. on Consumer Protection and Quality in the Health Care Indus., Subcomm. on Consumer Rights Protections and Responsibilities (visited March 1, 1998) <http://www.hcqualitycommission.gov/jun25.26/testcons.html> (discussing debate regarding which standard is more strict).

Unhappiness with such open-ended reasonableness standards is commonplace. See Antonin Scalia, Assorted Canards of Contemporary Legal Analysis, 40 CASE W. RES. L. REV. 581, 591 (1990) (“But what guidance does such a principle provide for the lower courts, and what check is it against the personal preferences of future judges? ‘Be reasonable and do not go too far’ is hardly more informative than ‘Do justice,’ or ‘Do good and avoid evil.’”); Stanley S. Surrey, Treasury’s Need to Curb Tax Avoidance in Foreign Business Through Use of 482, 28 J. TAX’N 75, 76 (1968) (“While the test of reasonableness has its uses in some situations, in this area it is not sufficiently precise to provide guidance—reasonable by what or by whose standards?”).

110. But see Peter Passell, Economic Scene: When Politicians Seek to Please on Medical Benefits, N.Y. TIMES, Oct. 10, 1996, at D2 (arguing that diversity of coverage for some kinds of benefits, such as trauma care, are unlikely to be valued, since “[h]ardly anyone, presumably, would choose to opt out of the right to trauma care
If patients actually want increased ex ante certainty about which visits to the ED will be covered, the prudent layperson or reasonable person standard will probably not make things better—particularly when the enforcement of the “new and improved” standard is left in the hands of the MCOs in the first instance. In addition, if the current high level of inappropriate ED utilization is any guide, the prudent layperson or reasonable person standard is an extremely overinclusive coverage term. Either all of these people are being imprudent or unreasonable, or the MCOs will have to pay for “inappropriate” but reasonable ED visits, which account for somewhere between ten and ninety percent of total ED visits. Coverage that includes this term will also be more expensive than more restrictive alternatives—especially if coupled with limitations on the use of copayments and deductibles.

in the emergency room in order to save on insurance premiums”).

111. See Gerlin, supra note 108, at D1. As this article reflects, even some groups that participated in formulating the “prudent layperson” standard, as it is known, question whether it’s so subjective that health plans will continue to challenge the prudence of patients’ actions during emergencies and deny claims for ER charges. What is prudent to one person, they note, may not be prudent to another—or to a health plan. “This is in a legal sense considered to be an objective standard, but it’s not going to eliminate legal disputes over emergency visits... You’re going to find Monday morning quarterbacking going on by certain health plans.”

Id.

112. For a discussion of the frequency of inappropriate ED visits, see supra note 78 and accompanying text.

113. Some of the consumer protection bills at the federal level preclude insurers from setting copayments and deductibles for the use of the ED any higher than would be the case for such services provided in other settings, unless the Secretary of Health and Human Services determines that the copayment is reasonable and will deter inappropriate use of ED services. See, e.g., The Health Insurance Bill of Rights Act of 1997, S. 373, H.R. 820, 105th Cong. How much more expensive such standards will turn out to be is an open question. See Hoffman, supra note 70, at 395-96 (noting limited data on effect of mandated emergency care coverage on insurance premiums).

Unfortunately, there is little empirical evidence available on the impact of a prudent layperson standard—and the impact obviously depends a great deal on where the baseline is pegged, and the population to which it is applied. Medicare managed care has mandatory appeals of all MCO claim denials to an outside contractor. See id. at 362-68 (analyzing Medicare approach). In 1992, the Health Care Financing Administration modified the guidelines for determining coverage from a more restrictive objective standard to one which emphasizes prospective subjective reasonableness. See id. at 365 (stating that guidelines provided that emergencies are determined when service is rendered and clear cases of “routine illness[es]” are not covered). Although the number of appeals was minuscule, the extraordinarily high rate at which the contractor upheld claim denials (78% denials in 1992) was not significantly affected by this change in the standard (72% in 1995). See id. at 367. The rate of appeals also dropped modestly, but the number of appeals is so tiny to begin with that it is impossible to determine whether the change in the standard actually eliminated the necessity for appeal. On the other hand, some research suggests that most ED visits are justified under a prudent layperson standard. See Buesching et al., supra note 78, at 672.
Finally, if reasonableness is such an excellent (and virtually cost-neutral) standard, then why did Congress abandon its use of reasonable cost reimbursement under Medicare in 1982 by adopting the prospective payment system?\footnote{114} Similar questions are raised by the efforts of the nation’s governors, who lobbied Congress for years to eliminate a similar term forcing state Medicaid programs to reimburse the reasonable costs of providers.\footnote{115} Those who live by the sword should be prepared to have it turned against them—and the reluctance of the states and Congress to accept a reasonableness standard when they are footing the bill counsels caution when they propose imposing a similar standard on private parties.

2. Restrictions on Prior Authorization

Depending on the circumstances, many MCOs require prior authorization before they will agree to cover care provided at an ED.\footnote{116} Most of the consumer protection statutes prohibit the use of this contractual term, although there is some variation in whether the statute encompasses screening examinations and stabilizing or emergency treatment, or all care provided in an ED. Some statutes specify maximum periods within which the MCO must provide a response or the care is deemed authorized. Other statutes prohibit advance authorization unless the MCO maintains twenty-four-hour medical coverage.

As with the reasonable or prudent person standard, this consumer protection has considerable intuitive appeal. There seems little purpose in requiring advance authorization in an emergency. Yet, as noted previously, many people go to the ED for nonemergencies. Requiring advance authorization discourages such conduct and allows the MCO to divert some such patients from the ED, or at least forces members to self-insure for the resulting expense if they do not obtain such approval. MCO administrators refer to these efforts as demand management, and many pa-
patients get better care at lower cost as a result.117

Prohibitions on advance authorization unless twenty-four-hour coverage is maintained also have the effect of conferring a significant advantage on larger and more established MCOs. Perhaps people only want to purchase coverage from such MCOs, but there is no a priori reason to think so. Each MCO offers its own mix of providers, restrictions on access, coverage and cost. Against this diversity of arrangements, consumer protection laws should not be used to dictate the terms on which ED care is provided. If anything, the objective of this "consumer protection" seems to be the restriction of competition from smaller and less well-established MCOs.118

3. Reasonable Access to Any ED

The two consumer protections outlined so far do not explicitly address whether a patient can go to any ED. Absent financial constraints, many people would obviously prefer a free-access rule, but such a rule prevents MCOs from using their financial leverage to extract lower rates from EDs through selective contracting. Accordingly, MCOs typically provide limited coverage if care is sought from an out-of-network provider, absent a true emergency.119 The consumer protection initiative eliminates this disparity, at least as long as it was prudent to go to the ED in the first place.

As with the other provisions, this model contractual term sounds perfectly sensible, and it is clearly a reasonable corollary to the first two consumer protection initiatives. The term, however, suffers from many of the same infirmities. The closest ED is not necessarily the best one, and MCOs are likely to be in a better position to assess such matters. In addition,

117. See Peter T. Kilborn, For Managed Care, Dial the Keepers of the Cures, N.Y. TIMES, Nov. 3, 1997, at A14 (describing specific instances of how pre-authorization works and how it saves MCOs money). But see Anders, supra note 6, at 132-49 (acknowledging phone screening can result in benefits for patients, but adding extensive list of anecdotes suggesting bad outcomes can easily happen).

118. See Pear, supra note 36, at A1. As this article reflects, [t]hree big health maintenance organizations joined two consumer groups today in calling for more regulation of managed health care, saying all health plans should be subject to 'legally enforceable national standards.' . . . Kaiser, HIP and the Group Health Cooperative see themselves as having a deeper commitment to consumer protection than many commercial H.M.O.'s, but they say it is difficult to fulfill that commitment if they can be undercut by competitors not bound by the same standards. Id. (emphasis added).

For a more general perspective on such conduct, see Steven C. Salop et al., A Bidding Analysis of Special Interest Regulation: Raising Rivals' Cost in a Rent Seeking Society, in The Political Economy of Regulation: Private Interests in the Regulatory Process 102 (1986).

119. See Anders, supra note 6, at 144-46 (describing instances in which insurance company denied claims because patients were treated at out-of-network facilities); Hoffman, supra note 70, at 329, n.49 (noting prior approval is "most often required for 'out of network' care").
free-access is expensive, and cost is clearly a relevant consideration for many people ex ante, even if they voice different views ex post.

4. **Required Reimbursement for Screening Examinations**

EMTALA forces EDs to perform screening examinations on everyone seeking treatment, but many MCOs are (understandably) not keen about paying the retail cost for such screening examinations, especially when the problem was not an emergency.\(^{120}\) This model contractual term mandates reimbursement of the expenses for the screening examination, although there is some variation at the state level on whether the initial visit had to be prudent or reasonable. The President’s Commission’s recommendations require the initial visit to be prudent or reasonable, as does the pending Federal legislation.

As with the other model contractual terms, MCO subscribers are forced to purchase coverage for a risk for which they had contractually self-insured, and coverage makes it more likely the ultimate cost for screening examinations (both per patient and total) will be higher. The principal beneficiaries of this provision are hospitals and ED physicians—which explains why such legislation has been a top priority for emergency physician groups at the state and national levels. The consequences will ultimately be reflected in the premiums MCOs charge their members.

It does seem unfair for hospitals to get stuck with the bills for insured patients, when it was clearly Congress’ intent that they only be stuck with the bills for uninsured patients.\(^{121}\) The implicit assumption, however, that we must build another layer of statutory oversight on top of EMTALA to solve the problems EMTALA has induced strikes one as a peculiar strat-

\(^{120}\) See Williams, *supra* note 78, at 643-44 (noting that charges are substantially higher for care received in ED, even though marginal cost and average cost are not significantly more expensive); Lippman, *supra* note 103, at 20 (“HMOs are certainly willing to pay for screening costs but object to paying high ER costs when no emergency exists [according to] a spokesman for the American Association of Health Plans.”).

\(^{121}\) See H.R. REP. No. 99-241, pt.1, at 27 (describing Congress concern “about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients... if [they] do not have medical insurance”). The time to rethink the policy underlying EMTALA may have finally come. Opposition to unfunded mandates is now near universal and EMTALA certainly qualifies as an unfunded mandate, albeit one imposed on private parties. See Daniel H. Cole & Carol S. Comer, *Rhetoric, Reality, and the Law of Unfunded Federal Mandates*, 8 STAN. L. & POL’Y REV. 103, 103 (1997) (noting widespread opposition to unfunded mandates); David A. Dana, *The Case for Unfunded Environmental Mandates*, 69 S. CAL. L. REV. 1, 1 (1995) (“Federal mandates—unfunded federal legislation inducing state and local governments to take some action—now have achieved something akin to the status of Soviet Communism during the heyday of the McCarthy era: Everybody is against them.”).

More importantly, if the touchstone for EMTALA was that everyone should have access to the ED because the insured do, the restrictions which managed care has imposed on access to the ED undercut the moral case for EMTALA. See generally Hyman, *supra* note 95.
More generally, as the developments outlined in this Article make clear, EMTALA effectively pegs the level of emergency care coverage above the amount that people are voluntarily willing to pay—a strategy that is inspirational, but has little else to recommend it.\footnote{See id. But see Hoffman, supra note 70, at 349-51 (arguing that various market imperfections and externalities prevent Americans from purchasing level of emergency care coverage they “really” want).}

5. **Pay for Everything Performed in an ED**

The final statutory model requires MCOs to pay for all services performed in the ED. No state has adopted a statute based on this model, but Maryland is coming close. House Bill 615, which was passed by the Maryland General Assembly and vetoed by the Governor, required MCOs to pay for all care received by their members at an ED without regard to prior authorization or contractual restrictions.\footnote{See H.B. 615, 1995 Leg., 1st Sess. (Md. 1995) (stating that MCOs were required to pay for all ED care). As originally proposed, the bill contained certain provisions relating to emergency services (required reimbursement at specified rates and restrictions on use of prior authorization) and nonemergency services (MCO had to pay for care if it directed or referred the member to the ED, but could collect from the patient otherwise). The provisions relating to nonemergency services were struck prior to enactment by the Maryland House of Representatives, which added additional restrictions on the use of prior authorization in an emergency. The Maryland Senate passed a bill with slight differences from the House version. When the bill emerged from the Conference Committee, it had become transformed into a bill that mandated coverage of all services provided in an ED, and prohibited entirely the use of pre-authorization as a condition for payment.}

In his veto letter, the Governor objected to House Bill 615 because the State of Maryland would end up footing some of the bill. The veto letter estimated the on-budget cost of House Bill 615 at $1.6 million for the remainder of fiscal year 1996 and $3.4 million for fiscal year 1997, but observed that the costs could be substantially greater. It is hard to escape the suspicion that the on-budget cost was a major factor in the decision to veto the bill.

More recently, Maryland enacted House Bill 859, which effectively requires an MCO to reimburse EDs for care provided to its members, but allows the MCO to seek repayment from its members if it concludes the care was not covered.\footnote{See H.B. 859, 1996 Leg., 1st Sess. (Md. 1996) (specifying that MCO must reimburse for ED screening examinations required by EMTALA and all medically necessary services if MCO “authorized, directed, referred, or otherwise allowed” use of ED or if MCO does not provide 24-hour access to services).}

Obviously, such consumer protection statutes are the most sweeping of all of the models. Although they ensure compensation of the ED, they do so by largely destroying the ability of an MCO to constrain the behavior of its members, resulting in higher medical and insurance costs for all involved.
E. Summary

Even with a well-defined self-contained problem, designing a cost-effective consumer protection is not an easy task. As the stakes and complexity of the issues increase, the difficulty increases exponentially. In the rush to embrace sensible-sounding solutions, one should not overlook the infirmities that accompany the proposed reform and the dangers of oversimplifying the problem. In the ED, the reforms outlined in this Article are based on the notions that everyone would buy the specified coverage if given a choice; that it is clear to prudent or reasonable laypersons whether a particular set of symptoms requires evaluation and treatment in an ED; that economic considerations should not enter into such life-or-death decisions; and that the cost and character of an appropriate diagnostic work-up and treatment is not debatable. These claims are inspiring, but reflect an overly optimistic view of human behavior, an oversimplification of the issues and a misunderstanding of the universality of scarcity. Even when economic incentives are taken out of the picture, there is considerable variation in the perceived need for a visit to the ED.126 The economic issues complicate matters considerably. In the abstract, everyone wants comprehensive health insurance, but those who foot the bill quickly realize there is a difference between coverage that is good and coverage that is good enough. Consumers have voted with their feet for cheaper (more restrictive) health care coverage, and their ex post complaints about the same do not change that fact.127 These statutes are not really about consumer protection, but rather the maintenance of implicit cross-subsidies, provider protection and legislative posturing. The relatively trivial example of access to the ED shows that legislative caution is likely to be the better part of consumer protection.

V. Narrative Perspective

For those who prefer narrative scholarship, the following story may be more persuasive.128 A friend owned a home, but traveled a great deal on

126. See Anders, supra note 6, at 142 ("Many cases are hard enough to diagnose that there is no dramatic showdown between medical professionals on one side and HMO bureaucrats on the other."). For a discussion of the varying interpretations of "emergency," see supra notes 88, 102 and accompanying text.

127. To be sure, additional complexity is induced by the fact that many employers do not offer a choice of plans, so we do not have a fair market test among different managed care providers and coverage options. Yet, the bundling that is necessary to accomplish group coverage means that there will always be some people who were unable to buy the precise coverage they wanted. Such market imperfections are troubling, but to some extent are inevitable—and merely identifying such problems does not mean that all bets are off. No one would argue that Medigap insurers selling Plans A through G should provide coverage for prescription pharmaceuticals because the omitted services are lifesaving or important. Yet, that is precisely the argument on which advocates are relying to advance consumer protections against managed care.

128. Narrative scholarship has been booming, despite criticisms of its typicality and truthfulness. See Hyman, supra note 106, at 797.
business. He was deeply concerned about the risks of a break-in while he was away because he had many valuable possessions, and the area was experiencing a rash of burglaries on weekends. He was also worried about his personal safety in the event of a robbery or home invasion. A large dog would lower the risk of robbery or home invasion, but was not really an option because he traveled so much.

My friend happened to see an advertisement for a home alarm system, and decided to have one installed. The alarm was state-of-the-art. All of the doors and windows were wired, and there were motion detectors inside the house. There was also external monitoring; the alarm would go off if someone came to the front or rear doors after dark. The alarm was hooked up to a central location, which called the house if the alarm went off. If no one answered, or if someone answered and gave the wrong password, the police were called. The police came out and if no one was home, they walked around the outside of the house to make sure there had not been a break-in.

My friend believed casual burglars would be deterred by the alarm company stickers he had on the front and rear doors. However, he was still concerned about sophisticated burglars—especially because he had just been featured in the local newspaper as a jet-setting lawyer. He decided on his next business trip he would try and have the police check on his house every weekend. To his dismay, he discovered that the police were unwilling to provide such services and would only go to check his house if there was an alarm or a phone call to 911.

The alarm was so advanced, my friend could check on its status (including arming and disarming the system, and setting off the alarm) by phone. My friend realized that he could set off the alarm on Friday and Saturday nights by calling in, and the police would come out and check on things in his absence. On his next month-long trip out of town, he called the house every weekend night at different times and set off the alarm. Coincidentally, the alarm went off on its own a half-dozen times, when people came to the door after dark.

On his return, my friend was faced with unhappy neighbors, irritated police and a staggering bill from the local township, which had decided the only way to stem the tide of false alarms was to start charging people...
for them. My friend was unhappy because he did not realize that his decision to try and protect the things that were most precious to him would result in such heavy financial consequences. One of his neighbors, however, pointed out to him that his payment of a monitoring fee did not entitle him to unlimited personal security—particularly when the costs of his decisions were borne by his neighbors, the taxpaying citizens of the local township and the police.

My friend is not alone. As fear of crime has increased, home alarm systems have become ubiquitous in many parts of the country. Most such systems are hooked into a central monitoring station that either notifies the police or sends private security guards in the event of an alarm. Although the alarm is intended to be triggered only when there is a threat to property or life (a burglary or home invasion), false alarms account for an exceedingly high percentage of alarms. The police have grown increasingly tired of responding to false alarms because they divert the police from other law enforcement efforts. With the enthusiastic support of the alarm industry, many communities have imposed substantial fees for each false alarm.

Thus, private efforts to obtain personal security that imposed excess costs on one's fellow citizens were shifted back to the individual—even in a nation in which crime is a perennial top priority. Treating every alarm as a true emergency was simply not a sustainable strategy when the aggregate social costs swamped the marginal individual safety benefit. In short, the payment of a modest monthly fee did not entitle one to "cry wolf" more than once or twice. In like fashion, the payment of a monthly health insurance premium does not entitle a subscriber to more than the contract provides—if the contract is limited to the provision of necessary emergency care, the subscriber has no complaint if nonemergency serv-

130. See National Burglar & Fire Alarm Assoc., Inc., Quick Facts & Stats About the Electronic Security Industry (visited Mar. 1, 1998) <http://www.alarm.org/quick.htm> [hereinafter Quick Facts & Stats] (discussing home alarm systems); National Burglar & Fire Alarm Assoc., Inc., The Model Cities Program (visited Mar. 1, 1998) <http://www.alarm.org/modcity.htm> [hereinafter The Model Cities Program] (same). There were approximately 2.6 million burglaries in the United States in 1995, or one every twelve seconds. See Quick Facts & Stats, supra. Approximately 20% of American homes are electronically protected, although not all of these alarms are connected to a central monitoring system. See id. Homes without security systems are reported to be three times more likely to be broken into, and suffer greater losses when they are broken into. See id. ("Independent studies show that a homeowner is 3 to 6 times less likely to be burglarized than homes without security systems; Losses due to burglary average $400 less in residences with security systems than for a residence without security systems.").

131. See, e.g., Bill Dries, Readers Sound Off on False Alarm Fines and Firms, Com. Appeal, Sept. 15, 1997, at A1 ("The latest local [Memphis, Tennessee] statistics show 98 percent of the 125,000 burglary alarm calls police answered last year were false alarms.").

132. See The Model Cities Program, supra note 130 (noting support of National Burglar and Fire Alarm Association for imposition of fines for false alarms as part of effective false alarm reduction plan).
ices are not covered or if the insurer loses its patience after too many false alarms.

A benign explanation for the fundamental inconsistency between the way in which our society handles false burglar alarms and false ED alarms is that it reflects a difference in the stakes. Yet, burglaries can result in severe financial losses, and home invasions can result in death or permanent disability. A more plausible explanation is that the costs of false burglar alarms are an on-budget expense (and the reform moves them off-budget), while the government bears only a modest percentage of the cost of false ED alarms and the consumer protections it enacts.

This point deserves some additional elaboration because the consensus view seems to be that the federal and state governments are necessarily honest brokers of disputes between MCOs, providers and plan beneficiaries. Unfortunately, as a historical matter, governmental resistance to rent-seeking behavior has been dismal at best. The government’s record in dealing with externalities is little better. See, e.g., Apache Bend Apartments, Ltd. v. United States, 702 F. Supp. 1285, 1287-89 (N.D. Tex. 1988), aff’d, 964 F.2d 1556 (5th Cir. 1992), reh’g en banc granted, 974 F.2d 588 (5th Cir. 1992), aff’d in part, rev’d in part, 987 F.2d 1174 (5th Cir. 1993) (en banc) (reviewing legislative history indicating preferential transitional tax treatment of certain individuals and industries with access to influential members of Congress); Jeffrey H. Birnbaum & Alan S. Murray, Showdown at Gucci Gulch: Lawmakers, Lobbyists, and the Unlikely Triumph of Tax Reform 6-17, 240-43 (1988) (reviewing tax preferences granted to all and sundry but disproportionately to those with political influence; even tax reform bill had favorable transitional rules and tax breaks for favored few); Glenn R. Simpson, Pizza Makers’ Success on Tax Break Reveals a Slice of Political Life, WALL. ST. J., Sept. 9, 1996, at A1 (noting that home delivery “pizza moguls” secured tax break that softens impact of increase in minimum wage laws).

And what of “corporate welfare”? Several governmental programs confer private benefit without corresponding societal benefit and come with price tags of almost $100 billion per year. See Stephen Moore, How to Slash Corporate Welfare, N.Y. TIMES, Apr. 5, 1995, at A25 (listing “eight of the most egregious examples of corporate welfare in the federal budget”). These governmental programs include Sematech; sugar price supports; subsidies to the electric utilities, the timber industry, the Department of Agriculture’s market promotion program, the advanced technology program and clean car initiative; and tax breaks for companies producing ethanol. See id.; see also Corporate Welfare: Hearing Before the Committee on the Budget, 104 Cong. 20 (1996) (statement of Robert Greenstein, Executive Director, Center on Budget and Policy Priorities) (expressing concern that “not much has been done in corporate welfare”); Gary Mucciaroni, Reversals of Fortune: Public Policy and Private Interests 1 (1995) (noting rise and fall of favored groups with subsidies delivered through preferential tax treatment, anticompetitive regulation, trade barrier and price supports); Martha Derthick & Paul J. Quirk, The Politics of Deregulation 207-36 (1985) (examining effects of regulation and deregulation on “natural gas pricing, air pollution control, wages paid on federally supported construction projects, milk marketing, and ocean shipping”).

133. Space considerations preclude a full review of this topic, but highlights would include the tax preferences and transitional tax rules that riddle the Internal Revenue Code—and coincidentally happen to favor the wealthy and well connected. See, e.g., Apache Bend Apartments, Ltd. v. United States, 702 F. Supp. 1285, 1287-89 (N.D. Tex. 1988), aff’d, 964 F.2d 1556 (5th Cir. 1992), reh’g en banc granted, 974 F.2d 588 (5th Cir. 1992), aff’d in part, rev’d in part, 987 F.2d 1174 (5th Cir. 1993) (en banc) (reviewing legislative history indicating preferential transitional tax treatment of certain individuals and industries with access to influential members of Congress); Jeffrey H. Birnbaum & Alan S. Murray, Showdown at Gucci Gulch: Lawmakers, Lobbyists, and the Unlikely Triumph of Tax Reform 6-17, 240-43 (1988) (reviewing tax preferences granted to all and sundry but disproportionately to those with political influence; even tax reform bill had favorable transitional rules and tax breaks for favored few); Glenn R. Simpson, Pizza Makers’ Success on Tax Break Reveals a Slice of Political Life, WALL. ST. J., Sept. 9, 1996, at A1 (noting that home delivery “pizza moguls” secured tax break that softens impact of increase in minimum wage laws).

134. As with the previous topic, space considerations preclude a complete review. Commerce Clause litigation provides numerous examples of the routine
men were angels, no government would be necessary, but one should not therefore conclude that the government is populated by angels—particularly in the face of considerable empirical evidence to the contrary. In short, the government is not a neutral party when it comes to these matters—especially when it is enlisted by providers to create or enforce a cartel, in which event most of the surplus is likely to be captured by those same providers.

VI. Where Do We Go from Here?

It is one thing to identify weaknesses in proffered reforms, but quite another to argue that the current situation cannot be improved. Consumers are weak, ignorant, poor and disorganized, and their ability to get the terms they want is limited by ERISA, their bounded rationality and their limited ability to "shop around." When these limitations are coupled with the agency problems induced by employer-based insurance, the case for aggressive consumer protection regulation seems self-evident.


And what of crop subsidies, including those secured by those masters of the art, the dairy industry? See Scott Kilman, Inside the Byzantine World of Milk Prices, WALL ST. J., Nov. 25, 1997, at B1. Kilman noted that

Sen. Patrick Leahy (D., Vt.) helped tag onto the 1996 farm bill approval for a six-state New England milk-price compact. Because the compact essentially flouts the constitutional protection of interstate commerce, it required congressional approval. Called the Northeast Interstate Dairy Compact, it insures that cheap Midwest milk doesn't undercut local producers' prices by pricing all milk the same . . . . For the average Vermont dairy farmer, the compact is putting about $1,000 more a month into the bank. New England shoppers, meanwhile, are paying collectively about $5 million more for milk monthly, Public Voice figures . . . . Now, state lawmakers and milk lobbyists elsewhere are rushing to follow New England's example.

Id.

135. See John Shepard Wiley Jr., A Capture Theory of Antitrust Federalism: Reply to Professors Page and Spitzer, 61 S. CAL. L. REV. 1327, 1339 (1988) ("To rest content with identifying flaws in policy suggestions, however, indulges the nirvana fallacy. The motif of policy debates should not be whether a proposal is perfect but whether it beats the alternatives in improving the status quo.").

Unfortunately, as Part V suggests, matters are not so simple. As an empirical proposition, if the consumer protections outlined in Part III are so important, how does one explain the striking lack of evidence indicating that those enrolled in self-funded ERISA plans (where there is effectively no substantive regulation) are any more unhappy with their insurance than those enrolled in plans that are aggressively regulated at the state level? One would have thought such evidence would be imme-

benefits consulting firm of KPMG Peat Marwick, 45 per cent [sic] of Americans who get their health insurance through their employers are offered only one plan.”); Robin Toner, *Harry and Louise Were Right, Sort Of*, N.Y. Times, Nov. 24, 1996, at 4:1 (“[A]mong mid-size employers, 52 percent now offer their workers only one plan.”). Davis and Schoan elaborated on the limited choices available to American workers:

Based on preliminary data from the 1997 *Kaiser/Commonwealth National Health Insurance Survey*, 40 percent of those currently employed are working for an employer who offers a choice of plans. An equal proportion have only one plan. One out of six (17 percent) have no plans offered through their employer. Full-time employees are the most likely to have a choice.

The choice available to a given worker, however, does not necessarily reflect the degree of choice available to the family. Taking into account plans offered by a spouse’s employer, as well, 52 percent of working age adults (age 18 to 64) who are employed (or have an employed spouse) have a choice of plans. . . .

Often the choice of plans provided by employers does not include a fee-for-service (FFS) plan. More than one out of four workers (28 percent) say that their employers do not offer “a plan that will pay when you see any doctor you want.”

Davis & Schoan, *supra*.

Even when employers offer multiple plans, their preference structure appears, in some instances, to differ from that of their employees. See Danay Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and a Regulatory Quagmire*, 31 *Wake Forest L. Rev.* 1037, 1055-57 (1996) (noting empirical evidence suggesting variety of differences between employers’ and employees’ health insurance preferences); see also Hoffman, *supra* note 70, at 350-51 (discussing reasons why employers do not always make decisions regarding health plans with employees’ best interests in mind). Of course, there are other arguments in favor of consumer protection, including the risk of exploitation and the externalities that can result from limited coverage.

At H.L. Mencken observed, “[f]or every complex problem, there is a solution which is simple, elegant, . . . and wrong . . . .” Mark A. Hall & John D. Columbo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 *Wash L. Rev.* 307, 330 n.76 (1991). Other versions of the same aphorism are readily available. See, e.g., United States v. Michael, 645 F.2d 252, 264 n.6 (5th Cir. 1981) (“For every complex problem, there is usually a simple answer—and it’s usually wrong.”); United States v. McCoy, 32 M.J. 906, 909 (A.F.C.M.R. 1991) (“For every complex problem there is a simple solution . . . and it is usually wrong.”); Bing v. Florida, 492 So. 2d 833, 835 n.9 (Fla. Dist. Ct. App. 1986) (“For every complex problem there is a solution that is short, simple and wrong.”).

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138. Even if there were such evidence, a complete assessment of the issue requires consideration of the offsetting benefits received by the policyholders from the existence of the self-funded plan as such. See *Pilot Life Ins. Co. v. Dedaux*, 481 U.S. 41, 54 (1987) (“[T]he detailed provisions of §502(a) of ERISA set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest..."
diately at hand if the problems are as severe as is commonly believed. 139 Absent such evidence, those arguing for across-the-board consumer protections should be required to provide a great deal of evidence about the merits of each incremental reform, as well as some insight into their ultimate objective. 140

But what if there are such problems in the health insurance market? The correct response to that observation is a further question: Does regulatory intervention offer a solution or will it create a different (and potentially worse) set of problems? 141 In drafting consumer protections, there

in encouraging the formation of employee benefit plans." (emphasis added).

Employers need not offer any coverage at all, but there are distinct advantages—lower search costs, less expensive coverage, compensation for bounded rationality—in securing group coverage through employment. See Matthew, supra note 135, at 1042-45 (examining several advantages of employment-based health coverage). Even half a loaf is better than none—and participants in ERISA plans receive a great deal more than half a loaf. To be sure, there are always trade-offs within the common pool because the demand for health care varies in ways that are generally predictable along a number of parameters, including age, race and sex. Because insurance only shifts and spreads risk for which the policy provides coverage, the specification of such coverage necessarily implies a series of trade-offs within the common pool, with significant distributional implications within and across identifiable groups. Although legislative mandates can reallocate resources within the common pool, they do not create resources, and the new services are covered at the expense of something else, or of increased premiums or both.

139. For a discussion of complaints about managed care, see supra note 3 and accompanying text.

140. At the federal level, there is no mistaking the desires of the administration. One commentator observed that although the Clinton administration was only proposing consumer protection, the President made clear that the old impulses, the yearning for health security for all, are just below the surface. "There is," he said, "an emerging consensus that while people may not have wanted to bite the whole apple at once in 1994, almost the whole population wants to keep nibbling away at the apple until we actually have solved the problems of cost, accessibility and quality for all responsible American citizens."

Pear, supra note 48, at A18. Although one naturally wonders how these problems will be solved by making coverage more expensive, a substantial percentage of Congress seems inclined to go along, if only to avoid being tarred as anticonsumer protection. See id. (noting approval by one-third of congressional Republicans of Clinton's proposed legislation). But see Dick Armey, Socialized Medicine on the Installment Plan, WALL ST. J., Nov. 17, 1997, at A26 (opposing consumer protection initiative); Eric Weissenstein, Word from Washington: The Ghost of ClintonCare: In Fight Against Managed-Care Regulation, Republicans Return to Successful Theme, MOD. HEALTHCARE, Nov. 17, 1997, at 36 (noting opposition of business groups, managed care organizations and some Republicans to consumer protection legislation).

If we are to adopt universal coverage, it should be after a debate on the merits of that proposal (which its proponents have lost each and every time it has been raised) rather than by slouching toward a national health plan.

141. The problem was wryly summarized by a long-time (but now former, and until recently, incarcerated) Chairman of the House Ways and Means Committee: "Fundamental reform almost always runs the risk of making things worse." Flat Tax Proposals Before the Senate Finance Comm., 104th Cong. (1995) (statement of Sheldon D. Pollack) (quoting Daniel Rostenkowskí); see also Judith Miller, Selling
is little guarantee that the legislature will actually target the right problem because its selection is heavily influenced by bad anecdotes and perceived public appeal. Even if the legislature fortuitously picks a reasonable target today, there is no guarantee it will do so tomorrow. "Mom and apple pie" legislation, of which consumer protection against managed care is clearly an example, is particularly prone to legislative posturing and overreaching. Even if there is an agency problem with employer-based

142. The history of the gag clause controversy is particularly revealing on this point. After condemnation of such clauses by every member of Congress who spoke on the subject, the General Accounting Office determined that there were no true gag clauses in any of the 1,150 contracts they examined—and the majority of the contracts included express statements that any provisions included therein were not intended to prevent or limit discussions between physician and patient. See generally General Accounting Office, GAO/HEHS 97-175, Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, but Physician Concerns Remain (1997). Opponents of managed care also have yet to produce a single true gag clause—and the antidisparagement and commercial secrecy clauses on which they have focused are common in many contracts. Even if a true gag clause had been included, there is plenty of evidence indicating that parties to a contract will frequently ignore contractual rights to maintain reputational interests. See, e.g., Daniel Keating, Measuring Sales Law Against Sales Contracts: A Reality Check, 17 J. L. & Comm. (forthcoming 1998) (observing that concern for reputation is greater restraint than contractual terms). More to the point, in a market where MCOs can terminate providers at will, they hardly need a gag clause.

The controversies over the appropriateness of drive-through deliveries and the desirability of routine mammograms for women in their forties are other examples of the same phenomenon. See generally Hyman, supra note 22; see also Steven H. Woolf & Robert S. Lawrence, Preserving Scientific Debate and Patient Choice: Lessons from the Consensus Panel on Mammography Screening, 278 JAMA 2105, 2107 (1997) (recounting congressional pressure to revise consensus panel recommendation and stating that congressional "positions, influenced by ballot concerns and special interests, can misinform the public and can assume the power of law, effectively taking decisions out of the hands of patients and physicians").

143. See Goodman, supra note 70, at 10A. As Mr. Goodman pointed out, [a] lot is at stake here. One silly regulation invariably leads to many more. Bowing to special-interest pressures, state legislatures already are forcing insurers to pay for services ranging from acupuncture to in vitro fertilization. Insurers must pay for hairpieces in Minnesota, marriage counseling in California and pastoral counseling in Vermont. Id.; see also Robert H. Jerry, Understanding Insurance Law 437-39 (1996) (reviewing mandates). Another commentator observed that [l]egislating a two-day minimum maternity stay will raise health insurance costs by just a fraction of 1 percent. The real danger here is the precedent in an era of tight government budgets. Elected officials who cannot please constituents with additional spending or tax cuts still have the option of curtailing favor by mandating private benefits. And as long as there is a plausible rationale along with emotional appeal, minimum-benefit creep will be hard to resist.

Passell, supra note 110, at D2.

144. See Kassirer, Practicing Medicine, supra note 60, at 1747 ("This is decision making by emotional and opportunistic concensus.") The problem is worsened because the costs of such efforts are largely off-budget. See Goodman, supra note
insurance, it is a mathematical certainty that the agency problem is worse
if one regulates at the state level—let alone the federal level.

Similarly, although they are usually off-budget, consumer protection
regulations are not free. They are borne by consumers in the
form of higher premiums or lesser coverage—or both. In short, one

70, at A10 ("[S]pare us the spectacle of craven, vote-seeking politicians kowtowing
to people who want to have their cake and eat it, too."). The debates over the
Newborns' and Mothers' Health Protection and Mental Health Parity Acts ref-
The problem is obviously not unique to health care. See generally David A. Hyman,
When Bad Laws Happen to Good People: The Case Against A Duty to Rescue (Feb. 1997)
(unpublished manuscript on file with author) (collecting examples). Environ-
mental law is particularly prone to such symbolic legislation. As Professor Dwyer
has noted,

[m]ost regulatory statutes instruct agencies to balance competing con-
cerns in setting standards. Some regulatory statutes, however, impose
short deadlines and stringent standard-setting criteria that are designed
to address a single, overriding concern to the exclusion of other fac-
tors. . . . The programs mandated by such legislation are more symbolic
than functional. Frequently, the legislature has failed to address the ad-
inistrative and political constraints that will block implementation of
the statute. By enacting this type of statute, legislators reap the political
benefit of voting . . . against "trading lives for dollars," and successfully
sidestep the difficult policy choices . . . .
John P. Dwyer, The Pathology of Symbolic Legislation, 17 ECOLOGY L.Q. 233, 233

145. When Congress extends consumer protections to the Medicare and (to a
lesser extent) Medicaid populations, it bears the costs of its decisions. As de-
scribed previously, a variety of consumer protections have been implemented in
the Medicare and Medicaid markets—and a number of commentators have sug-
gested that other health plans should follow this lead. Although Congress has
clearly indicated that it believes such protections are cost-justified, the troubled
financial status of the Medicare program might cause one to wonder about the
advisability of following Congress' lead. Indeed, one must wonder how serious
Congress is about the costs of its reforms when the bipartisan "solution" to Medi-
care's financial woes was to move home health care from Part A (funded through a
special tax) to Part B (largely funded through general revenues), thus deferring
the bankruptcy of the Part A trust fund for a few additional years, but doing noth-
ing whatsoever about the overall cost of the program.

When states have passed consumer protections, they have been known to ex-
clude Medicaid managed care beneficiaries and state employees from their protec-
tions—and the only thing these groups have in common is that the state bears
some or all of the costs of the protections it extends. See generally Hyman, supra
note 22.

146. See Ornstein, supra note 4, at A15. As Mr. Ornstein has observed,
if Congress, the president, business and the public want to see costs re-
strained, and if journalists want to present a complete and accurate pic-
ture, they all have to recognize that there is no free lunch here. Even
after more efficiencies and lower rates of return for HMOs, every pro-
dure that Congress requires insurance companies to provide means a cost
trim somewhere else, through lower doctor or hospital fees or another
procedure denied.

Id.

A specific numerical example is found in the Congressional Budget Office's
(CBO's) report on the estimated impact of the Newborns' and Mothers' Health

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does not get something for nothing, even from an insurance company. More generally, cost-quality trade-offs must be faced within and across every field of human enterprise. Regulations that hide those choices or (not so) arbitrarily pick a uniformly expensive floor do no one any favors—least of all those who are priced out of the market entirely. The usual response—that health is priceless—is of little help in a world of scarcity. Cost must always be considered, and those for whom price is no object are never those who ultimately foot the bill.

Finally, calling a statute “consumer protection” is no guarantee that it will actually accomplish that end. When statutes are proposed and backed by those who provide the mandated services, it is a safe first approximation that any consumer benefit is largely incidental—and frequently nonexistent. This is not to say that true consumer protection

Protection Act of 1996, which prohibited drive-through deliveries:
CBO estimates that the proposal would initially raise private group health insurance premiums by about 0.06 percent. In response, employers and employees would reduce coverage or drop benefits for other services. Because of these reductions, we assume that employer contributions for health insurance would rise by only 0.02 percent. Most of that increase would be passed back to employees in lower wage.

S. REP. NO. 104-326, at 12 (1996); see Laura Meckler, Medical Mandates Carry Price, Experts Tell Nation’s Lawmakers, CHATTANOOGA TIMES, Jan. 9, 1997, at D3 (noting costs associated with mandated coverage).

147. See George Stigler, The Theory of Economic Regulation, 2 BELL J. ECON. & MGMT. SCI. 3 (1971) (“[A]s a rule, regulation is acquired by the industry and is designed and operated primarily for its benefit.”); Fred S. McChesney, Commercial Speech in the Professions: The Supreme Court’s Unanswered Questions and Questionable Answers, 134 U. PA. L. REV. 45, 98 n. 210 (1985) (“[S]kepticism about the stated public-interest purposes of licensing goes back at least as far as Adam Smith.”).


[t]he rationale of every governmental action almost always has a nice version and a naughty version.... The “nice” version of the Filled Milk Act, for example, is that the bill was designed as a paternalistic measure to prevent uneducated and even illiterate consumers from purchasing a less expensive but less nutritious substitute for milk and cream.... On the other hand, the rationale of the Filled Milk Act also has a naughty version.... It is not too uncharitable, perhaps, to suggest that concern for the dairies’ pocketbooks rather than for the consumer’s health best explains the dairy lobby’s efforts. In fact, though the filled milk legislation seemed to be aimed at helping consumers, it may have harmed them. They were “saved” from “adulterated” products, but only at the cost of higher prices, while the dairy industry benefitted from reduced competition.

Id. (emphasis added). Even licensing creates similar opportunities for misbehavior. As Professor Gellhorn observed:

Of course many special interests perceive themselves as nurturers of the public interest rather than as self-seekers. The line between the common weal and one’s own is not always easily drawn. But occupational licensing has typically brought higher status for the producer of services at the price of higher costs to the consumer; it has reduced competition; it has narrowed opportunity for aspiring youth by increasing the costs of entry into a desired occupational career; it has artificially segmented skills so that needed services, like health care, are increasingly difficult to supply

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legislation must necessarily hurt the interests of all providers, but the systematic demonization of MCOs and the deification of fee-for-service providers provide some clues about the identity of the true beneficiaries of the legislation described in Part III.

One need not have much of a conspiratorial bent to view the “attacks by anecdote” outlined in Part II as part of an ongoing “Astroturf” lobbying campaign against managed care orchestrated by disaffected and unemployed or underemployed health care providers.149 These groups have spent considerable effort collecting and popularizing managed care horror stories.150 Their tactics are consistent, regardless of the underlying economically; it has fostered the cynical view that unethical practices will prevail unless those entrenched in a profession are assured of high incomes; and it has caused a proliferation of official administrative bodies, most of them staffed by persons drawn from and devoted to furthering the interests of the licensed occupations themselves. . . . Only the credulous can conclude that licensure is in the main intended to protect the public rather than those who have been licensed or, perhaps in some instances, those who do the licensing.


149. See Lisa Belkin, But What About Quality?, N.Y. TIMES, Dec. 8, 1996, at 6:68 (noting that managed care is being judged by “attack by anecdote”); Stuart Auerbach, Managed Care Backlash: As the Marketplace Changes, Consumers Are Caught in the Middle, WASH. POST, June 25, 1996, at Z12 (“Patients who feel wronged by the system have joined in a potent lobby with doctors, nurses, hospitals and other health care providers whose professional survival, incomes and long-held practice patterns are threatened by managed care.”); Olmos & Roan, supra note 34, at A1, (“[M]anaged care officials see the onslaught of legislation as a “public relations ploy” by medical groups unhappy with the growing influence of managed care over their profession.”).

“Astroturf lobbying” allows a group to present its position as a grass roots campaign, regardless of the actual degree of public concern. See Elizabeth Kolbert, Special Interests’ Special Weapon, N.Y. TIMES, Mar. 26, 1995, at 20 (“They look like grass-roots movements but are actually campaigns manufactured by special interest. . . . They are called ‘Astroturf.’”); They Don’t Want Your Input; They Just Want Your Name; Astroturf Lobbying Creates Phony ‘Grass Roots’, BUFF. NEWS, Dec. 31, 1995, at F6 (“Astroturf lobbying is simply fake “grass-roots” pressure . . . . A typical tactic is to hire phone solicitors to call unsuspecting citizens, read them a misleading description of a bill and then ask if they wouldn’t like to do the equivalent of supporting motherhood or opposing Satan.”). For an account of an Astroturf campaign that backfired, see David Segal, The Tale of The Bogus Telegrams, WASH. POST, Sept. 28, 1995, at A1.

150. See Auerbach, supra note 149, at Z12 (“[A] cottage industry has developed to solicit patients who have bad experiences with managed care and market their stories to the press, television, state legislatures, and Congress.”); Physicians Who Care, The HMO Page (visited Mar. 1, 1998) <http://www.hmopage.org> (announcing “Managed Care Atrocity of the Month,” posting “Managed Care Hall of Shame” and soliciting additional managed care related stories); Physicians Who Care, Physicians Who Care in Action (visited Mar. 1, 1998) <http://www.pwc.org/summer97/art4.html> (“Physicians Who Care members continue to be active in providing HMO horror stories to the media, giving interviews to newspaper and magazine reporters, as well as appearing on radio and television shows.”); Consumer Coalition for Quality Health Care, The Quality Watchline (visited Mar. 1, 1998) <http://www.consumers.org/wline.htm> (announcing Consumer Coalition
issue. Economic constraints are assailed for interfering with the doctor-patient relationship. Favored but costly treatments are labeled "safe" and "appropriate," while disfavored cut-rate treatments are tarred as "unsafe" and "inappropriate." The implied appeal to absolute safety is a dodge; the real issue is how much relative risk should be self-insured and how much should be socialized.\footnote{151} The use of the term "appropriate" is equally disingenuous: "Who, after all, can be found to stand up for 'inappropriate' treatment or actions of any sort?"\footnote{152}

There is no question that managed care poses some hazards for its customers, but so does fee-for-service medicine. More generally, any agency relationship has inherent and inescapable conflicts of interest. These conflicts can be made better or worse by the system of compensation that is employed, the significance and half-life of reputational interests, the ability to recover for misbehavior and the nature of the agency relationship (one-shot or repeated). Nevertheless, agents will never be principals. As such, efforts to enact consumer protection reforms in managed care, when their conspicuous absence was tolerated in fee-for-service medicine, should be approached with a jaundiced eye. The government has no business picking sides in the trench warfare that some providers are waging against managed care—let alone doing so under the guise of consumer protection. The overwhelming urge to "get in there and do the right thing" should be tempered by the repeatedly validated knowledge that regulatory intervention frequently has the opposite result.

\section{VII. Conclusion}

Pursuant to federal law, cigarettes carry an explicit warning that they are hazardous to one's health. As yet, the surgeon general has not had anything to say about the perils of managed care, but it may just be a matter of time—particularly because the only industry with a worse reputa-

for Quality Health Care's toll-free phone number and e-mail address to report complaints about managed care).

Many of those espousing consumer protection claims are provider groups, who clearly have their own interests at stake. \textit{See, e.g.}, Consumer Coalition for Quality Health Care, \textit{Participating Organizations}, (visited Mar. 1, 1998) <http://www.consumers.org/members.htm> (listing provider groups who support consumer coalition).

\footnote{151. \textit{Cf.} Victor Cohn, \textit{Vaccines and Risks: The Responsibility of the Media, Scientists, and Clinicians}, 276 \textit{JAMA} 1917, 1918 (1996) ("I believe we should all refrain from invoking the overused word 'safe.' . . . Almost nothing is completely safe, and we should officially and individually consider substituting 'relatively safe' or 'as safe as possible,' and indicating, in the best numbers and rates we can muster, the degree of safety or risk.").}

\footnote{152. Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 271 (6th Cir. 1990); \textit{see also} Thomas L. Shaffer & Julia B. Meister, \textit{Is This Appropriate?}, 46 \textit{Duke L.J.} 781, 781 (1997) ("The word 'appropriate' is so wildly overused in American culture that, as with other vacuous words and phrases, a person learns to read right through it. 'Appropriate' is verbal tofu.").}
tion than managed care is tobacco. Yet "attack by anecdote" provides no basis with which to assess the overall merits and inadequacies of a system with hundreds of millions of annual encounters between health care providers and patients. Even if the complaints in Part II are accurate, representative and frequent, such complaints provide no evidence that consumers are actually prepared to pay the necessary amounts to solve these problems.

Consumer protection against managed care looks like an easy winner for media-savvy politicians—who, after all, likes insurance companies? Yet, even if there are problems with managed care or particular managed care providers, it does not follow that consumer protection statutes can effectively solve such problems without inducing offsetting distortions or providing undue opportunities for rent-seeking. Even when each piece of incremental regulation is positioned as a necessary reform, the costs (both on- and off-budget) add up quickly. The result of such initiatives is restricted choice at a higher cost—an outcome that hardly serves consumers' interests. One could object that health care is special—but even if it is, the important question is whether regulation leads to better coverage design than voluntary arrangements, all things considered—including

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153. See Louise Kertesz, HMO Makeover: Are Managed Care's Efforts to Overhaul Its Image Too Little, Too Late?, MOD. HEALTHCARE, May 12, 1997, at 36 ("In a survey released by the public relations firm Porter/Novelli in February 1996, only 10% of consumers thought the managed-care industry was 'believable.' That placed it a notch above the tobacco industry."); Lee Bowman, Americans Don't Like or Understand HMOs: Many Don't Even Realize They're Enrolled in One, ROCKY MTN. NEWS, June 29, 1997, at 9G ("[A]n expert on public attitudes toward health care, cited a recent Harris poll that asked people which groups 'do a good job in serving consumers.' Only 51 percent said HMOs and managed care companies did a good job, ahead only of tobacco companies, which got approval from 34 percent.").

154. Although their use of anecdotes suggests otherwise, even the advocates of consumer protection seem to agree. See Serafini, supra note 9, at 2283 ("Even while unleashing numerous horror-story anecdotes, the authors of the Families USA study advise caution. An individual story cannot and should not be used . . . [as] the sole basis upon which new, far-reaching laws are legislated.").

155. See Milt Freudenheim, Many H.M.O.'s Easing Rules On Seeking Specialists' Care, N.Y. TIMES, Feb. 2, 1997, at 1:1 ("Dr. Friesen conceded that his group's patients 'love our price, they love our doctors, but they hate the referral process.' He questioned, though, whether the patients were ready to pay for a change. '[F]or $80 a month, [they want] access to networks that would cost $200 a month.'"); see also E. Douglass Williams & Richard H. Sander, The Prospects for "Putting America to Work" in the Inner City, 81 GEO. L.J. 2003, 2047 n. 180 (1993) ("In a 1987 . . . poll, 71% of respondents agreed with the statement that 'the government in Washington should see to it that everyone who wants a job has a job.' . . . The high support level, however, tells us little about how much Americans would be willing to pay to accomplish this goal.").

156. Cf. Randall R. Bovbjerg, Liability and Liability Insurance: Chicken and Egg, Destructive Spiral, or Risk and Reaction?, 72 TEX. L. REV. 1655, 1655 (1994) ("Something there is that doesn't love an insurer.").

157. For a discussion of consumer preference for wide selection of health plans, see supra note 97 and accompanying text.
Unfortunately, the usual approach of regulators is to take a “health is special,” “price is no object” and “nothing but the best” view of the coverage market—a wonderfully egalitarian, but wholly unrealistic view of the situation. The more special health care is, the more important it is to not make things worse than they already are by opting for the wrong uniform solution.

What then should be done? As always, the government must prevent force, fraud and duress. The government should also encourage the development of better measures for assessing the quality of the health care that is actually delivered—including its impact on clinical outcomes. There are also a number of nonglamorous things that the state and fed-


159. See Uwe E. Reinhardt, Uncompensated Hospital Care, in Uncompensated Hospital Care: Rights and Responsibilities 1, 11 (Frank A. Sloan et al. eds., 1986) (“The champions of the poor, and the poor themselves must recognize that, in the political and budgetary climate of the 1980s [and 1990s], pursuit of the maxim ‘for the poor, nothing but the best’ may leave the poor with nothing.”). Professor Siliciano noted similar difficulties with the impact of tort law on access to medical care:

Tort law instructs health care providers to treat the poor the same as the rich, but then blithely ignores the fundamental impact that resource scarcity and the provider’s freedom to refuse care to the poor have on the efficacy of its command. . . . By embracing the chimera of equality between the rich the poor, [tort law] effectively disables health care providers from offering reasonable, low-cost care to large numbers of the medically indigent. Thus, through its adherence to the unitary ideal, tort law may end up killing the poor with an unthinking and misguided kindness.


160. See Epstein, supra note 158, at 311. As Professor Epstein has observed, [i]nstead the importance, so to speak, of importance is simple: it is important to get the right set of solutions, be it private or public, to the problem at hand. Importance does not create a presumption in favor of government, or for that matter against it. It only raises the stakes for making a correct decision in the matter at hand.

Id.

161. In the health insurance context, fraud would include promising broad ED coverage (and collecting premiums on that basis) and then delivering more restrictive coverage, as well as refusing to pay if care was pre-authorized, without regard to whether there was a true emergency. It would not, however, include promising narrow ED coverage and delivering the same, or placing restrictions on access to the ED.

162. See Robert H. Brook, Managed Care Is Not the Problem, Quality Is, 278 JAMA 1612 (1997) (arguing that failure to address quality of care is real problem with modern medicine and health policy).
eral legislatures could do to enhance the operation of the health insurance market. These reforms would include the leveling (preferably down, but more likely up) of the tax consequences of purchasing health insurance in the employer-based and nonemployer-based markets; unrestricted access to medical savings accounts for those who wish to purchase them; the repeal of community rating, genetic antidiscrimination provisions and similar impediments to true risk-based insurance; broader availability of large group coverage for those currently covered in the individual and small-group markets; the elimination of EMTALA’s protections for those who are insured and the expansion of the ERISA free-fire zone to encompass all group health insurance plans. To the extent the government feels absolutely compelled to directly regulate in these areas, it should limit itself to disclosure-oriented provisions.

163. A full explanation of the reasons for each of these true reforms would occupy another article. Instead, I limit my comments to the reform most applicable to the subject of the paper, the repeal of EMTALA for those who are insured. As outlined in an earlier article, the case for repealing EMTALA for the insured is as follows:

[i]nstead of adding an additional layer of laws to fix the problems created by EMTALA, why not get rid of EMTALA in the first place, at least for those who are insured? Once this is done, MCOs will not be able to impose costs on hospitals, and the insurance market will be free to seek the level of coverage for emergency care demanded by its customers. MCO members will be able to pick a plan that provides the level of coverage they want, and make their own trade-offs in the Benefit/Cost No Man’s Land. The likely increase in self-insurance will also lower the rate of inappropriate ED utilization. Coverage will probably end up looking nothing like that implicit in the ‘consumer protection’ bills... but isn’t that one of the benefits of having a voluntary insurance market?

Hyman, supra note 63, at 68.

For more background on the Cost/Benefit No-Man’s Land, see Clark Havighurst, Contract Failure in the Market for Health Services, 29 WAKE FOREST L. REV. 47, 51-54 (1994); Clark Havighurst & James F. Blumstein, Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs, 70 NW. U. L. REV. 6, 17 (1975).

164. Of course, disclosure-oriented provisions are not perfect. One commentator has noted some of the difficulties:

At its core, the true market failure we are experiencing in health benefits is that (1) a growing number of Americans face restricted choices in health care; (2) those Americans lack the ability to determine whether the effect of those restrictions will be harmful to their health; and (3) they do not automatically trust either health plans or providers to act in their best interest in the emerging market environment. Short of a legislated reversion to the status quo ante of, say, 1975, it is unclear how government action could address these concerns. While government could, in theory, purport to address the problem through information-related regulation, it is difficult to visualize the information that would be needed to materially affect public confidence on so fundamental a question. We could, of course, bury consumers in a pile of descriptive information about health plans, their provider networks, and their performance against various objective measures. Even if consumers were willing to wade through the pile, however, the vast majority would find the information ambiguous at best... Although it is tempting to think that governmental efforts could be directed to manufacturing answers to all known...
As for the rest, leaving well enough alone is likely to be sufficient unto the day. As the modest example of consumer protection outlined in this paper establishes, any given rule or standard for handling problems with managed care has imperfections. The determination of the right mix of premium, health care services (preventative, nonurgent, urgent and emergent) and administrative expense is hardly self-evident, even without factoring in the agency, error and incentive costs. Despite the many imperfections that dog the health insurance system, the market is likely to provide a better long-term solution to these trade-offs than any of the alternatives. Voluntary credentialing, employer-driven report cards and other rating initiatives happened without regulatory coercion, and reputation is always important in a repeat-business market. Even imperfect clinical controversies, it is naïve to believe that the American people would trust the outcome of such a process any more than they trust capitated health plans and providers.

Moran, supra 58, at 20-21.

165. Cf. Frank H. Easterbrook, Cyberspace and the Law of the Horse, 1996 U. CHI. LEGAL F. 207, 210, 215 (“Well, then, what can we do? By and large, nothing. If you don’t know what is best, let people make their own arrangements. . . . ‘Better’ terms (as buyers see things) support higher prices, and sellers have as much reason to offer the terms consumers prefer (that is, the terms that consumers find cost-justified) as to offer any other ingredient of their products.”).

166. Indeed, as Alfred Kahn, former chairman of the long-since abolished Civil Aeronautics Board noted, “the superiority of open markets . . . lies in the fact that the optimum outcome cannot be predicted.” DERTHICK & QUIRK, supra note 132, at 124. That observation is of particular significance when consumer preferences are heterogeneous, and the coverage market is offering bundled products.

167. See Johnson & Derlet, supra note 64, at 139-41 (listing various alternatives for EDs in managed care world); J. Stephan Stapczynski, Capitation for Emergency Physicians, 27 ANNALS EMERGENCY MED. 501, 503-04 (1996) (stating that EDs should experiment with providing after-hours coverage on capitated basis for MCO members); The Challenge for Managed Care, N.Y. TIMES, Oct. 31, 1997, at A26 (noting that innovative MCOs are developing ways to handle various chronic illnesses); Milt Freudenheim, H.M.O. Switches to Flat Fee for Treatment by Specialists, N.Y. TIMES, Oct. 10, 1997, at A1 (identifying move by HMO to charge set fee for specialist treatment as “sharp departure from industry practice”); Freudenheim, supra note 155, at A1 (noting increase in freedom to seek care by specialist offered by HMOs); Bruce Goldfarb, Shopping for Triage, BALTIMORE MAG., Feb. 1996, at 56, 58-59 (reviewing development of specialized EDs); Ron Winslow, Oxford to Give More Control to Specialists, WALL ST. J., Mar. 25, 1997, at B1 (examining decision by Oxford to treat certain patients with specialists not primary-care physicians).

The market also provides a valuable feedback device that is lacking in other institutional arrangements. See Regina E. HERZLINGER, MARKET-DRIVEN HEALTH CARE 283-91 (1997) (arguing that only providers and MCOs that provide high-quality product at reasonable price with good service will survive in market-driven world); Reed Abelson, Behind the Bleeding at Oxford, N.Y. TIMES, Dec. 9, 1997, at D1 (noting that innovative MCO may well have been too innovative, judging by complaints about unpaid bills).

168. See, e.g., Gottlieb, supra note 97, at 3:1. As this article reflects, information, from disinterested sources, patient surveys and hard-knocks experience, is growing significantly, a result in part of the concern of the more responsible and established segments of the managed care industry, which have helped fund much of the work. . . . [A]ccreditation
markets develop effective mechanisms to inform, protect and serve consumers, and those MCOs that are overly aggressive in constraining ED access relative to the balance of coverage and the premium they charge should bear the consequences. Nothing keeps an MCO from packaging itself as particularly virtuous—particularly in light of the growing diversification of the MCO market. In short, competition can result in innovative solutions that differ dramatically from the consumer protection remedy, but are pareto superior.

It is no answer to point to isolated examples that have gone wrong, because there will always be such cases. The trade-off between adminis-

surveys are [also] a good basis for measuring plans' performance. The surveys, which are voluntary, are conducted by impartial professional organizations like the National Committee for Quality Assurance. Id.; see How Good Is Your Health Plan?, CONSUMER REP., Aug., 1996, at 28, 35 (ranking plans). But see Arnold Epstein, Performance Reports on Quality—Prototypes, Problems, and Prospects, 333 NEW ENG. J. MED. 57, 60 (1996) (noting various problems with report cards); George Anders, Polling Quirks Give HMOs Healthy Rating, WALL ST. J., Aug. 27, 1996, at B1 (noting that survey techniques influence results of polls testing health plan satisfaction).

Of course, the decision to be "virtuous" on the payment of ED charges is likely to be reflected in the premium, other coverage terms or both.

170. Professor Epstein nicely described why such cases are inevitable: First-best solutions are rarely, if ever, possible; thus the beginning of wisdom is to seek rules that minimize the level of imperfections, not to pretend that these do not exist. No contract, no association is ever bullet proof: no matter what rights, duties, institutions, and remedies are chosen, in some circumstances they will be found wanting. Bad outcomes are therefore consistent with good institutions, and we cannot discredit these institutions with carefully selected illustrations of their failures. Counterexamples may be brought to bear against any set of human institutions. The social question, however, is concerned with the extent of the fall from grace. The fact of the fall should be taken as a necessary truth, not a shocking revelation. Perfection is obtainable in the world of mathematics, not in the world of human institutions.

RICHARD EPSTEIN, SIMPLE RULES FOR A COMPLEX WORLD 32 (1995). From the other end of the political spectrum, see Carrie Menkel-Meadow, The Trouble with the Adversary System in a Postmodern, Multicultural World, 38 WM. & MARY L. REV. 5, 41 (1996) ("Although I have labored long and hard to canvas the faults of the adversary sys-
trative and incentive costs is inevitable—and attempts to drive the latter to zero send the former to astronomical heights in short order. Those who claim we can design our health insurance system as an exception to this general rule should face a heavy burden of proof to explain exactly how they will do so, and platitudes like "the proposed reform fairly balances the interests of all involved" or "the proposed reform is the best solution" fall far short of the necessary showing.

Perhaps we should let these ardent reformers demonstrate the merits of their reform on something else first. Why don't we start with the Internal Revenue Code, whose enforcement and refund provisions are built around the same trade-off? Or perhaps we could begin with civil discovery, where the debate over the mandatory disclosure provisions was fought on the same grounds? After they have established that the proposed reform is a net improvement on the status quo, the reformers should also explain why their solution will improve the operation of cost-limiting private contracts that are freely entered into by both parties.

171. See Epstein, supra note 169, at 32 ("[T]he social function of law is to minimize the sum of administrative (including error) costs and the costs associated with the creation of poor incentives for individual action."). Of course, a comparative institutional perspective might lead one to opt for a different system, with a different mix of administrative and incentive costs, or a larger total pie from which these costs are subtracted. See generally Neil K. Komesar, Imperfect Alternatives (1994).

172. See, e.g., United States v. Brockamp, 117 S. Ct. 849, 851-52 (1997) (holding that courts lack equitable power to toll statute of limitations for filing tax refund claims set forth in Internal Revenue Code and stating "[T]he nature and potential magnitude of the administrative problem suggest that Congress decided to pay the price of occasional unfairness in individual cases (penalizing a taxpayer whose claim is unavoidably delayed) in order to maintain a more workable tax enforcement system"); Surrey, supra note 109, at 75 ("All this being so, the task of the Service, and indeed of any tax administration, is how to achieve a rational administration of Section 482 where there is a considerable potential area for its application, where some companies sufficiently serious in number take unwaranted advantage of the situation created by the preference, but where every company cannot and should not be carefully scrutinized and its activities second-guessed just because those who yield to temptation are mixed among the throng.").


It may be that in the disclosure system, on occasion, some information helpful to a party that exhaustive discovery would uncover will not come to light. But the question must be asked whether the marginal value of preventing such occasional failures is worth the great cost of unrestrained discovery. As Donald Elliott has observed, "Nourishing the fiction that justice is a pearl beyond price has its own price."

Id. (footnote omitted).

174. One could argue that such contracts are inappropriate, because they undermine the purchase of public goods like emergency care. In fact, emergency
Finally, the reformers should explain why, if the need for consumer protection reforms is so self-evident, the states have been so reluctant to implement them in the Medicaid program and state employee health insurance plans, in which some or all of the costs of such reforms are on-budget. In the absence of compelling evidence on each of these points, the devil we know looks more and more appealing. The alternative to the unattractive process of cost cutting is to accept indefinite increases in the cost of health care—while other worthy projects are squeezed out or go begging.

By setting a floor on the permissible level of coverage, the consumer protections outlined in Part III constrain diversity of coverage and increase its cost. Conversely, a health insurance market in which true consumer protections were operative would offer a far-broader range of coverage than is currently available and force policy-holders to face the true costs of their decisions. The current system is designed to do almost precisely the opposite, with consequences aptly described by Phil Gramm, one of the few Senators with any training in economics:

We are putting people in a position where, when they are buying health care, it is like going to the grocery store and having a grocery insurance policy, where 95 percent of what you put in your grocery basket is going to be paid for by grocery insurance. Needless to say, if you had such a policy, you would eat differ-

care is not really a public good—although it might well be good for the public for it to be generally available. Even if emergency care is a public good, it does not follow that one should pay for care for those in need by smacking those who are insured and happen to go to the ED. The entire argument is reminiscent of that made by those who opposed competition in the long-distance telephone market because they knew it would destroy the long-standing substantial cross-subsidies of local telephone service.

175. For an example of consumer protection legislation that was vetoed when the state would have footed a substantial portion of the bill, see supra note 124.

176. See Ornstein, supra note 4, at A15 ("Cutting costs is not pretty. It involves both disruptions and painful trade-offs.") In the face of such painful trade-offs, further privatization of cost-containment initiatives is likely to be beneficial because it will lead to quicker and more differentiated results. See Havighurst, supra note 35, at 123 (arguing that centralized decision making on consumer protection will lead to poor results, and private contracts should be used to implement differential demands for health insurance coverage). Professor Reinhardt echoed these sentiments in discussing medicare reform:

[The] delegation of the task of regulation to private regulators . . . will spare Congress the unwelcome task of mud-wrestling annually with doctors, hospitals and other providers over fees and regulations, leaving that troublesome task to private regulators (the private insurance industry) who are not encumbered by notices of rule making, public commentaries, hearings, and the like. One great advantage of cost and quality control through private regulators is that the latter are swift and usually not open to appeal.

Uwe E. Reinhardt, Demagoguery and Debate over Medicare Reform, 14 HEALTH AFF. 101, 103 (Winter 1995).
ently, and so would your dog—this is part of the problem.177

The current approach to consumer protection compounds this problem by proceeding on the erroneous assumption that markets are fallible and regulation is not.178 When our efforts to regulate make worse the problems they seek to solve, it is time to call a halt and rethink the entire strategy. It is too bad we cannot call 911, and have those who claim to be protecting us receive some instruction on that point.


178. See Easterbrook, supra note 165, at 215 ("[E]rror in legislation is common, and never more so than when the technology is galloping forward. Let us not struggle to match an imperfect legal system to an evolving world that we understand poorly."); Epstein, supra note 158, at 311 ("It would be easy to assume that collective responses are preferred when markets are corrupt and governments virtuous. It is far harder to reach that conclusion when self-interest and corruption creates [sic] difficulties from both quarters."); see also RONALD COASE, THE FiRM, THE MARKET, AND THE LAw 26 (1988) ("The fact that governmental intervention also has its costs makes it very likely that most 'externalities' should be allowed to continue if the value of production is to be maximized. This conclusion is strengthened if we assume that the government is . . . ignorant, subject to pressure, and corrupt.").