Health Care Is Not a Typical Consumer Good and We Should Not Rely on Incentivized Consumers to Allocate It

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INTRODUCTION

Many believe that health care is, or should be treated as, a "typical" economic good.[1] As such, its delivery and distribution should be governed by "standard economic theory,"[2] in the context of a "free"[3] or

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1. *See* STEPHEN MORRIS ET AL., ECONOMIC ANALYSIS IN HEALTH CARE 20 (2007) (describing health care as an economic good operating within a normative and positive economic market); *but see* Clark Havighurst & Barak Richman, *Who Pays? Who Benefits? Unfairness in American Health Care*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 493, 511 (2011) (noting that the electorate does not realize that health care is an economic good because the government does not present it with the requisite information to make informed decisions).

2. Standard economic theory is a normative theory that proposes that humans have the ability to consistently make rational decisions based on what they believe to be their current situation, and the markets and institutions that will regulate them. Efficiency under this model relies on the advent of complete markets (i.e., perfect information on the parts of consumers and price-taking behavior on behalf of producers). Dan Ariely, *The End of Rational Economics*, HARV. BUS. REV. (2009), https://hbr.org/2009/07/the-end-of-rational-economics; *see* Grant Hayden & Stephen Ellis, *Law and Economics After Behavioral Economics*, 55 U. KAN. L. REV. 629, 633 (2007) (tracing the origins of the standard economic theory).

3. Under traditional economic theory, resources are exchanged within a free market system, which includes the characteristics of private property, freedom of choice, motivation of self-interest, competition, and limited government interference. Sangeeta Agarwal, *5 Essential Features of Capitalism or Free Market Economy*, PRESERVE ARTICLES (2012), http://www.preservearticles.com/201105056260/features-of-capitalist-or-free-market-

"competitive"[4] market. While each of these terms means something different, all of the terms share one characteristic: the primacy of consumers having "complete" or "perfect" knowledge of the good being sold.[5] This knowledge is related to the "value" of the good—its price and quality—so that consumers can make informed choices.[6]

Even a cursory review of the attributes of the health care market, however, raises serious questions as to whether consumers have, or can ever have, the knowledge necessary for a competitive market to work in health care.[7] Medical care is complicated, and insurance policies are dense documents. And because we habitually minimize risks that we cannot, or would rather not, contemplate,[8] in a moment of need and

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economy.html. Perfect competition consists of a market structure where there are enough firms that each have a relatively small market share, while selling identical products and acting independently so as to not affect the overall market through their production decisions. Perfect competition also expresses the idea that if people have the freedom of choice, resources will be allocated appropriately among participants in the market. Kent Greenfield, *Choice and the Free Market*, MONTREAL REV. (Jan. 2012), http://www.themontrealreview.com/2009/The-Myth-of-Choice-Personal-Responsibility-in-a-World-of-Limits-by-Kent-Greenfield.php.

4. Competitive markets exist where a large number of producers compete in serving many consumers, and where no individual can control the operation of the market or determine the costs of goods or services and can only be formed when certain requirements are met. Competitive markets also depend on the assumption that while people will act in their own self-interest, overall market efficiency will ultimately be achieved. Simon Willkie, Symposium, *Current Regulatory Realities: Overcoming the Regulatory Quandary*, 2003 MICH. ST. DCL L. REV. 599, 599; *Competitive Markets*, ECON. ONLINE, http://www.economicsonline.co.uk/Competitive_markets/Competitive_markets.html (last visited Apr. 12, 2017).

5. Perfect or complete knowledge refers to the absence of information failure or delay in the flow of information. *Perfect Competition*, ECON. ONLINE, http://www.economicsonline.co.uk/Business_economics/Perfect_competition.html (last visited Apr. 12, 2017); *see* Richard Sexton, *Welfare Loss from Inaccurate Information: An Economic Model with Application to Food Labels*, 15 J. CONSUMER AFF. 214, 216 (1981) (explaining the effects of the consumer's lack of perfect and complete information on the demand curve); Dennis Yao, *Beyond the Reach of the Invisible Hand: Impediments to Economic Activity, Market Failures, and Profitability*, 9 STRATEGIC MGMT. J. 59, 68 (1988) (noting that consumers who lack perfect information will make rational decisions based on their experiences in the marketplace).

6. George B. Sproles, *Conceptualization and Measurement of Optimal Consumer Decision-Making*, 17 J. CONSUMER AFF. 421, 423 (1983) (noting that a consumer assesses the value of a product based on the information he or she has at the time of his or her decision).

7. *See* MORRIS ET AL., *supra* note 1, at 14–16 (establishing that the health care market is fundamentally different from other markets because it depends on critical evaluations of economic theory and empirical analysis to deduce the explicit and implicit normative content of data); Diane Duffy, *Market Model Fails: Linkages Between Health Policy and Performance Outcomes in Western Industrial Countries*, 21 J. HEALTH & HUM. SERVS. ADMIN. 278, 300–02 (1999) (determining that the health care market violates assumptions of a traditional economic system and therefore should not be amenable to market pressures).

8. DEBORAH LUPTON, RISK 120 (1999) (suggesting that the rational decision maker will avoid risks on a conscious level when engaging in a cost-benefit analysis); *see generally* Du Du, *General*

vulnerability, the last thing one wants to do is negotiate prices pursuant to those dense and complicated documents.

Of course, this is not to imply that the current health care market is working—at best, the market is characterized as a strange mixture of competition and "command and control" that is lacking in transparency.[9] Prices continue to rise;[10] consumers still find the individual insurance market challenging to navigate;[11] many individuals still lack high-quality, accessible health care services;[12] and many common measures of public health in the United States rival those of third world countries.[13]

Still, there is a worry that the current movement toward more fully embracing competition as the means to allocate health care services is fraught with peril. Wrong choices made by patients acting as consumers

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Equilibrium Pricing of Options with Habit Formation and Event Risks, 99 J. FIN. ECON. 400 (2011) (explaining the impact of habit formation on consumer risk aversion).

9. Bill Clinton recently stated that Obamacare (i.e., the Patent Protection and Affordable Care Act ("ACA")) is the "craziest thing" he has ever seen. GOP War Room, *Bill Clinton: Obamacare "Crazy System," People End Up w/ "Premiums Doubled and Coverage Cut in Half*," YOUTUBE (Oct. 3, 2016), https://www.youtube.com/watch?v=VsCg-0GAbt4; *but see* Sarah Kliff, *Bill Clinton's Anti-Obamacare Remarks, Explained*, VOX (Oct. 4, 2016, 4:10 PM), http://www.vox.com/policy-and-politics/2016/10/4/13162654/bill-clinton-obamacare (noting that Bill Clinton was referring to the health care system as a whole and that small businesses and people just above the poverty line are disparately impacted by the overall system).

10. *See* KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TR., EMPLOYER HEALTH BENEFITS: 2016 SUMMARY OF FINDINGS 1 (2016), https://kaiserfamilyfoundation.files.wordpress.com/2016/09/employer-health-benefits-2016-summary-of-findings.pdf (noting increases in health care insurance premiums).

11. David Blumenthal & Sara Collins, *Turmoil in Individual Private Health Insurance Markets: Welcome to Real Competition*, COMMONWEALTH FUND (July 26, 2016), http://www.commonwealthfund.org/publications/blog/2016/jul/turmoil-individual-private-markets (listing the major issues in individual insurance as financial losses and proposed price increases by participating insurance companies); David Boddy et al., *Emerging Trends and Enduring Challenges in U.S. Health Care*, BROOKINGS (Oct. 7, 2015), https://www.brookings.edu/blog/health360/2015/10/07/emerging-trends-and-enduring-challenges-in-u-s-health-care/ (noting that consumers often lack relevant information and insurance literacy when selecting their private insurance).

12. Boddy et al., *supra* note 11 (noting that the insurance coverage gap in the United States leaves an estimated 33 million people without insurance); Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in the United States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Oct. 19, 2016), http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ (explaining the consequences of the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* to make the ACA Medicaid expansion optional for the states, leaving millions of people who have incomes above Medicaid eligibility, but are unable to qualify for tax subsidies, without access to insurance that is actually affordable).

13. *See* David Squires & Chloe Anderson, U.S HEALTH CARE FROM A GLOBAL PERSPECTIVE, COMMONWEALTH FUND (Oct. 8, 2015), http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective (documenting that the United States spends more on health insurance than other countries, but has substandard care and quality).

lead to delays in accessing services. Even further, some companies may capitalize on the fact that these patients-consumers make wrong choices and might not thoroughly consider all options by incentivizing avenues of care that may be suboptimal with enormous consequences. This Essay advocates that health care should not be treated like any other good and that the vagaries of a competitive free market should not be the approach to achieve health care's so-called "Triple Aim": high-quality, low-cost, accessible health care.[14]

This Essay's concerns about the role of competition are further heightened given the current movement toward "consumer directed"[15] or "defined contribution"[16] health care—the idea being that consumers should be empowered to make cost/benefit choices on their desired (if any) type of insurance coverage and then fully bear the implications of those choices. This is very much a competitive market approach, as it assumes that the industry must empower consumers to make self-interested choices to improve quality and reduce the cost of health care.

In this defined contribution world, employers will no longer provide health care insurance to workers,[17] but rather will provide a fixed amount

14. The Triple Aim refers to the systemic goal for all residents of the United States to access quality health care. *IHI Triple Aim Initiative*, INST. FOR HEALTHCARE IMPROVEMENT, http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx (last visited May 1, 2017); *see* Robert McCann, *Something Old, Something New: Accounting for Accountable Care in Antitrust Analysis*, *in* 27 HEALTH L. HANDBOOK 147, 157 (Alice G. Gosfield ed., 2015) ("The Triple Aim embodies the premise that improving clinical processes and improving the coordination and management of care will lead simultaneously to better patient outcomes and lower expenditures."); *but see* Jean Shami, *A Promise Realized? A Critical Review of Accountable Care Organizations Since the Enactment of the Affordable Care Act*, 71 U. MIAMI L. REV. 312, 316 (2016) (commenting that in relation to Accountable Care Organizations ("ACOs") "the 'Triple Aim' has been undone by the disproportionate emphasis on 'restraining costs' [and this] financial focus overshadows the two remaining priorities of American health reform: improving quality of care and facilitating access to care").

15. *See Consumer-Directed Health Care*, NAT'L CTR. FOR POL'Y ANALYSIS, http://www.ncpa.org/about-cdhc/ (last visited Dec. 31, 2016) (defining consumer-directed health care plans as those that allow patients "to control and manage their own health care dollars, [and] help individuals become more conscientious consumers of health care").

16. *Healthcare Solutions: Defined Contribution Plan*, NFIB, http://www.nfib.com/cribsheets/defined-contributions/ (last visited Apr. 12, 2017) (defining health care contribution plans as plans where "the employer provides the employee with a fixed quantity of money [and] the employee [then] uses these funds to purchase a health insurance policy of his or her own choice").

17. *See* PAUL M. HAMBURGER, 1 MANDATED HEALTH BENEFITS: THE COBRA GUIDE ¶ 1216 fig. 1216-A (2016) (listing the five types of defined contribution plans as employee-paid reimbursable health flexible spending accounts ("FSAs"), reimbursable health FSAs that are a combination of employer and employee paid, employer-paid health reimbursement arrangements, health savings accounts, and archer medical savings accounts); Robert Galvin, *How Employers Are Responding to the ACA*, 374 NEW ENG. J. MED. 604, 605 (2016) (noting that employers have turned

of money that an employee can deposit into a health savings account—along with the employee's own money—to pay health care expenses.[18] Coupled with a high-deductible health plan, whereby the employee is required to pay a minimum deductible of $1,300 (individual) and $2,600 (family) for catastrophic health care coverage,[19] this "skin in the game" is designed to interject a degree of value consciousness into health care purchasing to parallel any other consumer good.[20]

In considering the impact of this expansion of consumer-directed health care and its increased cost-sharing obligations, one must realize that insurance is not just a payment mechanism, but rather the key to entering the health care marketplace. Health care services are expensive, and few can afford a long course of treatment without insurance coverage.[21] While private hospitals have a legal obligation to provide care, this only arises in the context of an emergency or a possible urgent

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to consumer-driven and defined contribution health plans as a way to cut costs and fix contributions based on a benefit design where employees can buy up or buy down their insurance).

18. *See* Brian Shiker, *Defined Contribution Health Plans: HRAs and HSAs*, 30 J. PENSION PLAN. & COMPLIANCE 96, 97–98 (2004) (explaining that a health savings account ("HSA") is an employer-funded nonforfeitable trust established for an individual employee participating in the employer's health care plan with an annual fixed amount per year that the employee can add to if desired).

19. INTERNAL REVENUE SERV., DEP'T OF TREASURY, PUBLICATION 969, HEALTH SAVINGS ACCOUNTS AND OTHER TAX FAVORED HEALTH PLANS 3 (2016); *see also Out-of-Pocket Maximum Limits on Health Plans*, OBAMACARE FACTS, http://obamacarefacts.com/health-insurance/out-of-pocket-maximum/ (last visited Apr. 13, 2017) (noting that minimum deductibles for HSAs will remain unchanged in 2017).

20. *See* DAVID M. ADAMSON, RAND CORP., SKIN IN THE GAME: HOW CONSUMER-DIRECTED PLANS AFFECT THE COST AND USE OF HEALTH CARE 1 (2012), http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9672.pdf (positing that consumer-directed plans aim to make consumers responsible for a higher share of the price); William Safire, *Skin in the Game*, N.Y. TIMES (Sept. 17, 2006), http://www.nytimes.com/2006/09/17/magazine/17wwln_safire.html (quoting Senator Tom Coburn as saying that HSAs "give consumers some 'skin in the game' by putting them in charge of health-care dollars"); *see also* Samantha Howe, Public Engagement in Health Policy Formulation: Contexts, Content & Identity Construction (2013) (unpublished Ph.D. dissertation, The Ohio State University), https://etd.ohiolink.edu/!etd.send_file?accession=osu1376662937&disposition=inline (discussing that by having individuals have "skin in the game" in regards to their health care plans will improve efficiency and quality of care); *but see* NAT'L COUNCIL OF LA RAZA, HEALTHY CHOICES OR BAD MEDICINE?: HEALTH TAX INCENTIVES ROUNDTABLE TRANSCRIPT 36 (2008), http://publications.nclr.org/bitstream/handle/123456789/41/TranscriptFinal.pdf?sequence=1&isAllowed=y (noting that the United States has the most "skin in the game" out of any other developing countries (i.e., the highest ratio of costs borne by consumers)).

21. Timothy Jost, *Affordability: The Most Urgent Health Reform Issue for Ordinary Americans*, HEALTH AFF. BLOG (Feb. 29, 2016), http://healthaffairs.org/blog/2016/02/29/affordability-the-most-urgent-health-reform-issue-for-ordinary-americans/ (noting that even though the ACA makes health insurance more affordable, premiums and cost-sharing plans are still costly).

condition.[22] Private physicians, pharmaceutical companies, and many other health care providers have no legal obligation to provide services or products for free or reduced costs. Therefore, one must present an insurance card within five minutes of visiting a physician. By design, pulling back the scope and level of coverage will cause patients-consumers to consider their need for care. While to some extent, benefit levels and cost sharing have always impacted health care access, the higher level of cost sharing brings affordability of health care to a point where patients-consumers cannot access essential services because patients-consumers are considering the costs of their health care before the service is rendered.

Not only has defined contribution thinking taken sway amongst private employers,[23] but it appears to be gaining headway in possible Medicare and Medicaid program reforms. While the views of President Trump's administration continue to be unclear,[24] House Speaker Paul Ryan calls for the implementation of Medicare vouchers, which would enable beneficiaries to shop the private insurance market for the type of coverage they would prefer.[25] And some state Medicaid programs, such as

22. While there is no general duty for private hospitals to provide care, under certain circumstances, federal statutes require hospitals to provide care to patients. One example is the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which requires hospitals with emergency departments participating in the Federal Medicare program to provide medical screening to any patient seeking emergency care and to provide treatment to unstable patients. Emergency Medical Treatment and Active Labor Act of 1935, 42 U.S.C. § 1395dd (2003). A hospital is prohibited from transferring a patient until their condition is stabilized. *Id.*; *see also* BARRY FURROW ET AL., HEALTH LAW § 5.2 (3d ed. 2014) (providing a general overview of EMTALA). On the other hand, public hospitals have a duty to provide care to the indigent and their clientele often consists of Medicare and Medicaid patients. *See* Brietta Clark, *Disentangling Fact from Fiction: The Realities of Unequal Health Care Treatment*, 9 DEPAUL J. HEALTH CARE L. 1023, 1046 (2005) (noting that while public hospitals have a duty to provide care, private hospitals do not).

23. This is because of its significant ability to lower employer costs as it caps the employer contribution typically at a lower level. *See* AKSHAY KAPUR ET AL., BOOZ & CO., THE EMERGENCE OF PRIVATE HEALTH INSURANCE EXCHANGES: FUELING THE "CONSUMERIZATION" OF EMPLOYER-INSPIRED HEALTH INSURANCE 2 (2012), http://www.strategyand.pwc.com/media/uploads/Strategyand-Emergence-Private-Health-Insurance-Exchanges.pdf ("This model allows the company to cap its healthcare cost at a desired threshold, improving control of current expenses and future liabilities."); Katherine Stone, *A Fatal Mismatch: Employer-Centric Benefits in a Boundaryless World*, 11 LEWIS & CLARK L. REV. 451, 451 (2007) (noting that employers prefer defined contribution plans in the face of the aging baby boomer population).

24. Peter Sullivan, *What We Know and Don't Know About Trump's Healthcare Plans*, HILL (Jan. 22, 2017, 6:00 PM), http://thehill.com/policy/healthcare/315387-what-we-know-and-dont-know-about-trumps-healthcare-plans.

25. *See* Bernie Becker, *Ryan Set for Collision Course with Obama*, HILL (Nov. 20, 2014, 6:00 AM), http://thehill.com/homenews/house/224805-ryan-set-for-collision-course-with-obama

Arkansas,[26] implemented a version of Medicaid vouchers in addition to the Centers for Medicare and Medicaid Services ("CMS") approving similar programs in Iowa, Indiana, Michigan, and Pennsylvania.[27] Given the significant cost savings associated with a defined contribution approach, the idea is likely to gain even further sway.[28]

This Essay argues that overall reliance on competition and free market thinking (particularly value-incentivized consumers) to achieve an appropriate, fair allocation of health care services will cause significant harm to many people. In arguing this proposition, this Essay focuses specifically on the lack of transparency in health care; this lack of transparency means that the sine qua non of a free market—educated, self-interested consumers—is lacking.

This Essay also contends that the free market approach will not work because it ignores the reality that invariably society will intercede to "rescue" individuals who made poor choices regarding their scope of insurance coverage, ultimately increasing the cost of every other patient-consumer's health care services.[29] Finally, reliance on this approach

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(noting that the Speaker of the House, Paul Ryan, "has proposed sweeping overhauls of entitlement programs, including partially privatizing Medicare through a premium support plan"); *see also* Susan A. Channick, *Taming the Beast of Health Care Costs: Why Medicare Reform Alone Is Not Enough*, 21 ANNALS HEALTH L. 63, 71–72 (2012) (noting that under Speaker Ryan's "path to prosperity," "the federal government would provide beneficiaries a subsidy toward the purchase of a private health insurance plan through the states' Health Insurance Exchange [and] any costs in excess of the premium support would be the responsibility of the beneficiary").

26. *Waiver Services*, ARK. DEP'T HUM. SERVS. (last visited May 1, 2017), http://humanservices.arkansas.gov/ddds/Pages/waiverServices.aspx; *see Medicaid Expansion in Arkansas*, KAISER FAM. FOUND. (Feb. 12, 2015), http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/ (providing an overview of the Arkansas Medicaid waiver program); *but cf. Privatization: Not Right for Medicaid, Not Right for Medicare*, CTR. FOR MEDICARE ADVOC., http://www.medicareadvocacy.org/privatization-not-right-for-medicaid-not-right-for-medicare/ (last visited May 1, 2017) (arguing that "a move to managed care could disrupt long-standing relationships between patients and their doctors, all in the name of quick savings").

27. An additional twenty-nine states are considering similar avenues. *Medicaid Expansion in Arkansas*, *supra* note 26 (listing various states that have followed a similar path as Arkansas in regards to Medicaid waiver and voucher programs); *Status of State Action on the Medicaid Expansion Decision*, KAISER FAM. FOUND., http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0 (last visited Jan. 3, 2017) (providing data on state action on Medicaid expansion as of January 1, 2017).

28. *See, e.g.*, BRITTON D. WEIMER ET AL., 22 MINNESOTA PRACTICE SERIES, INSURANCE LAW & PRACTICE § 11.23 (2016) (explaining that defined contribution health plans lower an employer's responsibility to its employees); *but see generally* Laura Cohn & Phoebe Eliopoulos, *What Comes After Managed Care?*, 3704 BUS. WK. 149 (2000) (arguing that defined contribution health plans shift too many costs from employers to employees).

29. The public absorbs costs through the vehicles of charity care and cost-shifting. *See* Teresa Coughlin et al., *Uncompensated Care for the Uninsured in 2013: A Detailed Explanation*, KAISER FAM. FOUND. (May 30, 2014), http://kff.org/uninsured/report/uncompensated-care-for-the-

serves to further erode the social compact where everyone should be entitled to the basic building blocks of life to make their way in the world.[30]

I. HEALTH CARE LACKS TRANSPARENCY

The health care industry is not transparent with respect to price or quality,[31] and its primary beneficiary—the patient—often lacks the capability and capacity to make informed choices.[32] Because an informed consumer able to make value judgments is lacking, the very foundation necessary for a competitive market to work is absent, causing the market to fail.

The lack of transparency regarding the quality and price of health care

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uninsured-in-2013-a-detailed-examination/ ("While providers incur significant costs in caring for the uninsured, the bulk of their costs (about two-thirds) are compensated through a web of complex funding streams that are financed largely with public dollars."); Abdulrahman El-Sayed, *Five Reasons Free Markets Don't Work in Health Care*, HUFFINGTON POST (Apr. 5, 2012), http://www.huffingtonpost.com/abdulrahman-m-elsayed/health-care-market_b_1405396.html (noting that a free market will not work for health care because consumers' bad choices will ultimately lead to more disease and more costs for all); *see, e.g.*, Jason Hart, *"Under-Compensated Care Will Become a Larger Issue in the Long-Term" for Carolina Hospitals*, WATCHDOG.ORG (Mar. 10, 2016), http://watchdog.org/259153/compensated-care-will-become-larger-issue-long-term-carolina-hospitals/ (determining that Medicaid expansion will result in an increased percentage of charity care costs).

30. AMIR PAZ-FUCHS, THE FOUND. FOR LAW, JUSTICE, & SOC'Y, THE SOCIAL CONTRACT REVISITED: THE MODERN WELFARE STATE 14–15 (2011), http://www.fljs.org/files/publications/Paz-Fuchs-SummaryReport.pdf (positing that the social contract is broken in the health care system).

31. Austin Frakt, *Price Transparency Is Nice. Just Don't Expect It to Cut Health Costs.*, N.Y. TIMES (Dec. 19, 2016), http://www.nytimes.com/2016/12/19/upshot/price-transparency-is-nice-just-dont-expect-it-to-cut-health-costs.html (noting that a lack of price transparency results in increased consumer costs); *see* Kevin Volpp, *Price Transparency: Not a Panacea for High Health Care Costs*, 315 JAMA 1842, 1842 (2016) (noting that price transparency tools are counterintuitive because consumers do not have the relevant information on quality and alternative options when utilizing them); *but see* FURROW ET AL., *supra* note 22, § 7.8 (noting that available options and information should lead to reduced costs in health care for consumers).

32. *See* DALE SHALLER, CONSUMERS IN HEALTH CARE: THE BURDEN OF CHOICE 6 (Oct. 2005), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ConsumersInHealthCareBurdenChoice.pdf (noting that consumers often lack comprehensive data on health care options which results in an inability to make educated decisions); Joel White, *Promoting Transparence and Clear Choices in Health Care*, HEALTH AFF. BLOG (June 9, 2015), http://healthaffairs.org/blog/2015/06/09/promoting-transparency-and-clear-choices-in-health-care/ ("Consumers have less information on health provider cost and quality than they do on the cost and quality of televisions or hotel services."); *see, e.g.*, Reed Abelson, *Hospital Choice May Be a Matter of Life or Death*, N.Y. TIMES, Dec. 16, 2016, at B5 (positing that when making important choices (e.g., which hospital to go to), patients lack necessary information (e.g., which hospital has a higher survival rates for a particular procedure)).

services has been long known and lamented.[33] And there is a legitimate concern that this lack of transparency will create severely detrimental consequences in the new world of limited health insurance.[34] The nature of health insurance is changing: health plans are minimizing coverage and consumers can expect to bear more of the cost of care and to comparison shop cost and quality to a degree never expected. Invariably, these burdens will result in choices to delay care or seek less competitive, lower-quality options, causing harm.[35]

The lack of transparency in large part results from health insurance historically shielding beneficiaries from the full cost of care.[36] Thus, unlike other types of common insurance where coverage is purchased for catastrophic events and rarely used, health insurance has traditionally been designed for the patient-consumer to pay for low-risk, often-encountered occurrences. While *society* may not agree that everyone has a right to health care,[37] insured individuals seem to agree that this right

33. *See* HEALTHCARE FIN. MGMT. ASS'N, PRICE TRANSPARENCY IN HEALTH CARE: REPORT FROM THE HFMA PRICE TRANSPARENCY TASK FORCE 4 (2014) (noting that price transparency has been a long-term issue in health care).

34. The percentage of individuals enrolled in high-deductible plans has increased from 20–43 percent in the past five years. Donna Rosato, *The Downside of High Deductible Health Insurance*, CONSUMER REP. (Feb. 19, 2016), http://www.consumerreports.org/health-insurance/downside-of-high-deductible-health-insurance/; *see* AHIP CENTER. FOR RES. & POL'Y, 2015 CENSUS OF HEALTH SAVINGS ACCOUNT—HIGH DEDUCTIBLE HEALTH PLANS 4 (Nov. 2015), https://www.ahip.org/wp-content/uploads/2015/11/HSA_Report.pdf (noting an increase of six million enrollees in HSAs and high-deductible health plans).

35. *See* Lisa Rosenbaum, *The Problem with Knowing How Much Your Health Insurance Costs*, NEW YORKER (Dec. 20, 2013), http://www.newyorker.com/tech/elements/the-problem-with-knowing-how-much-your-health-care-costs (discussing consumer delay tactics in seeking care); Tina Rosenberg, *The Cure for the $1000 Toothbrush*, N.Y. TIMES (Aug. 13, 2013, 10:08 PM), http://opinionator.blogs.nytimes.com/2013/08/13/the-cure-for-the-1000-toothbrush/?_r=0 (noting how a lack of price transparency may lead to financial ruin).

36. *See* John Santa, *Transparency in the Cost of Care*, *in* THE HEALTHCARE IMPERATIVE: LOWERING COSTS AND IMPROVING OUTCOMES: WORKSHOP SERIES SUMMARY 337, 337–38 (Pierre L. Young & LeighAnne Olson eds., 2010) ("Shielded in the past by comprehensive public or private insurance coverage, consumers are faced with substantial increases in cost sharing."); *see, e.g.*, Susan J. Stabile, *State Law Health Care Initiatives*, 19 ST. THOMAS L. REV. 87, 88 (2006) ("The idea is insurance shields consumers from actual health care costs and leads them to demand more services than they would if they were paying directly for the services with after-tax dollars.").

37. *See* Stefan Bernard Baumrin, *Why There is No Right to Health Care*, *in* MEDICINE AND SOCIAL JUSTICE: ESSAYS ON DISTRIBUTION OF HEALTH CARE 91, 91–95 (Rosamond Rhodes et al. eds., 2d ed. 2012) (utilizing Kantian deontology to determine that while it may seem that health care ought to be a right does not necessarily mean that it can practically be a right); *but see* Andrea Christopher & Dominic Caruso, *Promoting Health as a Human Right in the Post-ACA United States*, 17 AM. MED. ASS'N J. MED. ETHICS 958, 958–59 (2015) (discussing that while society generally believes that the disadvantaged should be cared for, difficulty accompanies the reference to health care as a fundamental right because it is a positive right and the United States largely recognizes negative rights over positive rights); *c.f.* Lance Gable, *The Patient Protection and*

exists, because once coverage is secured, they often immediately seek health care services.[38] Indeed, while an important part of the difficulty in pricing insurance products on the exchanges is the lack of younger, healthier individuals opting into the market,[39] another significant factor is the higher-than-expected utilization of services as newly covered individuals seek (presumably delayed) medical care.[40]

Government and private insurers have largely focused their efforts on cost containment, giving much shorter shrift to quality.[41] The Institute

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Affordable Care Act, Public Health, and the Elusive Target of Human Rights, 39 J.L. MED. & ETHICS 340, 340 (2011) (noting that though the ACA does not establish a right to health care, "it does set in motion a number of significant structural and normative changes to [United States] law that comport with the attainment of the right to health").

38. Puneet Sandhu, *A Legal Right to Health Care: What the United States Can Learn from Foreign Models of Health Rights Jurisprudence*, 95 CALIF. L. REV. 1151, 1154 (2007) (noting that though the government has failed to guarantee universal access to health care, Americans believe that health care access should not be limited to individuals who can afford it); *but see generally* Amy Anderson, *The Impact of the Affordable Care Act on the Health Care Work Force*, HERITAGE FOUND. (Mar. 18, 2014), http://thf_media.s3.amazonaws.com/2014/pdf/BG2887.pdf (noting the disparate impact that the influx of Americans with recently acquired health insurance will have on the medical workforce and how this trend will increase overall health care costs because these individuals will seek care for conditions that might have been treated more easily and less expensively, but for the delay due to the lack of health insurance).

39. For a description of the penalty provided by the ACA for not purchasing health insurance, see Maintenance of Minimum Essential Coverage and Liability for the Shared Responsibility Payment, 26 C.F.R. § 1.5000A-1 (2014). *See also* JENNIFER TOLBERT, KAISER FAM. FOUND., THE COVERAGE PROVISIONS IN THE AFFORDABLE CARE ACT: AN UPDATE 28 (2015) (explaining that the penalty was meant to deter young, healthy individuals from not purchasing insurance). The enrollment of younger individuals in the health insurance exchanges was meant to prevent an insurance "death spiral" in the ACA, and it is debatable whether this was successful. *Compare* Topher Spiro, *The ACA Isn't in a 'Death Spiral'—It's Undergoing a Correction*, WASH. POST (Nov. 7, 2016), https://www.washingtonpost.com/posteverything/wp/2016/11/07/the-aca-isnt-in-a-death-spiral-its-undergoing-a-correction/?utm_term=.51636dcedb78 (insisting that the market will stabilize after the November 2016 increase in insurance premiums), *with* John Goodman, *Obamacare's Ugly Death Spirals*, FORBES (Aug. 26, 2016, 9:53 AM), http://www.forbes.com/sites/johngoodman/2016/08/26/obamacares-ugly-death-spirals/#11e4d75b48f8 (arguing that Obamacare will cause a downward spiral in quality due to scarce resources which will result in an upward spiral in price).

40. *See, e.g.*, Stacey McMorrow & Daniel Polsky, *Insurance Coverage and Access to Care Under the Affordable Care Act*, PENN. LEONARD DAVIS INST. HEALTH ECON. (Dec. 8, 2016), http://ldi.upenn.edu/brief/insurance-coverage-and-access-care-under-affordable-care-act (noting that Medicaid enrollees have an increased difficulty making appointments with their providers due to an influx of newly insured patients and the reduced numbers of provider participation in Medicaid); *but see* J. Michael McWilliams, *Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications*, 87 MILBANK Q. 443, 486 (2009) (suggesting that "[n]ewly insured adults' greater demand for health care may lead to more timely initiation of care, greater use of effective services, or better adherence to recommended treatments").

41. Christopher Smith, *Between the Scylla and Charybdis: Physicians and the Clash of Liability Standards and Cost Cutting Goals Within Accountable Care Organizations*, 20 ANNALS HEALTH

of Medicine's 2000 report, *To Err Is Human*,[42] sounded a clarion call on the poor quality of health care services—likening the number of deaths caused by provider error to a daily crashing of a Boeing 747.[43] Sixteen years later, however, it is fair to say that quality initiatives are still at a fairly basic level of development and implementation.[44] Consumers are traditionally shielded from cost and have focused little on quality. Because of this shielding, there is little consumer demand for tools to assist consumers' assessment of quality providers.[45]

L. 165, 165–66 (2011) (noting that the health care reform movement is heavily focused on cost containment, evidenced by managed care organizations, pay-for performance programs, and consumer-driven health plans); *but see* Neelam Sekhri, *Managed Care: The US Experience*, 78 BULL. WORLD HEALTH ORG. 830, 838 (2000) (saying that care through health maintenance organizations ("HMOs") is on equal footing with traditional fee-for-service settings). The industry sees ACOs as a potential solution to the cost versus quality conundrum, with the intent of rewarding the ACO-participants for cost containment *and* quality. Timothy C. Gutwald, *Bending the Health Cost Curve*, 90 MICH. B.J. 20, 22 (June 2011) (explaining that ACO participants receive a shared savings bonus if they meet specified quality standards and cost-savings goals, but if the goals are not met, the ACO member will lose the bonus and potentially suffer a reduction in payments); *see also* NAT'L CONFERENCE OF STATE LEGISLATURES, HEALTH COST CONTAINMENT AND EFFICIENCIES: NCSL BRIEFS FOR STATE LEGISLATORS 55 (2011), http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf (clarifying that ACOs are not cost-containment strategies, but are meant to "implement[] comprehensive payment reform and health care system redesign in order to control the growth in health care costs and obtain better value for each health care dollar").

42. INST. OF MED., TO ERR IS HUMAN: BUILDING A BETTER HEALTH SYSTEM (Linda Kohn et al. eds., 2000), https://www.ncbi.nlm.nih.gov/books/NBK225182/pdf/Bookshelf_NBK225182.pdf [hereinafter TO ERR IS HUMAN]; *see also Cost Containment and Quality Improvement Prioritized by the States*, ST. COVERAGE INITIATIVES, http://www.statecoverage.org/node/1349.html#_ednref4 (last visited Apr. 13, 2017) ("The seminal 1999 Institute of Medicine report, *To Err Is Human*, shone a light on the pervasiveness of medical errors in the U.S. health care system, estimating 98,000 deaths per year attributable to medical errors."); HEALTH LAW HANDBOOK § 11:2 (Alice G. Gosfield ed. 2009) ("[*To Err Is Human*] estimated that the total costs of these medical errors in the form of lost productivity, disability, and costs for health care were between $17 and $29 billion.").

43. TO ERR IS HUMAN, *supra* note 42, at 55 (distinguishing active errors as "the pilot who crashed the plane" from latent errors which are "previously undiscovered design malfunctions causing the plane to roll unexpectedly in a way the pilot could not control and the plane crashed").

44. *See* Lucian L. Leape & Karen Davis, *To Err Is Human; To Fail to Improve Is Unconscionable*, COMMONWEALTH FUND (Aug. 15, 2005), http://www.commonwealthfund.org/publications/from-the-president/2005/to-err-is-human--to-fail-to-improve-is-unconscionable (noting that the medical community has only made progress in reducing errors, but has not come as far as they should have since the publishing of *To Err Is Human*); *To Err Is Human: 15 Years Later*, WEST HEALTH (Nov. 12, 2014), http://www.westhealth.org/to-err-is-human-15-years-later/ ("Though many organizations are working toward a culture of safety, and have built quality and safety systems, we are still far short of six sigma care."); *see also* JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., ACCREDITATION ISSUES FOR RISK MANAGERS 3 (2004) (tracing the origins of the quality improvement movement from the 1990s).

45. *See* CONSUMER REPORTS, CONSUMER-FACING HEALTHCARE COST AND QUALITY TOOLS

Widespread disparities relating to price and quality, seemingly unhinged from outcomes, are rampant.[46] For many years, the Dartmouth Atlas highlighted significant treatment differences in a wide variety of health care procedures, including tonsillectomies, coronary, stents, and hip fractures—all with no discernable link to quality.[47] Researchers long ago concluded that physician training and practice patterns were responsible for care variation, and that if the nation adopted best practices, then savings associated with standardized approaches would be

3 (Nov. 2016), http://nyshealthfoundation.org/uploads/resources/consumer-facing-health-care-cost-quality-tools-consumer-reports-brief.pdf ("Overall usage and awareness of cost-estimator tools is low, despite high consumer interest in healthcare costs."); THE HASTINGS CTR., HEALTH CARE QUALITY IMPROVEMENT: ETHICAL AND REGULATORY ISSUES 135 (Bruce Jennings et al. eds., 2007), http://www.thehastingscenter.org/wp-content/uploads/Health-Care-Quality-Improvement.pdf (noting that "even when [consumers] are provided with applicable quality data, consumers continue to rely on personal recommendations of their physicians, family, and friends"); KATY HENRICKSON ET AL., HEALTH CARE COST COMPARISON TOOLS: A MARKET UNDER CONSTRUCTION 4 (June 2006) (noting that while tools are available to consumers, the tools tend to be educational rather than comparison oriented); *see also* John Santilli & Randy Vogenberg, *Key Strategic Trends that Impact Healthcare Decision-Making and Stakeholder Roles in the New Marketplace*, 8 AM. HEALTH & DRUG BENEFITS 15, 18 (2015) (establishing that younger consumers and new-age wellness providers are more likely to use quality assessment tools than past generations).

46. *See* ELLIOT FISHER ET AL., DARTMOUTH INST. FOR HEALTH POLICY & CLINICAL PRACTICE, HEALTH CARE SPENDING, QUALITY, AND OUTCOMES: MORE ISN'T ALWAYS BETTER 1 (Feb. 27, 2009), http://www.dartmouthatlas.org/downloads/reports/Spending_Brief_022709.pdf (discussing the relationship between regional differences of spending and quality in health care); *see also* Jonathan Skinner & Amitabh Chandra, *The Elusive Connection Between Health Care Spending and Quality*, 28 HEALTH AFF. 119, 122 (2009) ("[I]mproving health care quality is not a matter of simply adding more specialists or hospital beds; it is far more challenging and requires grappling with barriers to improving productivity in health care services—better quality at lower cost."). Beyond disparities in treatments due to medical training and community standards, racial and ethnic disparities have a significant impact on the disparate healthcare provided in America. *See* Samantha Artiga, *Disparities in Health and Health Care: Questions and Answers*, KAISER FAM. FOUND. (Aug. 12, 2016), http://kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/ (defining health care disparities as the "differences between groups in health insurance coverage, access to and use of care, and quality of care"); *cf.* Omar K. Danner et al., *Healthcare Outcome Disparities in Trauma Care*, 13 WESTERN J. EMERGENCY MED. 217, 219 (2012) (providing that "improving cultural competency, addressing health literacy, and implementing quality-of-care improvement initiatives focused on equity and educating the public may reduce disparities in healthcare"); Peter Franks & Kevin Fiscella, *Reducing Disparities Downstream: Prospects and Challenges*, 23 J. GEN. INTERNAL MED. 672, 672–73 (2008) (proposing that health care is a social good and that disparities in health care indicate a deficit in quality of care that is not inevitable).

47. JOHN E. WENNBERG & MEGAN MCANDREW COOPER, DARTMOUTH ATLAS OF HEALTH CARE IN THE UNITED STATES 2 (1996), http://www.dartmouthatlas.org/downloads/atlases/96Atlas.pdf; *see* CTR. FOR THE EVALUATIVE CLINICAL SCIS., PREFERENCE SENSITIVE CARE 2 (2007), http://www.dartmouthatlas.org/downloads/reports/preference_sensitive.pdf (noting multiple differences in treatment options).

immense.[48]

Serious efforts at the federal, state, and private levels are underway to provide consumers with quality and price information to enable intelligent choices. For example, on a federal level, CMS' Quality Initiative provides consumers with quality-of-care information and provides the Hospital Compare[49] online platform for consumers to research hospital quality, patient satisfaction, and pricing.[50] In addition, the Patient Protection and Affordable Care Act ("ACA") allotted $250 million in state funds for the improvement of price transparency and requires CMS to make standardized extracts of Medicare claims available for provider evaluation.[51] States (e.g., Massachusetts and New Hampshire)[52] have also led the charge to provide information to consumers.[53] Massachusetts pioneered with its October 2013 legislation, which required insurers, physicians, and hospitals to provide health care consumers with the costs of health care procedures ranging from office visits at a primary care provider's office to surgical procedures.[54] In

48. WENNBERG & COOPER, *supra* note 47, at 6. *See* ANITA ARORA & ALICIA TRUE, WHAT KIND OF PHYSICIAN WILL YOU BE?: VARIATION IN HEALTH CARE AND ITS IMPORTANCE FOR RESIDENCY TRAINING 3 (2012) http://www.dartmouthatlas.org/downloads/reports/Residency_report_103012.pdf (explaining that institutional treatment practice variations cause variations in physician training).

49. *Hospital Compare*, MEDICARE.GOV, https://www.medicare.gov/hospitalcompare/search.html? (last visited Apr. 13, 2017).

50. Julia Hudson, *Have Your Cake and Eat It, Too: How States Could Leverage Data on Quality to Promote Health Care Transparency & Patient Privacy Within Consumer-Driven Health Care Initiatives*, 10 IND. HEALTH L. REV. 663, 669 (2013) (explaining the Medicaid Quality initiative).

51. Medicare Program: Availability of Medicare Data for Performance Measurement, 76 Fed. Reg. 76,541 (Dec. 7, 2011); *see* FAMILIES USA, PRICE TRANSPARENCY: AN INTRODUCTION 7 (2014), http://familiesusa.org/sites/default/files/product_documents/HSI%20Price%20Transparancy%20Brief_final_web.pdf (providing data on ACA funding); Hudson, *supra* note 50, at 670 (commenting on Medicare provisions of the ACA).

52. *See* FAMILIES USA, *supra* note 51, at 8–9; *see also* Anna Sinaiko & Meredith Rosenthal, *Increased Price Transparency in Health Care—Challenges and Potential Effects*, 364 NEW. ENGL. J. OF MED. 891, 891 (2011).

53. *See* FAMILIES USA, *supra* note 51, at 8 (noting that states are influential, but warning that their practices vary significantly); Martha Hostetter & Sarah Klein, *Health Care Price Transparency: Can It Promote High-Value Care?*, COMMONWEALTH FUND (2012), http://www.commonwealthfund.org/publications/newsletters/quality-matters/2012/april-may/in-focus (noting state and federal policies that promote price transparency); *see also* Sinaiko & Rosenthal, *supra* note 52, at 892 (noting that most states' legislation focuses on "average or median within-hospital prices for individual services").

54. *See* William Hudec, *Massachusetts Becomes First State to Post Prices of Health Care Services*, ADVISORY BOARD (Dec. 4, 2014), https://www.advisory.com/research/medical-group-strategy-council/practice-notes/2014/december/mass-price-transparency (providing an overview of Massachusetts' health care cost transparency legislation); Liz Kowalczyk, *Comparison Shopping for Medical Procedures*, BOSTON GLOBE (Dec. 9, 2013),

2005, New Hampshire passed legislation that created the New Hampshire Comprehensive Health Care Information System, and mandated the creation of an all-payor claims data base ("APCD") and a consumer-friendly public website.[55] This information system collects provider data from a broad array of providers and services, and the New Hampshire APCD lists total and out-of-pocket costs for consumers.[56] Private insurers have also moved to empower consumers. For example, Blue Cross Blue Shield of Illinois provides detailed information on comparisons of in-network versus out-of-network provider services, ranging from CT scans to preferred brand drugs for certain medical conditions.[57]

All of these initiatives are supported by incentivizing consumers to focus more deeply on the quality and cost of their care through increases in their out-of-pocket health care expenditures. Even if a consumer wishes to secure price and quality information, however, their ability to appropriately interpret this data may be rudimentary at best.[58] And, in many cases involving elderly, vulnerable, or frail individuals, the expectation of seeking and interpreting data may be completely unreasonable.

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http://www.bostonglobe.com/lifestyle/health-wellness/2013/12/09/new-law-requires-insurers-providers-give-consumers-cost-estimates-for-their-medical-care/Sxk01bNeqgi0mEU95uMOAM/story.html (explaining that insurers have a forty-eight-hour deadline to provide consumers with price data after a request is made); *see also* Kerry Ann Hayon, *What You Need to Know About Price Transparency Regulations*, MASS. MED. SOC'Y (Sept., 2015), http://www.massmed.org/News-and-Publications/Vital-Signs/What-You-Need-to-Know-about-Price-Transparency-Regulations/#.WHLLvrYrLBI (giving guidance to providers on how to comply with Massachusetts' cost transparency regulations); *but see* Melanie Evans, *Prices Hard to Come by for Massachusetts Patients Despite Transparency Law*, MOD. HEALTHCARE (June 24, 2015), http://www.modernhealthcare.com/article/20150624/NEWS/150629939 (listing the difficulties that still exist despite the new Massachusetts legislation).

55. *See* CATALYST FOR PAYMENT REFORM, PRICE TRANSPARENCY REPORT FOR THE COMMONWEALTH OF PENNSYLVANIA 13 (2016) [hereinafter PRICE TRANSPARENCY REPORT] (discussing New Hampshire's health care reform); Hostetter & Klein, *supra* note 53 (contrasting New Hampshire's health care transparency policies with other states).

56. *Health Costs & Quality of Care in New Hampshire*, NH HEALTHCOST, http://nhhealthcost.nh.gov/ (last visited Apr. 11, 2017); *see* PRICE TRANSPARENCY REPORT, *supra* note 55 at 13 (discussing provider data collection methods); Hostetter & Klein, *supra* note 53 (discussing New Hampshire's all-payor claims data base requirements).

57. BLUECROSS BLUESHIELD OF ILL., SUMMARY OF BENEFITS AND COVERAGE: WHAT THIS PLAN COVERS & WHAT IT COSTS 1–2 (2014), https://www.bcbsil.com/PDF/2014_abbott_ppoplus.pdf; *see also What is a PPO?*, BLUECROSS BLUESHIELD OF ILL., https://www.bcbsil.com/insurance-basics/how-health-insurance-works/what-is-a-ppo (last visited Apr. 13, 2017) (providing a comparison of participating provider option ("PPO") versus HMO plans for consumers).

58. *See supra* note 32 and accompanying text (noting consumer illiteracy in the health care market).

To date, for example, leading quality indicators used by the federal government to determine value-based Medicare payments include percutaneous coronary intervention ("PCI") received within 120 minutes of hospital arrival, thrombolytic agent received within thirty minutes of hospital arrival, and ACE Inhibitor or Angiotensin Receptor Blocker for Left Ventricular Systolic Dysfunction and Beta Blocker prescribed at discharge for a heart attack.[59] These particular measurements, however, have very little resonance with consumers desiring to learn the quality reputation of potential providers whose care they may solicit.[60]

"Star" ratings, on a one-to-five scale, are more meaningful as they distill a multiplicity of factors in a consumer-friendly manner.[61] But even these ratings may capture areas of little or no concern to a particular consumer, or oversimplify issues causing the rating to be misleading. And, ratings may fail to equalize across patient characteristics, thus incorrectly identifying providers as substandard, for example, because

59. CTRS. FOR MEDICARE & MEDICAID SERVS., OVERVIEW OF SPECIFICATIONS OF MEASURES DISPLAYED ON HOSPITAL COMPARE AS OF DECEMBER 14, 2006 2–4 (2006), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalOverviewOfSpecs200512.pdf (providing quality measures for heart attacks); *see also What Are the Value-Based Programs?*, CMS.GOV, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html (last visited Jan. 17, 2017) (providing an explanation of value-based programs that the Centers for Medicare and Medicaid Services ("CMS") reimburses); *see generally QualityNet News*, QUALITYNET, https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetHomepage&cid=1120143435383 (last visited Apr. 13, 2017) (providing resources for quality assessment for hospitals, physician offices, ambulatory surgery centers, cancer hospitals, end stage renal disease facilities, inpatient psychiatric facilities, and quality improvement organizations).

60. *See, e.g.*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, AHRQ QUALITY INDICATORS: INPATIENT QUALITY INDICATORS 1–2 (2015), http://www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V50/IQI_Brochure.pdf (listing inpatient quality indicators); *see also* Jill Mathews Yegian et al., *Engaged Patients Will Need Comparative Physician-Level Quality Data and Information About Their Out-of-Pocket Costs*, 32 HEALTH AFF. 328, 335 (2013) (noting that further research must be conducted to improve consumer engagement in health care quality and cost information).

61. To view the consumer five-star evaluation tool, see *Plan Quality and Performance Ratings*, MEDICARE.GOV, https://www.medicare.gov/find-a-plan/(S(1hp4zh45baqbl52pt1blig2m))/results/planresults/planratings/compare-plan-ratings.aspx?PlanType=MAPD&AspxAutoDetectCookieSupport=1 (last visited Jan. 14, 2017); *see, e.g.*, *Five-Star Quality Rating System*, CTRS. FOR MEDICAID & MEDICARE SERVS., https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/fsqrs.html (last visited Jan. 14, 2017) (explaining the Five-Star Quality Rating System as applied to nursing homes); *The Five-Star Rating System and Medicare Plan Enrollment*, MEDICARE INTERACTIVE, https://www.medicareinteractive.org/get-answers/overview-of-medicare-health-coverage-options/changing-medicare-health-coverage/the-five-star-rating-system-and-medicare-plan-enrollment (last visited Jan. 14, 2017) (explaining the five-star system in relation to Medicare Part-D plans).

their patient population is sicker and consequently more prone to poorer outcomes.

In sum, meaningful measures of value are lacking in the health care arena. Serious questions also arise regarding consumers' abilities to correctly interpret the available data so as to make reasonable choices impacting their access to quality care.

II. THERE IS NO AVAILABLE PROXY HAVING AN INTEREST UNIFIED WITH CONSUMERS TO EVALUATE QUALITY AND COST DATA

If we grant the notion that consumers may not be able to possess the knowledge necessary for a free market in health care to function, we might next look to see if there is an available agent, or proxy, able to fill this role on consumers' behalves. Logical agents include the government (in the case of Medicare and Medicaid beneficiaries), private insurers, or employers. And yet, the same tangle of relationships responsible for the regulatory burden and confusing incentives rife within health care come to the fore here.[62]

The government certainly has mixed incentives that may not give patient interest its deserved primacy. While there are many regulations focused on care quality, at their root, Medicare and Medicaid are insurance programs that have a goal of cost containment.[63] While higher

62. Examples of this include case-based reimbursement for hospitals and fee-for-service reimbursement for physician services. *See, e.g.*, Joel Swider, *A Dose of Reality: Unintended Consequences of Penalizing Hospital Readmissions in the PPACA*, 9 IND. HEALTH L. REV. 361, 366 (2012) (explaining that case-based reimbursement for hospitals causes perverse incentives that reward hospitals for shorter lengths of stays and results in hospitals discharging patients early); *see* Charles H. Newman & Jillian L. Romaniello, *Physician Compensation Models Post ACA: Has Anything Really Changed?*, N.J. LAW. 10, 11 (Apr. 2016) (noting that although the ACA promotes value-based reimbursement systems, the vast majority of physicians are reimbursed through fee-for-service models); Corbin Santo, *Walking a Tightrope: Regulating Medicare Fraud and Abuse and the Transition to Value-Based Payment*, 64 CASE WESTERN RES. L. REV. 1377, 1385 (2014) (noting that fee-for-service models have "dramatic implications" for cost-containment due to the prescription of unnecessary services by physicians); *see also* Donald M. Berwick & Andrew D. Hackbarth, *Eliminating Waste in US Health Care*, 307 JAMA 1513, 1514 (2012) (estimating that fee-for-service payments resulted in an excess of $158–226 billion in 2011 in services that were not beneficial or unnecessary to patients).

63. Medicaid is specifically affected by cost-containment strategies, because the states take a variety of perspectives on worthiness and value of expenditures for this population. *See* Vernon K. Smith, *A National Challenge: How States Try to Control Medicaid Costs and Why It Is So Hard*, *in* MEDICARE COST CONTAINMENT STRATEGIES IN NORTH CAROLINA AND OTHER STATES 14, 16 (Jenni Owen et al. eds., 2005), https://www.purdue.edu/hhs/hdfs/fii/wp-content/uploads/2015/07/s_ncfis01report.pdf (citing that state funding for Medicaid varies dramatically state by state, and the federal match rate can vary from 50–77 percent depending on the state); Maggie Mahar, *Why Your State Should Expand Medicaid*, HEALTHINSURANCE.ORG (July 29, 2012), https://www.healthinsurance.org/blog/2012/07/29/why-should-you-care-whether-

expenses, of course, do not necessarily equate with higher quality, neither are the two concepts divorced. Thus, the potential competing motivators of cost control and quality enhancement may cause these programs to not always align with patient interests.[64]

Private insurers have the exact same issue. The tension between cost and quality in insurer goals is readily apparent in numerous lawsuits over many years. These lawsuits challenged the propriety of payment incentives on physician behavior, where insurers were accused of corrupting physician judgment by compensation formulas incentivizing less, and lower-quality, medical care.[65] The ACA further highlighted this tension by limiting the "medical loss ratio"—the portion of the insurance premium spent on insurer administrative expenses—to 20 percent.[66] In addition, given the high degree of turnover within an insured population,

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or-not-your-state-decides-to-expand-medicaid-coverage/ (explaining that what states consider to be "worthy poor" can vary considerably depending on the state)*; see also* Howard L. Bailit & Cary Sennett, *Utilization Management as a Cost-Containment Strategy*, 1991 Supp. HEALTH CARE FINANCING REV. 87, 87 (Mar. 1992) (noting that utilization management strategies are the primary focus of private and publicly funded health care plans, including Medicare and Medicaid); Michael E. Porter, *Defining and Introducing Value in Health Care*, *in* EVIDENCE-BASED MEDICINE AND THE CHANGING NATURE OF HEALTHCARE: MEETING SUMMARY 161, 161–62 (Mark B. McClellan et al. eds., 2008), https://www.ncbi.nlm.nih.gov/books/NBK52822/pdf/Bookshelf_NBK52822.pdf (noting that the primary focus of health care actors involve cost containment, rather than patient value).

64. *See supra* note 62 and accompanying text (noting the varying incentives inherent in the health care industry).

65. Bush v. Dake, No. 86-25767-NM (Mich. Cir. Ct. Apr. 27, 1989) (determining that while financial incentives do not necessarily violate public policy there may be an issue of fact on whether they contributed to a physician's negligence); *but see* Pulvers v. Kaiser Found. Health Plan, 99 Cal. App. 3d 560, 564–65 (1979) (holding that the plaintiffs failed to state a cause of action with their allegations that incentive payment plans encouraged physicians to be conservative with prescribing unnecessary tests because the plaintiffs were not fraudulently led to believe they were receiving the "best quality" care). Gainsharing may also become an issue in these circumstances, where a physician, for example, receives a share of savings resulting from her changed practice protocol. *See Gainsharing*, BUS. DICTIONARY (2017), http://www.businessdictionary.com/definition/gainsharing.html (defining gainsharing); *see also* Nicole Martingano-Reinhart, *Gainsharing and the Patient Protection and Affordable Care Act*, 43 SETON HALL L. REV. 1325, 1325 (2013).

66. 42 U.S.C. § 18051(b) (2010); *see* SUZANNE KIRCHHOFF, MEDICAL LOSS RATIO REQUIREMENTS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA): ISSUES FOR CONGRESS 5 (2014), https://fas.org/sgp/crs/misc/R42735.pdf (providing the medical loss ratio ("MLR") calculation). Indeed, the mere fact that industry parlance termed the percentage of the premium dollar spent on medical care as a medical loss ratio aptly summarizes the tension between cost and quality as approached by insurers. *See* Scott Harrington, *Medical Loss Ratio Regulation Under the Affordable Care Act*, 50 INQUIRY 9, 10–11 (2013) ("More attention should be paid to the underlying tension between the MLR regulations and forward looking efforts to transform the health care system, including careful consideration of alternatives or modifications to the minimum MLR approach.").

insurance companies take a decidedly short-term perspective on patient outcomes, often in conflict with a patient's long-term perspective on their health.[67] And, of course, insurance companies function by carefully defining, and thereby limiting, the financial risk they assume, so transferring risk to consumers by definition benefits the insurer.

Finally, for many of the reasons articulated above regarding the government and insurers, employers too seem conflicted in their allegiance to access and health care quality.[68]

Thus, the industry lacks a proxy with a unified interest with consumers. There is no unbiased, credible party able to make value judgments on behalf of patients-consumers.

III. RELYING ON THE MARKET TO ALLOCATE HEALTH CARE IS WRONG

As the industry continues to move toward a defined contribution era where each patient-consumer is expected to conduct one's own research, balance cost and quality, and shop around, one must remember that not all consumers are equipped to manage these new responsibilities. The ability to access this type of information, process, and make an intelligent decision requires a level of sophistication that many people simply do not possess.[69] Further, unique aspects of an individual's medical condition may render it difficult for patients to properly evaluate competing criteria in a manner that facilitates free market choice.[70]

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67. *See* INST. OF MED., CONFLICT OF INTEREST IN MEDICAL RESEARCH, EDUCATION, AND PRACTICE 169 (Bernard Lo & Marilyn J. Field eds., 2009), https://www.ncbi.nlm.nih.gov/books/NBK22942/pdf/Bookshelf_NBK22942.pdf ("In general, payment methods have become more complex as public and private health insurers have offered incentive payments to physicians related to quality standards, patient satisfaction, and better patient outcomes."); Robert Coleman, *The Independent Medicare Advisory Committee: Death Panel or Smart Governing?*, 30 J. NAT'L ASS'N ADMIN. L. JUDICIARY 235, 289 (2010) ("[W]hile the actual number of uninsured Americans is somewhat constant from year to year, the actual individuals who are uninsured are rapidly shifting."); J.S. Hochman, *Insurance and Healthcare: An Irresolvable Conflict of Interest*, TEXANS FOR PATIENTS' & PHYSICIANS' RTS. (Dec. 11, 2007), http://www.txppr.org/newsletter.cfm?NewsletterID=58&CategoryID=0 (explaining that the primary focus of health care is caring for people while the primary focus of insurance is to make money).

68. *See Stakeholder Perspectives on Value*, *in* VALUE IN HEALTH CARE: ACCOUNTING FOR COST, QUALITY, SAFETY, OUTCOMES, AND INNOVATION 29, 35 (Pierre L. Young et al. eds., 2010), https://www.ncbi.nlm.nih.gov/books/NBK50929/pdf/Bookshelf_NBK50929.pdf (noting that employers may be focused more on saving money than ensuring services are provided to employees); Robert Mecklenburg, *A Better Way for Employers to Procure Health Care*, HARV. BUS. REV. (Nov. 17, 2016), https://hbr.org/2016/11/a-better-way-for-employers-to-procure-health-care (pointing out the general weaknesses in employers' approaches to health care).

69. *See supra* note 32 and accompanying text (noting how consumers lack the ability to make educated decisions in the health care industry).

70. *See* Peter A Ubel et al., *Full Disclosure—Out-of-Pocket Costs as Side Effects*, 369 NEW

Because of the highly personalized nature of health care services, the influence of procompetitive forces may actually cause harm to a patient. A patient may gravitate toward an option based on inappropriately weighing the cost of the service, without sufficiently considering the likely outcomes from a quality of life perspective.[71]

Finally, even if one wants to assume that an educated consumer can make informed choices in a competitive market, the attendant costs associated with this assumption may be hard to swallow. Externalities abound in health care, as one's health status can have a significant impact on others. Individuals unable to pay for their care may be able to hold off on certain types of medical care for some time, but this often leads to very serious, more expensive consequences.[72] From both an ethical and legal perspective, the industry is not going to deny care to individuals presenting in an emergent situation, even if there is no payor and the cost is high.[73]

In the end, however, the nation does not want individuals inflicting the social cost of their care—public health issues, accidents, and the like—on society merely because they were unable to make informed health care choices.[74] Even if we adopt a view of "buyer beware"—leading to high incidences of medical debt—this, too, has significant costs on society. In the end, delayed care is likely to be provided, but at a cost to society higher than might have been borne if it had been provided when first

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ENG. J. MED. 1484, 1484 (2013) (discussing the lack of physician disclosure to patients before prescribing treatment); *see generally* LAURIE KAYE ABRAHAM, MAMA MIGHT BE BETTER OFF DEAD: THE FAILURE OF HEALTH CARE IN URBAN AMERICA (1994) (discussing the complexity and difficulties associated with the American health system).

71. *See supra* notes 31–32 and accompanying text (recognizing the complexity inherent in health care information and noting how most consumers likely lack the sophistication to decipher it).

72. *See* ABRAHAM, *supra* note 70, at 60–77 (discussing how inconsistent primary care can lead to greater and potential life-threatening costs); Roger Blair & Christine Piette Durrance, *Licensing Health Care Professionals, State Action and Antitrust Policy*, 100 IOWA L. REV. 1943, 1951–52 (2015) ("If the prices of preventive health services increase, some patients will be priced out of the market, which may delay medical care. This may make the consumer worse off if they delay necessary medical care, which could worsen health care outcomes and lead to more expensive health care expenditures later."); Rosenbaum, *supra* note 35 (discussing consumers' delay tactics in pursuing medical care).

73. *See supra* note 22 and accompanying text (discussing legally required health services, such as those required through EMTALA).

74. *See* Terry Barnes, *Paying the Price for Affordable Health Risks*, ABC NEWS (Mar. 17, 2014, 5:08 PM), http://www.abc.net.au/news/2014-03-18/barnes-taking-responsibility-for-our-health-choices/5326254 (arguing that individuals who make uninformed health and injury decisions should be partially responsible for the cost of their care); *see generally* Leonard Fleck, *Just Caring: Do the Indolent, the Inebriated, and the Irresponsible Deserve Equal Access to Needed Health Care?*, 11 IND. L. REV. 553 (2014) (debating whether society should inflict the cost of care onto individuals who have made uneducated decisions regarding their health care).

needed. It is simply unimaginable that there will be an ethos amongst our caregivers, health care institutions, and the public that will accept otherwise.

There certainly is a place in health care for a consumer focus on cost and quality. An educated consumer is a good thing. We need to be mindful, however, that we do not attribute to the market a sophistication that it lacks when it comes to allocating as essential a service as health care.