American Health Care And The Law— We Need To Talk!

Lawmaking for the health care industry has evolved much by chance, yet its implications for consumers and the medical profession have been profound.

by Clark C. Havighurst

PROLOGUE: More than most industries, American health care is in the uncomfortable position of carrying out its core mission—making people healthy—in a legal environment featuring irrational rules and doctrines, conflicting paradigms, multiple policy-making authorities, and inconsistent public policies. The reigning legal confusion complicates the delivery and financing of care as well as the making of incremental reforms, which some view as the only politically feasible policy moves. Because the complexity of the industry and the sensitivity of affected interests make legal confrontations inevitable, this paper argues that the industry has a right to clearer guidance and more freedom.

Duke University's Clark Havighurst describes the evolution and current confused state of the law governing the health care enterprise and its directions. Important changes in health care law often occurred more by chance than by design, and policy incoherence is the rule rather than the exception. Moreover, without a single entity exercising plenary authority over health care law and policy, the legal system cannot easily set a constant, clear, or wisely charted course. A possible next step is a private, independent forum to focus high-level, policy-oriented attention on the many complex, interconnected legal issues associated with health care.

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ABSTRACT: The first section of this paper highlights five critical legal developments over the past half-century that, while not reflecting considered policy judgments about how the health care industry should operate, put American health care on some surprising paths. The second part then observes five fundamental policy contradictions discernible in health care law today, each of which reflects severe ambivalence in public attitudes toward health care. Although such confusion in the law is interesting in itself, the main purpose of the paper is to propose, in section three, the creation of a permanent high-level forum, perhaps in the Institute of Medicine, where leaders from the health and legal worlds could meet regularly with a view to helping the legal system resolve some of the policy confusion that exists.

ONCE UPON A TIME, the U.S. health care industry was not beset on all sides by law and lawyers. Indeed, when I first surveyed the field of health law in the late 1960s, the list of emergent legal issues in health care was quite short. In addition, the salient issues arose within relatively few fields of law, principally medical malpractice (including the area of informed consent), occupational licensure, the tort liability of hospitals, abortion, prescription drug development, human experimentation, and several other aspects of what we now call "bioethics." Although the federal Medicare and Medicaid legislation had recently been enacted, those programs did not yet present major legal problems, largely because they were still operating under widely accepted principles borrowed almost intact from private, nonprofit health insurance—which itself had not yet become controversial or raised prominent legal issues. Scholars and practitioners in the field did not anticipate an explosion of new laws and of legal attacks on time-honored institutions and industry practices. Health care was generally viewed as a charitable or public service and not as a business requiring a sophisticated legal regime to ensure that it performed responsibly. In short, the health care industry was largely left alone by the law and lawyers, and nearly everyone expected that it would always be so.

This paper provides some observations concerning the disorderly state of health care law today, suggesting in the process some possible answers to such questions as the following: What happened since the 1960s to create today's legal jungle? Are there explanations, logical or otherwise, for the proliferation of legal rules and the associated legal risks that have only lately engulfed health care providers, financing institutions, and others? Where did all this law come from? Did an imperialistic legal system unfairly single out the health care industry as a fruitful new field in which to extend its dominance? Were the new legal rules and enforcement mechanisms put in place by rational planners carrying out a coherent national policy toward the health care industry? Is the law, as it has evolved to this

point, internally consistent and clear about the objectives it seeks to achieve? If not, what can be done about it?

After briefly reviewing five areas of law where the public was blindsided by unheralded but crucially important changes in public policies toward the health care industry, I observe a number of anomalies and fundamental contradictions discernible in health care law, which also reflect a high degree of cognitive dissonance both in public attitudes toward health care and in health policy itself. I conclude by suggesting that the apparent legal confusion, attributable in part to the absence of a single source of law governing health care in the United States, reveals a need for a private synthesizing effort to bridge gaps between different policy-making authorities and between conflicting paradigms, legal doctrines, and public policies that coexist only because they have never had to be reconciled.

Watershed Events In American Health Care: The Law And Unintended Consequences

The U.S. legal system has been a major factor, for better or for worse, in creating the conditions that determined how American health care would evolve in the past half-century. In several watershed events, important implications of the legal changes were not recognized by the observant public, industry insiders, or even decisionmakers themselves. Yet each of these events set in motion powerful economic and political forces that dramatically altered the face of the industry. Although it is too much to expect that law will always evolve according to pure logic, lawmaking for the health care industry has been driven by chance to a particularly surprising degree.

The history of American health care in the past two generations has featured, first, the growth of provider-sponsored, employer-financed private health insurance, followed by the extension of similar public coverage to the over-sixty-five population, the disabled, and certain poor families. The uncontrolled moral hazard inherent in these financing arrangements eventually gave rise to unprecedented cost escalation, as benefit/cost ratios were almost totally neglected in physicians' clinical choices and, consequently, also in decision making on capital spending and technological development.[1] The cost explosion initially triggered a struggle for control of the system between the medical profession, which had taken responsibility for decision making in most elements of medical care, and government, which sought to impose regulatory controls as a forerunner to adopting universal health coverage. In the late 1970s, however, a "third way" appeared in national health policy debates, as advocates of greater reliance on market forces and competition began to win converts by pointing to the potential of health mainte-

nance organizations (HMOs) and other innovations (for example, selective contracting, incentive arrangements, and predetermination of coverage limits) to control moral hazard by consensual means, all in a context of accountability to purchasers.

With the defeat in 1979 of the Carter administration's proposal for universal hospital revenue controls and the election in 1980 of a conservative president, national health policy toward the private sector suddenly became one of benign neglect, as private purchasers and competitive markets were given a chance to show what they could do to control costs. Since that time there have been revolutionary changes in the way health services are bought and paid for in the private sector and some movement in public programs to build on these developments. These changes have succeeded in slowing the rate of cost increases but have also occasioned unhappiness about the entities that took responsibility for controlling costs, about their motives and methods, and about their accountability for any questionable practices or erroneous decisions.

The law was present at the creation of each of the major problems that has surfaced in the health care industry at various points in its recent history. It also was responsible for imposing or lifting, as the case may be, many of the constraints operating on industry actors as they addressed these problems. The following paragraphs show how the path the health care industry has taken was influenced by conditions that the legal system largely created with little awareness of what it was doing.

■ **Subsidizing employer-based health coverage.** During World War II wage controls prevented private employers from raising their workers' take-home pay. A loophole, however, allowed them to offer generous health benefits—which the tight labor market caused them to do. After the war, employers and workers lobbied successfully to have these benefits, to which they had become accustomed, made tax-free. Subsidizing the purchase of health coverage and other fringe benefits seemed like a good, progressive idea at the time. But, having aided middle-class employees in this way, government has ever since found it difficult to muster voter support for a more extensive program to ensure coverage for those whose jobs do not carry health benefits. By building this modest concession into the tax system, government laid the groundwork for the system of employer-based health coverage that we still have today.

The exclusion of employer-paid health premiums from taxable income has given the great majority of consumers a strong inducement to pay as many of their health bills as possible through an employer-sponsored health plan rather than out of pocket. In taking optimal advantage of this tax loophole, consumers have overinsured

themselves, resisting coverage with demand-suppressing deductibles and coinsurance (which would have to be paid from after-tax rather than untaxed income) and demanding more-comprehensive coverage than would be optimal if they were merely seeking protection against unpredictable costs. These choices by consumers, although rational, widened the impact of the moral hazard associated with health insurance, inviting more spending on health care than consumers would have elected normally. The tax subsidy also meant that consumers had a special reason to purchase their coverage through the workplace, where the true cost of coverage was effectively hidden from them. This encouraged labor unions and many employers to use overly generous health benefits strategically, to demonstrate their concern for workers' welfare. Employment-based health coverage, in which benefits are highly visible and costs are not, helped to breed the pervasive entitlement mentality that still distorts political discussions about health care. Today's backlash against managed care owes a lot to working Americans' ability to see only the possible drawbacks of their new coverage and not the substantial savings that managed care has added to their paychecks.

In many ways, therefore, the tax policy adopted naïvely in the postwar period still colors the political, institutional, and legal climate in which health care is financed and provided. Although policy wonks have long advocated capping the tax subsidy at an appropriate level, proposals to do so have not fared well over the years because opportunistic politicians could easily persuade voters to oppose the "taxing" of health benefits. A tax subsidy of this kind is insidious precisely because, in addition to being an off-budget public expenditure (amounting to about $125 billion in 1998), it can misallocate huge amounts of society's resources, yet be almost entirely invisible and painless at the level of individual producers, consumers, and taxpayers.[2] Since the affected interests simply adjust their behavior to the incentives created, they have no occasion to complain or call for political attention to the fact that U.S. spending on personal health care exceeds that of any other nation by several whole percentage points of gross domestic product (GDP).[3] This extravagant spending suggests the magnitude of the problem we inadvertently created for ourselves when government elected to use the tax code to encourage employed persons—those who could best afford its true cost—to purchase health coverage.

■ **Infusing new money through Medicare and Medicaid.** The launching of the Medicare and Medicaid programs in the mid-1960s was, of course, a well-recognized watershed in health policy. Although many physicians opposed Medicare in the belief that federal involvement would be detrimental to their calling (although not to

"The government's campaign against fraud and abuse reveals another legal time bomb in Medicare's original design."

their incomes), these warnings were discounted as reactionary. Moreover, Congress could not have foreseen how the infusion of so much new public money into the health care industry, coupled with the moral hazard that accompanies any form of third-party payment, would forever alter not just the economics but also the culture of medical care. Perhaps Medicare's most significant side effect was to make the health care sector an arena for profit-seeking activity more than ever before. For the first time, hospitals and physicians could expect to be paid well for much of the care they had previously provided for less. They also saw a huge increase in demand for even the costliest of their services. Entrepreneurs suddenly saw new opportunities in health care, and physicians saw opportunities to become entrepreneurs themselves. With so much money on the table, law and lawyers could not be far behind—not so much because they were lured by the money at stake as because their services would be needed (and worth paying for) as entrepreneurs rushed in and as the legal system was called upon to referee the inevitable disputes.

To be sure, the U.S. government's plunge into financing health care for the elderly and the poor probably could not have occurred without dramatic expansion in the role of law and lawyers. But the potential for legal problems was exacerbated by the way the programs were designed. In a political compromise, Medicare was designed to resemble the Blue Cross Blue Shield plans that hospitals and physicians had devised to enable consumers to purchase financial protection against unpredictable health care costs without intruding on providers' freedom or introducing price competition. Although the program thus avoided immediate confrontations with providers, its inflationary potential was clear, since it contained few tools for combating moral hazard. The rising costs of the public programs led eventually to regulation-like reforms, all of which increased the need for lawyers on all sides of every issue.

After Medicare shifted to prospective payment based on diagnostic groups in 1983, there were fewer occasions to litigate reimbursement issues. Nevertheless, the program's regulatory and entitlement features continue to generate controversies. An arguable virtue of proposals to shift away from a system of financing defined benefits (that is, entitlements) to one based on defined contributions (subsidizing beneficiaries' enrollment in private health plans) might be that many fewer legal problems would arise, at least between gov-

ernment and providers. Legal disputes would then be largely confined to the familiar private-law areas of torts and contracts, supplemented by public regulation such as that being seen in the regulation of managed care.

The recent spectacular boom in law business associated with the government's campaign against so-called fraud and abuse reveals another legal time bomb in the original design of Medicare. As part of the political deal, Medicare gave beneficiaries "free choice of providers" and permitted any provider to participate unless the government could show cause for disqualification. The government thus deprived itself of powers such as those that private payers use to protect themselves against exploitation through inappropriate kickbacks and self-referrals (for example, the power to select and deselect providers without "due process"). Although it took time for the problem to materialize, Medicare eventually became highly vulnerable to sophisticated schemes to induce lucrative referrals of beneficiaries. To be sure, the harm to either beneficiaries or the government was not always apparent as entrepreneurs scrambled for the available business. But the government was unable to assure itself that utilization abuses were not occurring and was offended by apparent profiteering at its expense. It therefore moved to address the problem by enacting increasingly stringent antifraud legislation on at least seven occasions between 1972 and 1996.

Under these laws, the federal government now uses the threat of criminal prosecution and heavy civil penalties against providers and entrepreneurs who may be guilty of nothing more reprehensible than adapting to the more entrepreneurial, incentive-driven health care marketplace and of taking advantage of weaknesses in Medicare's design and administration. Although some providers are unduly opportunistic, much of the conduct subject to penalty under the anti-kickback and Stark legislation (aimed to curb referral abuses) appears fairly well sanctioned and manageable in the private sector. Nevertheless, government has found it convenient to characterize provider conduct that exploits the program's shortcomings as "fraud and abuse" and to criminalize it. The moral spin was necessary to overcome the presumption that all providers are entitled to participate in Medicare and to shift responsibility for the program's deficiencies away from its designers. What is notable for present purposes is how decisions on the details of Medicare, which were made to satisfy providers' interests as well as certain ideological predilections of its sponsors, led the health care industry in unanticipated directions, into activities that have necessitated the enlistment of many, many lawyers.

■ **Applying antitrust law to physicians.** Many crucial changes

have occurred in the health care sector as a result of the enforcement of the antitrust laws in the health care sector since the mid-1970s. The watershed event here was the Supreme Court's 1975 decision in *Goldfarb v. Virginia State Bar*, which provided the warrant for this enforcement campaign.[4] In *Goldfarb* the court held that the so-called learned professions are engaged in "trade or commerce" and therefore do not enjoy an implied exemption from the Sherman Act. It is ironic that the case that opened up antitrust law as a new field of legal activity in the health care industry dealt specifically with a restraint of trade in the legal profession.

The significance of the *Goldfarb* decision for national health policy can hardly be overstated. Previously, both government and the private sector had largely acquiesced in the medical profession's view of itself as a self-regulating body and accepted the profession's hegemony over major portions of the health care system. Thus, nearly everyone discounted any substantial role for competition in the health care industry and tolerated some significant infringements on the operation of market forces. *Goldfarb*, however, effectively overturned the policy view that professionals could be trusted to determine the basic rules under which health care was provided. Its effect was suddenly to make health care competition mandatory, in the sense that competitors could not lawfully agree to restrain it. Not only did this fundamental policy shift occur without any public debate or legislative action, but it is doubtful that a legislative campaign to change the old, tolerant policy would have commanded much support. Nevertheless, one stroke of the Supreme Court's pen changed the basic legal regime governing professional services, opening the door for procompetitive private innovations that the medical profession had previously been able to suppress.

An equally significant consequence of the *Goldfarb* decision was to increase the relevance of the previously embryonic debate over whether competition might be a desirable force in health care. Indeed, *Goldfarb*, or something like it, was necessary to make a market-oriented health policy plausible, since as long as the medical profession could exercise effective control over the economic environment of physicians, it could prevent the emergence of corporate middlemen able and willing to act as purchasing agents for consumers in procuring physician services on competitive terms. After *Goldfarb* significant reform could be realistically looked for in the private sector, without direct government intervention. Partly on this basis, Congress defeated the Carter administration's hospital cost containment bill in 1979 and, with the support of the Reagan administration, began to rely explicitly upon competition and consumer choice to determine the health care industry's performance.

The antitrust battles that ensued thus paved the way for the revolution that occurred in the health care industry in the 1980s and 1990s.

It is at least arguable, on this basis, that *Goldfarb* was the most important event ever in the evolution of American health policy. It is also notable, however, that a much earlier antitrust case, by vindicating an early HMO in Washington, D.C., against efforts by organized medicine to drive it from the market, kept alive the possibility of creating alternative delivery systems, thus preserving the possibility of effective price competition in health care.[5] In any event, without the antitrust enforcement effort against physicians that began in earnest after the *Goldfarb* case, the nation would have had to wait much longer for private innovations making providers accountable to consumers for the cost as well as the quality of medical care. More likely, without antitrust enforcement clearing the way for private innovation, government would have assumed the dominant role in American health care, as it has in other countries. Thus, a seemingly technical clarification of the law, adopted without policy debate, had a truly fateful effect on the course of history.

■ **Preemption of state laws.** Another largely serendipitous event that has had profound effects on the course of American health care was the enactment in 1974 of the Employee Retirement Income Security Act (ERISA). ERISA's principal effect in the health care field has been to preempt state laws "insofar as they may now or hereafter relate to any employee [health] benefit plan." Despite recent interpretations leaving the states somewhat more regulatory freedom with respect to health care than they were previously thought to have, ERISA remains a serious impediment to many state regulatory and other initiatives and to many lawsuits against employers or organized health plans. Because ERISA itself provides very little regulatory control over employee health plans and only minor remedies for aggrieved enrollees in such plans, it represents a sizable loophole in the law. Although this loophole is troublesome in some respects, ERISA preemption has made possible a great deal of generally desirable innovation by employers and health plans that might otherwise have been precluded or discouraged by state regulation or by the threat of litigation under state law.

ERISA's effect in limiting the ability of state law to deal with health plans was as unintended on the part of Congress as it was significant in shaping the industry's course. ERISA was enacted in response to some highly publicized instances of fraud and mismanagement with respect to pension funds and was not perceived by Congress as a health care measure at all. It was specifically designed not to interfere with the business of insurance or with state regulation thereof. To this end, it included an exception (the so-called

saving clause) from the preemption provision for state laws regulating the business of insurance. Because Congress assumed that health coverage would continue to be governed by state law, it did not devise ERISA's regulatory scheme with health benefits in mind.

ERISA eventually proved, however, to have important unintended consequences in health care. One of its main effects was, in time, to induce nearly all employers large enough to do so to self-insure their health benefits, usually with the help of a third-party administrator, an insurance company providing "administrative services only," or a managed care plan assuming some of the employer's risk. The inducement to self-insure was inherent in ERISA's preemptive provisions, which permit self-insured plans alone to escape both the burdens of state insurance regulation and the impact of other state laws applicable to health insurers. Once again, the law inadvertently enhanced the role of employers in procuring health coverage. Unfortunately, however, the need for an employer to self-insure to qualify for ERISA preemption limited ERISA's value to small employers, which must obtain coverage for their employees, if at all, from a health insurer or HMO that is subject to state regulatory requirements that raise the cost of coverage and make it prohibitive for some of them.

Although it is reasonable to believe that ERISA leaves a vital part of American health care underregulated or inadequately policed by the courts, the revolution that began in American health care in the late 1970s would have been much less dramatic if ERISA-protected health plans had not been free from regulatory restraints and thus able to adopt innovative approaches to the design and administration of health benefits. Most of these innovations have benefited consumers. In any event, ERISA is still another legal guest at the party whom no policymaker ever intended to invite. For some it added to the fun; for others it has been a wet blanket.

■ **Recognizing corporate responsibility for medical care.** In the 1966 Illinois case *Darling v. Charleston Memorial Hospital*, the law took another important policy leap largely out of public view—recognizing for the first time that health care institutions have direct legal responsibilities to patients for the quality of medical care provided by physician independent contractors. Although *Darling* was recognized as a landmark decision at the time, it is not obvious, looking at it today, why it was so notable. After all, the court merely held a hospital liable for injuries received by a patient as a result of negligent treatment by a staff physician taking a turn on call in the hospital emergency room, and there had been many earlier cases in which hospitals had been held liable for the torts of their physician agents. Indeed, if the *Darling* court had simply applied the doctrine of

"apparent agency" and held the hospital vicariously liable because the patient believed that the doctor was its agent, the decision would have attracted little attention. But the court went further, holding that the jury could find the hospital negligent itself, either in its nurses' inattention to the poor care provided by the doctor or in its own failure to monitor that care. Given then-prevalent notions of professionalism and the law's general hostility to "the corporate practice of medicine," the court's recognition of a hospital's duty to supervise a physician's treatment was indeed surprising.

Because it recognized that corporations, as well as individual professionals, may have direct obligations to patients and thus the right to oversee the work of affiliated physicians, the *Darling* decision was a true watershed in health care law. Just as the paradigm undermined in *Darling* had been enshrined in previous public policy without much conscious thought or explicit consideration of alternatives, the *Darling* court gave little indication that it appreciated that it was embracing a new policy with important implications for power relationships throughout the industry. Nevertheless, *Darling* attracted attention at the time because it recognized a controversial role for hospitals vis-à-vis physicians, one that, although it may have been gradually emerging in practice, had not previously been explicitly recognized in law. Certainly it was this aspect of *Darling* that elicited applause among hospital administrators, who had long sensed a need to exercise some control over physicians and who were probably glad—even at the cost of new liability fears—to have a convincing, legitimizing excuse for moving in that direction. In health care today, corporate or institutional responsibility is widely recognized, even if the old paradigm also continues to color much legal, policy, and professional thinking.

Contradictions In U.S. Health Policy: The Law And Cognitive Dissonance

Because health care law comprises many different fields of law and springs from many different sources rather than from a single policy-making body, it should come as no surprise that it evolves in mysterious ways and is essentially incoherent on many points. Although logical inconsistencies permeate the law, in dealing with health care the legal system seems unusually capable of harboring and selectively employing incompatible decision-making principles.

In seeming at different times to prefer different horns of an important dilemma, health care law directly reflects similar confusion in the larger society. Indeed, cognitive dissonance—the simultaneous holding of incongruous attitudes or beliefs—is particularly prevalent in the public mind with respect to matters related to health

care. Guido Calabresi and Philip Bobbit have observed how society often suspends one or another disbelief in coping with "tragic choices"—that is, situations in which society's need to put its scarce resources to efficient uses is in direct conflict with the public's natural desire to see everything possible being done to avert a specific peril or hardship.[6] The public's occasional psychological need to suppress its normal concern over the scarcity of resources is illustrated most poignantly by its ability to tolerate tragedies that are revealed only through statistics while at the same time mobilizing virtually unlimited resources to save a single human life.

Because the legal system shares the public's ambivalence about counting costs in health care situations, its choices are not reliably aimed at getting the industry to strive for efficient outcomes. For example, the public's tendency toward unrealism about health care matters can create severe political, legal, or other risks for decisionmakers facing difficult trade-offs in potentially tragic situations, perhaps causing them to go out of their way to avoid so-called Type I errors—that is, errors whose adverse consequences, if any, are apt to be tragic, highly visible, and easily traceable back to the decisionmaker. Avoiding Type I errors, however, may entail running an increased risk of less palpable Type II errors, the consequences of which may be more serious statistically or economically but cannot so easily be laid at the decisionmaker's door. In general, a kind of moral hazard makes efficiency a common casualty in decisions that society entrusts to the legal system. After all, legislatures, courts, and juries are regularly in a position to commit others' resources to uses that reflect their own predilections or interests rather than thoughtful comparisons of benefits and costs or reasonable estimates of how consumers would rationally choose to spend their limited incomes.[7] The combination of this moral hazard and the tragic-choice element in health care decisions, all reinforced by the symbolic politics of health care, ultimately accounts for many of the following contradictions in the legal system's approach to certain issues.

■ **Decentralization and competition, yes! Freedom of contract, no!** National policy with respect to privately purchased health care purports to entrust health care choices to the competitive marketplace, apparently on the usual theory that allowing consumers to choose how their dollars are spent ensures an efficient allocation of resources. Yet, in reality, the law itself supplies most of the normative rules under which care is provided, leaving few significant decisions to be made by private parties. Indeed, the law's role in prescribing consumers' entitlements is such that health care is still rather far from being a typical consumer good as to which people routinely make trade-offs and economizing choices. The le-

gal system is very much at the heart of this contradiction in national policy. The difficulty lies largely in the limited role that the legal system allots, both *de facto* and *de jure*, to private contracts as instruments by which consumers can specify their health care preferences.[8] Not only are many important aspects of health care transactions prescribed by explicit regulation, but today's health care contracts do not even attempt to specify in customized terms the desired character, quantity, and quality of the services that consumers purchase. Such matters are left to be resolved under norms ultimately supplied by law.

It is conventional in health care law for courts to consult custom and consensus in the medical community, not specifications in private contracts, for the standards they use in defining the duties of providers in tort suits or the payment obligations of health plans in benefit disputes. These professional standards have rarely been examined, however, to see whether they represent good public policy and reflect realistic comparisons of benefits and costs. To be sure, legal prescriptions based on professional standards might make sense as "default rules" that apply in the absence of a contrary agreement among the parties. But professional standards are usually viewed as binding norms, not as merely a starting point for private bargaining. Moreover, even if such standards could in theory be varied by contract, there are reasons to believe that courts would be hard to satisfy that contractual departures agreed to *ex ante* should be enforced against a patient who regretted the agreement *ex post*.

Judicial attitudes toward private health care contracts do not leave private decisionmakers much discretion in contracting. Courts would be naturally skeptical, for example, about the circumstances in which consumer-plaintiffs selected their health plans, since it is unlikely that they clearly understood the details of their coverage or accurately anticipated their future needs. This skepticism may make a court hard to persuade that even a clear limitation on coverage should be enforced if it means denying a patient a service sanctioned by professional standards. Doubts about the contracting process also foster generous interpretations of contracts. Indeed, a time-honored principle of contract interpretation allows courts to construe ambiguous contract terms against the drafter (*contra proferentem*). This principle apparently applies even when the ambiguity was unavoidable, as would almost always be the case with a health care contract that sought to limit coverage in the gray zone of benefit/cost ratios. Because health plans cannot count on the courts to respect even their best efforts to authorize economizing, today's health care contracts are largely silent about the precise content of the service packages being purchased and instead define

"*Despite the seeming triumph of market-oriented policies, the law remains wedded to doctors' preferred paradigm of medical care.*"

service commitments in terms of "medical necessity," thereby incorporating costly professional standards by reference.

Like health plans' subscriber contracts, contracts between patients and providers also offer little opportunity for consumers to specify a different set of entitlements and rights than are prescribed for them by law. Indeed, under the prevailing paradigm of medical care, provider/patient relationships are not generally conceded to be a matter of contract at all. A North Carolina court has said, for example, that an agreement between a patient and a physician "creates a status or relation rather than a contract."[9] Thus, a doctor's obligations to his or her patients are usually deemed to be inherent in the relationship—a matter of law, not private agreement. To the extent that this antiquated view of contracts persists, consumers' freedom of contract is impaired.[10]

There are reasons to think, therefore, that despite the seeming triumph of market-oriented policies in the health care sector, American health care law remains closely wedded in many respects to the medical profession's preferred paradigm of medical care. Under this paradigm, economically significant decisions are characterized as technical and thus deemed inappropriate subjects for consumer choice or for resolution in private contracts. It is simply ironic that the same legal system that with one arm launched an antitrust initiative successfully challenging overt efforts by the medical profession to exercise decision-making authority has with its other arms given medical interests a monopoly over the most important economic decisions affecting American health care.

■ **Corporate responsibility for health care, yes! Corporate practice of medicine, no!** The managed care movement has invited HMOs and other corporate health plans to assume major responsibility for controlling the cost of care, and they have done so with impressive results, causing health care's share of GDP, which had previously risen every year at burdensome rates, to remain stable (around 13.6 percent) for six consecutive years, from 1993 to 1998.[11] At the same time that the public was realizing these cost savings, however, it was also becoming apprehensive about the effects of managed care on quality. Yet the law still treats quality of care as primarily a professional, not a corporate, responsibility. Only in limited circumstances has a health plan been held legally accountable for the actual quality of care delivered to a patient, and most

plans are able to arrange things so that the physicians whom they select to treat their enrollees are viewed as independent contractors, to whom patients must look exclusively for compensation in the event of mishaps. This state of affairs persists in large part because the law still embodies the tenet of the old professional paradigm of medical care that holds that corporations don't practice medicine, only licensed individuals do. But there is a certain inconsistency in allowing corporate health plans to assume responsibility for the cost of care while making it easy for them to exempt themselves from more than nominal responsibility for its quality.

There is little evidence that managed care has lowered the overall quality of health care.[12] But there is certainly room for disappointment that the new arrangements for financing, delivering, and "managing" care have gotten physicians to achieve so few improvements in health status and patient outcomes.[13] Most of today's health plans are financers of care, not organizers of it, and few are actually managing care to ensure its quality or ensuring that their subcontractors do so. Indeed, managed care today means little more than subcontracting and capitation, techniques by which health plans can lower their costs by exercising their purchasing power over providers and by transferring to them much of the financial risk.[14] Health plans routinely select their subcontractors based on low cost, not demonstrated skill in treating patients, and compensate them in ways that may easily induce neglect or undertreatment. Yet plans still successfully maintain that decisions about clinical matters are the responsibility of their subcontractors and the physicians they select. A close look at the managed care revolution thus reveals that we may have created the worst situation possible: corporate power being exercised to reduce costs and increase profits without significant legal responsibility for patient care.

The law has so far generally failed to entertain the idea that health plans should be presumptively liable for their physicians' torts. At least in the absence of an explicit contractual arrangement under which enrollees agree to look only to plan subcontractors for compensation in the event of negligent treatment, the law might reasonably impose "vicarious liability" on health plans, demanding that they stand behind the work of the agents they employ, whatever the private contractual arrangement between providers and the plan.[15] To be sure, one court has recently held that an HMO may be held vicariously liable for the torts of independent physicians if it exercises enough control over their behavior to justify finding an implied agency.[16] But that holding seemed to impose vicarious liability on the health plan only as a penalty for influencing medical decisions in the interest of cost containment and not as an inducement to encourage

all plans to take a more active and constructive role in improving quality. Unfortunately, the message sent to health plans was the wrong one: Conform your conduct to the old professional paradigm and take less, not more, responsibility for the quality of care.

■ **Accountability, yes! Legal liability, no!** The political backlash against managed care has generated renewed interest in making health care providers and designers and administrators of health plans accountable to consumers. Some observers believe that still more regulatory legislation making health plans accountable to public officials will suffice, while others hope that new methods being developed to measure quality of care and to report the performance of individual health plans and providers will soon make it easier for consumers or employers to demand quality improvements. There is true ambivalence in the legal system, however, about relying on ordinary tort liability as a significant instrument of accountability in the health care sector. Indeed, in recent years "malpractice reform" has mostly meant not improving the liability system to make it an effective deterrent of bad practices, but cutting back patients' legal remedies against health care providers. The legal system's lack of confidence in liability as a tool for holding private actors accountable to consumers has also been evident in Congress in connection with proposed managed care reforms. Not only is the idea of vicarious liability not being considered as a possible source of incentives to improve quality, but many in Congress are skeptical about proposals to amend ERISA to let patients sue health plans for personal injuries resulting when plans breach their payment obligations.

Admittedly, there are severe problems in the liability system as we know it. Because medical practice evolves in a market in which consumers do not regularly or systematically compare benefits to costs, the law's reliance on professional custom and practice as the principal source of standards for defining provider negligence in malpractice cases may be forcefully driving providers away from efficient practices. Similarly, the practice of referring to professional standards in determining health plans' payment obligations also may discourage appropriate comparisons of benefits and costs. In particular, the legal system's principal method of establishing standards—letting juries choose between the conflicting opinions of partisan experts—invites further skepticism that the law reliably pushes health plans or providers in the right directions. The fact that medical care accounts for such a high percentage of U.S. GDP suggests that efficient economizing is indeed discouraged by unreasonable expectations built deeply into the legal system.

There are other reasons, too, why policymakers might doubt that tort liability could improve matters. For example, the Harvard

Medical Practice Study not only presented evidence of a disturbing incidence of negligence in hospitals but also found that very few of the potential malpractice claims were ever brought to the attention of liability insurers or the legal system.[17] Moreover, litigation entails heavy transaction costs (about half the total insurance premiums paid for malpractice liability insurance goes to paying lawyers, experts, and liability insurers). Policymakers might reasonably resist incurring these costs if they lack confidence that the legal system is capable of holding providers appropriately accountable for their torts or of promoting optimal health care quality.

Instead of denying remedies to injured patients, however, the legal system might seek to improve its liability regimes so that they can effectively discipline providers and induce affordable quality improvements. The earlier suggestion that health plans (or their subcontractors) might bear presumptive vicarious liability for physician torts reveals one possible way that the legal system might be redesigned. Letting health plans modify the law's traditional remedies by contract is another way in which the tort system might be made more responsive to consumers' needs.[18] (Although a plan would normally have little reason to lower an enrollee's cost of bringing a lawsuit, it might agree to install a more efficient method of dispute resolution by contract if such a change could be coupled with one or more substantive changes, such as a modification of the operative standard of care or a limit on punitive or noneconomic damages.) Old proposals for imposing strict (non-fault-based) liability for selected adverse outcomes also may deserve new policy attention.[19] Finally, it should be possible to design health plan liability for errors in benefit determinations in such a way—without punitive damages, for example—as to induce plans not to be cavalier in denying claims while still enforcing their contracts to curb moral hazard.

It is unfortunate that the legal system has become so conflicted about the efficacy of liability just when the marketplace has the greatest need for incentives deterring quality shortfalls. Under earlier, more generous payment systems, there was little risk that quality would be intentionally stinted, and the tort system had a relatively unimportant role to play in quality assurance. Now that managed care has introduced new risks of undertreatment, the legal system should be actively striving to make liability an effective force for improving quality and ensuring patient welfare. Arguably, however, health care law would be more helpful if it focused less on enforcing uneconomic rights and entitlements of the law's own devising and more on facilitating efforts by private parties to define their own reciprocal rights and obligations by contract and on ensuring that those rights and obligations are evenhandedly enforced.

■ **Financial incentives, yes! Conflicts of interest, no!** The managed care revolution introduced new kinds of financial incentives into health care decision making. In the earlier era, providers had a strong incentive to provide more services than were optimal, and physicians could rationalize such overspending as serving their patients' interests as well as their own. Once payers developed the ability to select providers and new ways of paying them, however, incentives began to run in the opposite direction. Although this was initially viewed as a desirable development, it was inevitable that public attention would eventually focus on the apparent conflicts of interest that physicians now face in making clinical choices, including referrals to other providers.

Although the legal system has generally approved the new incentive arrangements in many ways, it also has a long tradition of opposing conflicts of interest, especially when they affect relationships between professionals and their clients. The law is thus pulled in two directions and is therefore arguably ill equipped to determine the acceptability of managed care and the incentives *cum* conflicts of interest on which it depends. For example, one court recently held, controversially, that any physician acting under economizing incentives is open to suit as a fiduciary under ERISA and thus possibly to higher standards of loyalty than the law imposes even on physicians acting in a professional capacity.[20] Likewise, as discussed earlier, fraud-and-abuse law has taken a highly literal, arguably unrealistic approach to the mere existence of inducements to physicians to refer patients, even in situations where referral may be the best clinical option. The legal system thus has begun to bring its natural hostility to conflicts of interest to bear on essential features of modern health care, with consequences yet to be determined.

Many thoughtful physicians have concluded that physician incentives, if properly designed and implemented, should be a part of any health plan.[21] In truth, any payment system or organizational structure creates conflicts of interest of some kind, necessitating some reliance on physicians' ethics to prevent abuses. The legal system appears to be wholly at sea in knowing how to evaluate compensation arrangements aimed ostensibly at countering moral hazard. Although the Supreme Court is grappling with such arrangements in a case to be decided this term, there is no reason to expect a satisfying resolution of the conflict.[22]

■ **Entitlements, yes! Public financing, no!** Even though the American public has not seen fit to fund a universal entitlement to health care, the legal system regularly gives patients legally enforceable rights to receive certain health services or to receive care of a particular quality or kind. Often these entitlements and legal rights

are created at the expense of private providers (and ultimately of those who must pay their charges). In other cases, public financing is provided but in a very selective way, creating a patchwork of entitlements that demonstrates compassion for certain afflicted persons but that also, if viewed from a distance, highlights the absence of universal coverage for other equally indicated care.

A leading example of an unfunded entitlement to health services at private providers' expense is the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). This law amended the Medicare act to require hospitals participating in Medicare to provide their usual emergency screening to any patient appearing in the emergency room (not just Medicare beneficiaries) and to stabilize any emergency medical condition discovered—all without regard to a patient's ability to pay. To be sure, emergency care makes a powerful appeal, and the entitlement created by EMTALA has not been an overwhelming burden for private hospitals, most of which had already assumed similar responsibilities in their communities. But legislation making hospital charity mandatory—even when the hospital in question is a proprietary, tax-paying enterprise—ought to raise some eyebrows. Nevertheless, even though the notion of compulsory charity is an oxymoron, the nation has apparently adopted a policy of relying on hospitals' widespread ability and willingness to cross-subsidize uncompensated care for the uninsured as a principal safety net for those who fall through the gaping cracks of private coverage. Congress's decision in EMTALA to prevent occasional holes from appearing in this safety net therefore has a certain expedient appeal, since it makes the policy of relying on private charity somewhat more responsible than it otherwise would be.

Other unfunded mandates to the private sector are less defensible. Congress is considering, for example, whether to implement a so-called bill of rights for patients vis-à-vis managed care plans. The regulatory requirements in that legislation will necessarily entail some increase in private costs—how much is hotly debated—that inevitably will price even more consumers out of the market for private coverage. Unfortunately, policymakers frequently seek political credit for their good intentions by siding with the best in health care. In so doing, they make the best the enemy of what many might regard as good enough for themselves.

Some moves by the political system in providing health care for afflicted individuals or groups can be seen as exercises in the magician's art of misdirection—that is, as ostentatious flourishes diverting attention from what is truly consequential (in this case, continuing major gaps in access to care). Thus, even though the Medicaid program was enacted in an admirable burst of real generosity, the

liberality of the coverage it extends to a subset of the underserved population is probably not optimal public policy, since the same resources could be better used in caring for more people. Medicaid's apparent generosity serves policymakers well, however, as a demonstration of their good will toward the poor. At the same time, inadequate payment for services often diminishes *de facto* what seems so generous *de jure*. Similar misdirection is also notable with respect to Medicaid coverage of long-term care. In this case, Congress's visible hand holds out a generous entitlement while hidden regulatory hands at the state level erode that entitlement by limiting the supply of nursing home beds under certificate-of-need requirements. Similarly, in the early days of liver transplantation, when efficacy was in doubt, cost extremely high, and private coverage extremely limited, some state Medicaid programs gained good publicity by generously covering transplants for the few who needed them, while at the same time neglecting more obvious needs.[23] The end-stage renal disease program under Medicare is an example of an entitlement that earned political credit for an earlier Congress but that contrasts strikingly today with the lack of universal coverage for other needs.

Needed: A Permanent Forum On Legal Issues In Health Care

Although the vagrancy of American health care law and its many contradictions are interesting, the practical aim of this paper is to suggest the potential value of creating a new private forum in which insiders from both sides of the medical/legal divide can freely and openly discuss both broad and narrow issues. Specifically, I propose the creation within the Institute of Medicine (IOM) of a permanent, professionally staffed Forum on Legal Issues in Health Care.[24] The focus on legal issues in health care rather than on "health law" conveys that the forum's main concern would be the law affecting the financing, delivery, and quality of personal health services, not all law affecting individual or public health or regulating biomedical research or biotechnology as such. Although the forum might strive initially only to issue occasional IOM-style reports surveying problem areas and the relevant literature, it might aspire in the long run to fill a role like that of the American Law Institute or the National Conference of Commissioners on Uniform State Laws, seeking common ground and issuing authoritative model statutes and pronouncements on what the law should be. The overriding goal of the forum would be to assist the legal system in adapting legal thinking and doctrine to the new health care environment.

The need for a forum of the kind visualized arises in part because, as this paper demonstrates, nowhere in the legal system is there a

single governmental authority responsible for making law and policy to govern the health care industry in all of its interrelated aspects. Indeed, the industry is too large and diverse to enable rationalizing the law through the legislative process without a complete federal takeover. As things now stand, Congress and state legislatures each have major, somewhat overlapping, but largely complementary roles in developing health care law. In addition, lawmaking in a number of legal fields affecting the health care sector is largely in the hands of courts acting in a common-law mode, often with even less policy awareness and flexibility in shaping new policies than legislatures bring to the exercise. In other areas, issues of health care law are resolved, at least initially, in federal and state administrative agencies. The legal system also regularly gives the force of law to customary standards or to standards developed by professional or other private associations to guide or dictate the conduct of health care providers. In a number of instances, important legal regimes have been created not by legislatures, agencies, or courts but through negotiated settlements of litigation, as in the case of Aetna U.S. Healthcare's recent agreement with the attorney general of Texas on how it will henceforth conduct business there.[25]

A private, nonprofit entity with a broad perspective could perform a useful synthesizing and coordinating function in health care law. Not only are Congress and state legislatures often inclined to see only one aspect of an issue—such as the possible benefits of legislation and not its true costs—but they typically lack responsibility for, or control over, many aspects of the health care system that their decisions affect. Both legislatures and courts are also influenced by special interests—lobbyists or litigants, as the case may be—and by overarching conventions and paradigms that, lacking plenary power, they cannot easily reexamine or alter. In these circumstances, an independent private forum could provide both valuable overviews and appropriate oversight of the legal system, at least occasionally going outside the bounds of conventional thinking.

The IOM seems to be the ideal convener of such a forum, being somewhat above the political fray and well positioned to examine objectively how the law is influencing the health care industry's overall performance. In particular, the IOM can mobilize some of the most thoughtful persons in the medical profession and the health care industry. This should enable it to attract equally leading lights from the legal world. In addition, the IOM's prestige, together with the eminence of those who participate in its deliberations, should draw attention and lend authority and influence to its work products. The involvement of thoughtful representatives of the health care and legal establishments in the reexamination and reformula-

tion of policy should not only improve the quality of thinking on legal issues in health care but also facilitate the education and reeducation of lawyers, judges, physicians, and other industry participants on difficult legal matters—perhaps through short courses and other educational endeavors. Finally, because the IOM is frequently asked by government for assistance on vexing issues of public policy, it is possible to visualize direct public benefits from a major effort to strengthen its ability to deal critically with legal issues. Another powerful reason for locating this effort in the IOM is its ability to bring the findings of health services research to bear on the questions studied under its auspices. It also could direct new research into areas where ignorance has legal consequences.

The goal of the projected forum should be to take a genuine "systems" approach in evaluating legal rules in the health sector and guiding the performance of courts and legislatures. As a prestigious convener of experts, finder of facts, and distiller of wisdom, an IOM Forum on Legal Issues in Health Care would be a vital source of new insights and principles to which legislators, judges, officials, advocates, and academics could turn in thinking about and shaping law for the health care industry in the twenty-first century.

NOTES

1. *Moral hazard* refers to the tendency of decisionmakers to incur greater costs or run greater risks when a third party stands to bear them.
2. J. Sheils and P. Hogan, "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs* (Mar/Apr 1999): 176–181.
3. G.F. Anderson et al., "Health Spending and Outcomes: Trends in OECD Countries, 1960–1998," *Health Affairs* (May/June 2000): 150–157.
4. 421 U.S. 773 (1975).
5. *AMA v United States*, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943).
6. G. Calabresi and P. Bobbit, *Tragic Choices* (New York: W.W. Norton, 1978).
7. Public decisionmakers regularly eschew making rational trade-offs on consumers' behalf, assuming instead that consumers want nothing less than the best health care, whatever the cost. This defeats a central purpose of substituting public choices for private ones. Public regulation is usually justified, after all, on the ground that the "bounded rationality" of consumers makes them less capable than public decisionmakers of sending reliable signals to market actors. See R. Korobkin, "The Efficiency of Managed Care Patient Protection Laws: Incomplete Contracts, Bounded Rationality, and Market Failure," *Cornell Law Review* 85, no. 1 (1999): 1–88. Nothing could be clearer, however, than that the signals that voters (consumers wearing a different hat and having less reason to think rationally or fully inform themselves) send to their representatives do not invite rational consideration of difficult trade-offs.
8. See C.C. Havighurst, *Health Care Choices: Private Contracts as Instruments of Health Reform* (Washington: AEI Press, 1995).
9. *Kennedy v Parrott*, 90 S.E.2d 754, 757 (N.C. 1976).
10. Gordon Wood observed that in pre-Revolutionary America, all contracts "were regarded as evidence that the parties...had mutual rights and obligations established in custom. Such patriarchal contracts did not create these rights and obligations; they merely recognized their existence." G.S. Wood, *The Radi-*

calism of the American Revolution (New York: Vintage Books, 1993), 162.

11. K. Levit et al., "Health Spending in 1998: Signals of Change," *Health Affairs* (Jan/Feb 2000): 124–132.
12. See, for example, R.A. Dudley et al., "The Impact of Financial Incentives on the Quality of Care," *Milbank Quarterly* 76, no. 4 (1998): 649–686.
13. New questions have lately been raised about the general quality of care. See Institute of Medicine, *To Err Is Human: Building a Safer Health System*, ed. L.T. Kohn, J.M. Corrigan, and M.S. Donaldson (Washington: National Academy Press, 1999). See also M.R. Chassin, "Is Health Care Ready for Six Sigma Quality?" *Milbank Quarterly* 76, no. 4 (1998): 565–591; and M.A. Schuster et al., "How Good Is the Quality of Health Care in the United States?" *Milbank Quarterly* 76, no. 4 (1998): 517–563.
14. See W.A. Zelman and R.A. Berenson, *The Managed Care Blues and How to Cure Them* (Washington: Georgetown University Press, 1998), 12: "The most recent trends suggest that...managed care plans may wind up watering down their products to such a degree that the potential for real coordination and cost and quality control may be lost. Today much of managed care...is beginning to look and act ominously like the old fee-for-service system, only with lower provider reimbursement rates."
15. See C.C. Havighurst, "Vicarious Liability—Relocating Responsibility for the Quality of Medical Care," *American Journal of Law and Medicine* 26, no. 1 (2000): 7–30 (including draft statutory language to establish vicarious liability as a default rule); C.C. Havighurst, "Making Health Plans Accountable for the Quality of Care," *Georgia Law Review* 31, no. 2 (1997): 587–647; and W.M. Sage, "Enterprise Liability and the Emerging Managed Health Care System," *Law and Contemporary Problems* (Spring 1997): 159–210.
16. *Petrovich v Share Health Plan, Inc.*, 719 N.E.2d 756 (Ill. 1999).
17. P.C. Weiler, H.H. Hiatt, and J.C. Newhouse, *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* (Cambridge: Harvard University Press, 1993).
18. See Havighurst, *Health Care Choices;* and Symposium, "Medical Malpractice: Can the Private Sector Find Relief?" *Law and Contemporary Problems* (Spring 1996): 1, 143–303.
19. See, for example, L.R. Tancredi, "Designing a No-Fault Alternative," *Law and Contemporary Problems* (Spring 1986): 277–286; and C.C. Havighurst and L.R. Tancredi, "Medical Adversity Insurance—a No-Fault Approach to Medical Malpractice and Quality Assurance," *Milbank Quarterly* 51, no. 1 (1973): 125–152.
20. *Herdrich v Pegram*, 145 F.3d 362 (7th Cir. 1998), *rehearing en banc denied*, 170 F.3d 683 (7th Cir. 1999) (four judges dissenting), *cert. granted*, 120 S.Ct. 10 (1999).
21. S.D. Pearson et al., "Ethical Guidelines for Physician Compensation Based on Capitation," *New England Journal of Medicine* 339, no. 10 (1998): 689–692.
22. *Herdrich v Pegram.*
23. C.C. Havighurst and N.M.P. King, "Liver Transplantation in Massachusetts: Public Policy as Morality Play," *Indiana Law Review* 19, no. 4 (1986): 955–987.
24. In fact, the IOM already has such a proposal under consideration, having explored it at a July 1999 workshop entitled "Creating in the IOM an Ongoing Interface between the American Health Care Industry and the American Legal System." This paper is adapted from one prepared for that workshop. Although the proposal received widespread support from the workshop participants, the necessary funding has not yet been obtained.
25. See "Cornyn Announces Landmark Agreement with Aetna U.S. Healthcare," available on the State of Texas Office of the Attorney General Website: www.oag.state.tx.us/newspubs/releases/2000/20000411aetna.htm.