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THE PATIENT LIFE: CAN CONSUMERS DIRECT HEALTH CARE?

CARL E. SCHNEIDER[†] & MARK A. HALL^{††}

*Then said Evangelist, "If this be thy condition, why standest thou still?"
He answered, "Because I know not whither to go."*

John Bunyan
The Pilgrim's Progress

ABSTRACT

The ultimate aim of health care policy is good care at good prices. Managed care failed to achieve this goal through influencing providers, so health policy has turned to the only market-based option left: treating patients like consumers. Health insurance and tax policy now pressure patients to spend their own money when they select health plans, providers, and treatments. Expecting patients to choose what they need at the price they want, consumerists believe that market competition will constrain costs while optimizing quality. This classic form of consumerism is today's health policy watchword.

This article evaluates consumerism and the regulatory mechanism of which it is essentially an example – legally mandated disclosure of information. We do so by assessing the crucial assumptions about human nature on which consumerism and mandated disclosure depend. Consumerism operates in a variety of contexts in a variety of ways with a variety of aims. To assess so protean a thing, we ask what a patient's life would really be like in a consumerist world. The literature abounds in

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For the reasons given in Richard A. Posner, *Goodbye to the Bluebook*, 53 U Chicago L Rev 1343 (1986), we renounce the iniquitous *Bluebook* and all its works. Instead we follow the University of Chicago *Manual of Legal Citation*.

theories about how medical consumers should behave. We look for empirical evidence about how real people actually buy health plans, choose providers, and select treatments.

We conclude that consumerism, and thus mandated disclosure generally, are unlikely to accomplish the goals imagined for them. Consumerism's prerequisites are too many and too demanding. First, consumers must have choices that include the coverage, care-takers, and care they want. Second, reliable information about those choices must be available. Third, information must be put before consumers, especially by doctors. Fourth, consumers must receive the information. Fifth, the information must be complete and comprehensible enough for consumers to use it. Sixth, consumers must understand what they are told. Seventh, consumers must be willing to analyze the information. Eighth, consumers must actually analyze the information and do so well enough to make good choices.

Our review of the empirical evidence concludes that these prerequisites cannot be met reliably most of the time. At every stage people encounter daunting hurdles. Like so many other dreams of controlling costs and giving patients control, consumerism is doomed to disappoint. This does not mean that consumerist tools should never be used. It means they should not be used unadvisedly or lightly, but discreetly, advisedly, soberly, and in the fear of error.

I. INTRODUCTION: THE CLATTERING TRAIN

*Who is in charge of the clattering train?
The axles creak and the couplings strain,
And the pace is hot and the points are near,
And sleep hath deadened the driver's ear,
And the signals flash through the night in vain,
For Death is in charge of the clattering train.*

Anonymous

The United States spends too much for the health care it receives. Yearly, the problem worsens.¹ More of the GDP (16%) goes to health care than in any comparable country without buying appreciably superior health. Medical goods and services cost more than in similar countries.² Their prices rise faster than inflation. And perhaps "more than 25 percent of all health care spending is either entirely unnecessary or is of only questionable or marginal benefit."³ Who is in charge of this clattering train?

Everyone wants the train subdued. Governments worry because they pay for so many people's care. Employers worry because the more they pay for insurance the less they can pay in wages. Employees worry because they defray ever larger shares of medical costs. We all should worry because while

¹ Clark C. Havighurst and Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 L & Contemp Prob 7, 11 (2006).

² *Id.* at 13.

³ Mark A. Hall, *Making Medical Spending Decisions: The Law, Ethics & Economics of Rationing Mechanisms* 21 (Oxford, 1997).

insurance appears to insulate us, ultimately we pay – as taxpayers, as employees, as consumers – for what we receive. And even while we worry about costs, we worry also about quality. Controlling the train means reducing costs while improving quality.

A. CONTROLLING COSTS AND QUALITY

Lawmakers, employers, health plans, and hospitals have long tried to stop the clattering train. But costs rise irrepressibly because irrepressible forces push them. Technology, for example, can be marvelous, but it can also be costly.⁴ And specialization combines with technology to require expensively bureaucratized medicine.

The financial structure of medical care also accelerates costs. Doctors and hospitals commonly charge fees for services. The more services, the more fees; the higher the fees, the higher the income. Doctors decide what patients need. Doctors are professionals, and “commercial” practices are undignified and displease professional associations, so historically, “[p]rice competition was disavowed as unbecoming a learned profession and as inappropriate for a vital service.”⁵ Thus “medical professionalism created a spiral of expanding capacity, technology, utilization, and cost. Fee-for-service payment to physicians and cost-based reimbursement to hospitals rewarded extensive and complex care. Physicians recommended more visits, more tests, and more procedures.”⁶ So even early in the twentieth century, costs climbed.⁷

The clattering train was once slowed by want of fuel. When shallow-pocketed individuals paid, costs could only go so high. Then came the deep pockets. Employers (stimulated by tax incentives) insured employees. Government (stimulated by social duty) insured the old and the poor. Insurers paid “usual and customary” rates – essentially, what doctors and hospitals charged. Thus fueled, the train sped up. Robinson puts it neatly:

⁴ Economists generally agree that the “principal factor by far [in rising costs] is medical innovations like new drugs, new surgical procedures and new diagnostic techniques.” Gina Kolata, *A Conversation with Victor Fuchs: An Economist’s View of Health Care Reform*, New York Times F6 (May 2, 2000).

⁵ James C. Robinson, *The Corporate Practice of Medicine: Competition and Innovation in Health Care* 21 (Berkeley, 1999).

⁶ Id at 23.

⁷ Committee on Costs of Medicare, *Medical Care for the American People* (Chicago, 1932).

Physicians and hospitals were motivated to provide ever more and better services, since higher costs generated higher revenues. Patients were motivated to demand more and better services since the costs were shifted onto insurers and thence to employers and taxpayers. Employers were motivated to expand the breadth and generosity of insured benefits to capture the tax subsidy. Medicare and Medicaid viewed their covered services as a statutory entitlement for beneficiaries . . . and were eager to accommodate physician interests so as to mitigate the traditional hostility of organized medicine. Everyone was saying yes and no one was saying no to the expansion of utilization, specialization, and expenditure.⁸

So the train rattled along briskly. But perhaps costs were justified by the quality of care? Alas, doctors were presumptively the only qualified judges, and the “profession systematically refused to discuss or divulge quality concerns to nonphysicians.”⁹ However, unsettling hints abound. For example, hospitalization and surgery rates have “varied widely across geographic regions, with the best predictor being the number of hospital beds and practicing physicians; the prevalence of disease was not consistently associated with the frequency and intensity of care.”¹⁰ And “[r]esearch studies, authoritative entities such as the Institute of Medicine (IOM), and the insurers’ own claims data reveal widespread overuse, underuse, and misuse of services, compared with evidence-based norms and clinical guidelines.”¹¹

Employers and governments particularly have labored to slow the train. Their best success has been managed care. It wants for patients what consumers shop for – low prices *and* high quality. It assumes that providers drive the clattering train and that they can be persuaded to slow, steer, and stop it. Managed care stems costs by limiting patients’ choice of providers and treatments and by inducing providers to economize. Inducements have included “oversight and report-card keeping on physicians’ prescribing practices, rules about the use of primary care physicians as gatekeepers or their elimination altogether . . . evidence-based medicine . . . and requirements that doctors gain permission for expensive procedures.”¹²

Managed care has had successes in controlling costs, but it has been savaged by patients who felt they were losing control of their medical care and by doctors who felt they were losing control of their work.¹³ So while managed care’s success has been limited, managed care may not have failed; it was from its mother’s womb untimely ripped.

⁸ Robinson, *The Corporate Practice of Medicine: Competition and Innovation in Health Care* at 23 (cited in note 5).

⁹ *Id.* at 28.

¹⁰ *Id.* at 24.

¹¹ James C. Robinson and Jill M. Yegian, *Medical Management After Managed Care*, Health Affairs W4-269, W4-269-W4-270 (2004 – Web Exclusive), online at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.269v1.pdf> (visited Feb 9, 2009).

¹² Daniel Callahan and Angela A. Wasunna, *Medicine and the Market: Equity v. Choice* 49 - 50 (Johns Hopkins, 2006).

¹³ Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J Health Politics, Policy & L 427 (2005).

Managed care seeks good care at good prices by influencing providers. Many of its practices survive in some form, but the top-down, supply-side principle has been pummeled. That left a bottom-up, demand-side principle: Why not treat patients like consumers? Won't they select the care they need at the price they want? Won't the market spur competition that expands consumers' choices while constraining costs? This "consumerism" is today's watchword.¹⁴ As two writers said fifteen years ago, "[I]f we want to solve the nation's health care crisis, we must apply the same commonsense principles to medical care that we apply to other goods and services."¹⁵ As the former HHS Secretary said last year, "We have a better option, to provide beneficiaries with reliable information about the cost and quality of their care. When given that kind of information, we know that consumers will make decisions that drive costs down and the quality up."¹⁶

B. CRESCENDOING CONSUMERISM

Consumers search for goods and services of high quality at low prices. Crucial among services is medical care, but few people shop for it like consumers, if only because of insurance.¹⁷ This is pleasant, but the dismal science warns us that when consumers want the best and ignore price, costs soar like the lark ascending. And when providers bill for each service, prices soar, well, like the hawk ascending.

Of course, patients have been buying medical services for years. Managed care actually accelerated the movement toward consumerism and competition, if only by hastening the organization of doctors and hospitals into groups that competed for patients. Thus Professor Sage could write years ago, "The last two decades have witnessed an extraordinary shift toward reliance on competitive forces to reshape the American health care system, which previously had been characterized by professional decisionmaking, consumer deference, and price-insensitive insurance payment."¹⁸

¹⁴ "It is clear that a consumer-driven revolution has begun, and there is reason to believe that it will shape the future direction of the health care system." Jill Quadagno, *Who Wins? Who Loses? Who Pays?*, 27 *Health Affairs* 294, 295 (2008). For especially intelligent treatments of consumerism, see Clark Havighurst's *oeuvre*. For his witty introduction to his own work, see Clark C. Havighurst, *I've Seen Enough! My Life and Times in Health Care Law and Policy*, 14 *Health Matrix* 107 (2004). An excellent and recent survey is Timothy Stoltzfus Jost, *Health Care at Risk: A Critique of the Consumer-Driven Movement* (Duke, 2007). Several book reviews provide an efficient (and sufficient?) introduction to consumerist writing. See Clark C. Havighurst, *Healthy Competition: What's Holding Back Health Care and How To Free It*, 25 *Health Affairs* 1740 (2006); Alan Maynard, *Who Killed Health Care? America's \$2 Trillion Medical Problem - and the Consumer-Driven Cure*, 26 *Health Affairs* 1783 (2007); Uwe E. Reinhardt, *Health Care Reform Now!: A Prescription for Change*, 27 *Health Affairs* 291 (2008).

¹⁵ John C. Goodman and Gerald L. Musgrave, *Patient Power: The Free-Enterprise Alternative to Clinton's Health Plan* vii (Cato Institute, 1994).

¹⁶ Robert Pear, *Bush Proposes Linking the Medicare Drug Premium to Beneficiaries' Income*, *NY Times* (Feb 16, 2008) (quoting Michael Levitt), online at <http://www.nytimes.com/2008/02/16/washington/16health.html>.

¹⁷ Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 *Geo L J* 583 (2008).

¹⁸ William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 *Colum L Rev* 1701 (1999). "The fundamental idea underlying the theory of managed care was to achieve social equity through the distribution of vouchers . . . that could

In any case, patients now make more purchasing decisions, and more consumerist proposals are aborning. These proposals vary,¹⁹ but they use similar methods, make similar assumptions, and raise similar questions. We therefore evaluate consumerism through an ideal type. In this ideal type, consumers make three principal purchases. First, they choose their health care plan. Like good consumers, they decide which plan best suits their wants and purses. As consumers buy plans, competition for their custom generates splendid plans at sensible prices.

Second, consumerism expects patients to choose doctors, hospitals, and other providers considering both quality and cost. Consumerist patients ask: Which providers offer inexpensive services? Which providers work with patients to control expenditures? Which providers treat patients decently? Which providers are competent – or truly excellent? Here, again, consumers already make some such choices – they may choose doctors, for instance.²⁰

Third, consumerist patients buy tests and treatments.²¹ In its strong form, consumerism has people spend their “own” money, not “insurance” money, to buy treatments, and hence patients choose thriftily. Few people can afford all the treatment they might need, so consumerism assumes insurance would pay “catastrophic” costs (that is, consumers get insurance with high deductibles).

Most people can't afford high deductibles either; they teeter too close to the economic brink to find thousands of dollars in their pockets.²² So the tax code now lets employers create tax-sheltered “health-savings accounts” in which unspent funds accumulate from year to year. To qualify for the tax shelter, deductibles must range (currently) from \$1,150 for individuals to \$11,600 for families.²³ Typically, employers put much of the deductible into the employees' account. Nevertheless, consumers spend their own money in several senses. First, they contribute to the account. Second, the employer's contribution is effectively part of the employee's salary. Third, consumers can use unspent money that accumulates (tax-free) for most health care expenses and can distribute it in their estates.

be used only for the purchase of health insurance offered by a variety of private, competing health insurance plans.” Uwe E. Reinhardt, *Can Efficiency in Health Care Be Left to the Market?*, 26 *J Health Politics, Policy & L* 967, 985 (2001).

¹⁹ Perhaps the most popular of the labels, “consumer-directed health care,” is “so widely used that many different concepts masquerade under its banner” Len M. Nichols, et al, *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence Is Waning*, 23 *Health Affairs* 8, 16 (2004).

²⁰ For evidence that people shop for doctors more than one might suppose, see Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (Oxford, 1998).

²¹ To avoid grating repetition of “test or treatment,” we normally use “treatment” to include “test.”

²² See Mark A. Hall and Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 *Mich L Rev* 643 (2008).

²³ US Dept Treasury, Treasury, IRS Issue 2009 Indexed Amounts for Health Savings Accounts, online at <http://www.treas.gov/press/releases/hp975.htm> (visited Mar 21, 2009). Seventy percent of the people with family coverage in a consumerist plan had “a family deductible of \$2,000 to \$4,999; 29 percent reported a deductible of at least \$5,000.” Paul Fronstin and Sara R. Collins, Findings from the 2007 EBRI/Commonwealth Fund Consumerism in Health Survey, 315 *EBRI Issue Brief* 1, 9 (2008), online at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=673661 (visited Feb 9, 2009).

Parts of the consumerist agenda are already operating. Many insurers have adopted consumerist devices. “Deductibles are increasing, copayments for physician office visits and prescription drugs are increasing, and health plans are increasingly more likely to provide incentives for beneficiaries to use generic drugs and/or mail order pharmacy services, and other forms of tiered benefits”²⁴ Already, “40% of primary care physicians are providing care to CDHP enrollees,” and this “may be an underestimate because it does not account for those physicians who are unaware of their patients’ CDHP coverage.”²⁵ In addition, “[t]his policy approach has been strongly adopted in the Medicare program, where older adults typically face choices among 50 or more prescription drug plans as well managed care options.”²⁶

So surely consumerism’s time is come. Not only are its three parts old hat; both sides of the ideological spectrum can like it. The right can like using markets to tame prices and ensure quality. Consumerism simultaneously fits neatly with the standard principle of the leftish “bioethics” side of health law: Offering patients control over their medical care is the *fons et origo*, the alpha and omega of bioethical law.²⁷ That law works mainly through mandated disclosure – by requiring patients be given good enough information to make their own decisions.²⁸ The paramount example is informed consent, but it is only one of many programs that – like consumerism – aspire to “empower” patients by giving them information and thus the power to choose what they want.²⁹

C. CONSIDERING CONSUMERISM

This article undertakes three enterprises. First, consumerism is the latest of many battered attempts to control costs while optimizing care. Will it work? Will it quiet the clattering train? Our second enterprise is evaluating the regulatory mechanism of which consumerism is an example – legally mandated disclosure of information so that one party to a transaction can make good decisions. Our third enterprise is assessing the crucial assumptions about human nature on which consumerism and mandated disclosure depend.

The consumerist agenda provokes *déjà vu* all over again. Many plans have been laid to tame costs, improve quality, and expand control. Taming costs fails with doleful regularity. Improving quality is horribly hard. And the

²⁴ Id at 4.

²⁵ Giridhar Mallya, et al, *Are Primary Care Physicians Ready to Practice in a Consumer-Driven Environment?*, 14 Am J Managed Care 661, 665 (2008).

²⁶ Jessica Greene, et al, *Comprehension and Choice of a Consumer-Directed Health Plan: An Experimental Study*, 14 Am J Managed Care 369, 374 (2008).

²⁷ Marsha Garrison and Carl E. Schneider, *The Law of Bioethics: Individual Autonomy and Social Regulation* 27-467 (West, 2003).

²⁸ William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 Columbia L Rev 1701 (1999).

²⁹ For example, the Patient Self-Determination Act seeks to encourage patients to use advance directives to make “pre-need” decisions lest incompetence should prevent them from exercising their authority. 42 USC § 1395cc(a) (2008). The PSDA requires that patients be given information about advance directives. HIPAA regulations seek to permit patients to protect the confidentiality of medical information about them. 45 CFR Parts 160, 162, 164 (2009). The regulations require doctors and hospitals to give patients the information they need to manage the handling of confidential information.

principal legal attempts to give patients more control routinely disappoint.³⁰ When plausible policies repeatedly fail to achieve excellent goals despite exceptional efforts, there are usually high, and sometimes insuperable, barriers to reaching the goals. Is it thus with consumerism?

Consumerism operates in a variety of contexts in a variety of ways with a variety of aims; its success thus depends on a variety of things and must be variously measured. All this variety is inevitable, if only because consumerism cannot simply be ordained. Rather, the federal government has used tax policy, its influence as an insurer, and its power as an employer to promote consumerism and all that may still be too little. Nor have commentators agreed on what consumerism is and how it should work. So “consumerism” in health care is various both in action and in books, and it has been defended and attacked in various ways.

To assess this Proteus,³¹ we scrutinize consumerism’s distinctive and crucial feature: purchasers choosing well. We use a fresh technique – we systematically ask what prerequisites must be met for consumerism to succeed and whether they will be met. Our answers rest on empirical evidence about how people buy health plans, choose providers, and select treatments. When there is no such evidence, we consult empirical research on comparable decisions.

More specifically, we ask what a consumer’s life would really be like in a consumerist world. What would the human experience of consumerism actually be? Would people behave as required? The literature abounds in theories about how these medical consumers *should* behave. We look for evidence.

This brings us to our article’s second enterprise. One of the law’s favorite devices is to require a more knowledgeable (and thus presumptively stronger) party to provide information to a less knowledgeable (and thus weaker) party.³² Securities laws are an ambitious example. Courts and commentators debate what disclosures should be required in boilerplate contracts. Product liability law invites manufacturers to disclose dangers their goods pose. Credit card companies must reveal their terms to card users. Truth-in-lending acts are supposed to make borrowers good judges of lending terms. *Miranda* warnings give suspects information to use in dealing with police. And there are hundreds of other examples.

Mandated disclosure and consumerism operate similarly. Their success depends on how well information can be assembled, disclosed, received, understood, analyzed, and used. This is why research on mandated disclosure

³⁰ For examples, see Carl E. Schneider, *After Autonomy*, 41 Wake Forest L Rev 411 (2006).

³¹ A complete evaluation would be broad. At the least, it would ask economic questions like: Isn’t much of our health care dollar spent on a small group of people whose care is so expensive that deductibles are irrelevant? Are health care costs driven by forces – like technology and the institutions of health care – that consumers can little affect? For an excellent survey of the issues, see Jost, *Health Care at Risk* (cited in note 14).

³² As we write, CNN tells us to “take heart, there may be more legislation . . . on the way. Last month New Jersey became the first state to enact a law that requires [match-making websites] to disclose whether they do background checks on members.” Jen Haley, *Be a Savvy Consumer When Looking for Love Online*, CNN.com, online at <http://www.cnn.com/2008/LIVING/personal/02/14/roym.online.dating/index.html> (visited Feb 10, 2009).

helps us understand consumerism, and why our technique for studying consumerism helps us evaluate mandated disclosure as a regulatory method.

So to our third enterprise. We conclude that consumerism, and thus mandated disclosure generally, are unlikely to accomplish the goals imagined for them. Consumerism's prerequisites are too many and too exigent. Consumers make many purchases with aplomb. Most things consumers acquire they buy regularly and judge easily. Those products are sold in national markets in which competition works its Smithian magic. But health plans, providers, and treatments are chosen sporadically, are hard to assess even after the purchase, and are often sold in small and stodgy markets. So health care choices are harshly more demanding than most other purchases, as Kenneth Arrow famously said long ago.³³

Consumerism and mandated disclosure, then, rest on suppositions about how people respond to incentives to buy unfamiliar products wisely. They rest, that is, on assumptions about human nature. Those assumptions are generally unexamined and generally misleading. They fundamentally misunderstand human nature. First, they misunderstand how people make decisions and over-estimate their willingness and ability to do so. Second, they misunderstand how people want to lead their lives; they forget that people have better things to do than becoming model consumers.

Our review of how people in a consumerist world would choose health plans, providers, and treatments, then, concludes that at every stage people would encounter daunting hurdles. Like so many dreams of controlling costs and giving patients control, consumerism is doomed to disappoint. This does not mean that consumerist tools should never be used. It means they should not be used unadvisedly or lightly, but discreetly, advisedly, soberly, and in the fear of error.

II. THE AVAILABILITY OF GOOD CHOICES

*Between the idea
And the reality
Between the motion
And the act
Falls the Shadow*

T. S. Eliot
The Hollow Men

We now begin our project of evaluating consumerism by systematically reviewing its prerequisites. The first prerequisite is that consumers need alternatives adequate to the variety of purchasers and circumstances for each purchase: plans, providers, and treatments. Will this happen? Sometimes somewhat, but often little.

³³ Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 *Am Economic Rev* 941 (1963).

A. THRIFTY HEALTH PLANS

Some prominent consumerists – Havighurst is a distinguished example – propose that costs may be moderated and patients may better match their expenditures to their preferences if they can purchase health insurance the way they purchase other services. The consumerist agenda will thus wither if consumers lack adequate choices. Yet many consumers have no such options and faint prospect of getting them.

Many people “have no real or perceived choice in their employment, health insurance, or health plan.”³⁴ Even larger employers in larger cities may offer employees only a few choices, and few employers offer many. For example, “in 1999 approximately half of individuals covered by employer-sponsored plans had no choice or limited choice of health plans.”³⁵ And “Robert Berenson . . . contends that ‘only a few large and prominent employers are redesigning employer contribution formulas to encourage value purchasing, contracting directly with provider-based delivery systems, or using quality data . . . in any meaningful way to select plans.’” Medium-sized employers “do not even seem to understand the difference between the price of particular provider services and their aggregate cost . . . , much less to be able to separate fact from fiction on quality measures.”³⁶

Even consumers offered several plans may have scanty choices. This insurance comes in *prix fixe* packages; you can’t choose *à la carte*. But you will rarely be offered the meal you want. Buying insurance is not (to change the metaphor) like buying a car, where you can take a showroom model or design your own farrago of options. Insurers cannot afford to let people buy only coverage they know they will need. Nor must competition inspire variety; on the contrary, competitors may converge around packages likeliest to attract buyers.

Employers might even dislike long *à la carte* menus. Employers don’t want under-insured and hence under-treated, bankrupt, and bitter employees. The more options consumers have, the likelier they are to choose improvidently, and pressure to economize drives employees toward under-insurance. Under-insurance matters, especially since the distance between lavish and stingy is wide. Under-insurance can wreck financial and physical health. Costs of illness (particularly medical bills and loss of income) contribute to more than half of personal bankruptcies.³⁷ And even shaving back coverage can hurt. One longitudinal study, for example, “demonstrate[d] significantly worse health outcomes among individuals who reported restricting their use of prescription medications because of cost. . . . [C]ost-related medication restriction was associated with almost twice the

³⁴ Amy B. Bernstein and Anne K. Gauthier, *Choices in Health Care: What Are They and What Are They Worth?*, 56 Med Care Res & Rev 5, 11 (1999).

³⁵ Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 SLU L Rev 365, 375 (2003).

³⁶ Lawrence D. Brown, *Management by Objection?: Public Policies to Protect Choice in Health Plans*, 56 Med Care Res & Rev 145, 157 (1999).

³⁷ See generally Melissa B. Jacoby, *The Debtor-Patient Revisited*, 51 SLU L Rev 307 (2007); Melissa B. Jacoby and Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 Nw U L Rev 535, 538-539 (2006); R.W. Seifert and M. Rukavina, *Bankruptcy Is the Tip of a Medical-Debt Iceberg*, 25 Health Affairs w89 (2006 – Web Exclusive).

odds of experiencing a significant decline in overall health over 2 years of follow up.³⁸

In short, health plans do not now meet consumerism's first prerequisite – adequate choice. Nor can they without restructuring health care financing in large, unlikely, and possibly unwise ways.

B. THRIFTY TREATMENT CHOICES

Consumerism promises to fix the clattering train by pressuring patients to “take a more active interest than they hitherto have had in the cost-effectiveness of their care.”³⁹ Patients spending their own money should buy treatments cheaply and eschew wasteful care. But will patients have scope to economize on treatments? Not if no savings are practically possible or if reforms have already eliminated excess expenditures. Nor need patients economize if they will exceed the year's deductible. So, how much opportunity and incentive to save will patients have?

This question has two parts. First, are there substantial unexploited opportunities for economies? After all, “health care plans today already contain both substantial cost sharing and managed care measures that are likely to reduce spending.”⁴⁰ Second, will consumerism induce patients to exploit any such opportunities?

Consumerism's easiest case is where equally effective treatments differ in cost. The classic example is generic drugs. Since by hypothesis the drugs are identical, the cheap treatment is so plainly preferable that doctors hardly need offer patients a choice. In these areas it's not clear how much room for improvement is left and whether referring decisions to patients helps. After all, managed care has campaigned for years to get doctors to substitute generics for brand-name drugs, and health plans increasingly use formularies to get doctors to prefer cheap to expensive drugs.⁴¹ These efforts and a changing medical culture have helped. For example, as early as ten years ago “[o]nly 8% of physicians preferred brand-name medications over generic drugs regardless of cost.”⁴² Similarly, patients who use emergency rooms or specialists for routine problems notoriously waste resources, but health plans have already attacked this problem by increasing copayments for ERs and by requiring referrals to specialists.

Another easy case for consumerism is where patients decide whether a genuinely elective treatment is worth paying for. This category's borders are hazy, but some decisions, like cosmetic surgery, fit it neatly enough. But how

³⁸ Michele Heisler, et al, *The Health Effects of Restricting Prescription Medication Use Because of Cost*, 42 *Med Care* 626, 630 (2004).

³⁹ Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 *Health Affairs* 57, 65 (2006).

⁴⁰ Dahlia K. Remler and Sherry A. Glied, *How Much More Cost Sharing Will Health Savings Accounts Bring?*, 25 *Health Affairs* 1070, 1073 (2006).

⁴¹ On formularies, their promise and problems, see Peter J. Neumann, et al, *Do Drug Formulary Policies Reflect Evidence of Value?*, 12 *Am J Managed Care* 30 (2006).

⁴² Steven Reichert, et al, *Physicians' Attitudes About Prescribing and Knowledge of the Costs of Common Medications*, 160 *Arch Intern Med* 2799, 2800 (2000). For the contrasting view three decades ago, see Peter Temin, *Taking Your Medicine: Drug Regulation in the United States* 103, 105 (Harvard, 1980).

much can consumerism save here, since patients already pay for most such treatments?

Consumerists' remaining core case is an optimal treatment and a cheaper sub-optimal treatment. At one extreme, the efficacy gap is so small and the cost gap so great that consumer choice is hardly needed to reach the economical result. At the other extreme, the efficacy gap is so great and the ailment so severe that the cheaper treatment seems hardly better than no treatment. Are there enough cases between these extremes to permit substantial savings?

Two cases may exemplify this category. The patient has an upper respiratory tract infection and acute sinusitis. A cheaper antibiotic works 70% of the time, a costlier one 80% and about a day faster. The consumerist patient weighs "the increased cost and potential side effects against the possibly quicker return to health." A "day of lost work may be more costly to her, in money or in other ways, than the additional cost of the more expensive antibiotic."⁴³ Another example: In *Pegram*,⁴⁴ the plan delayed a test that could have revealed the patient's appendicitis. Delay was probably cost-effective for the patient population, but an individual patient might want to pay extra for peace of mind or to avoid coping with a burst appendix.⁴⁵

Tests are a common example in this category. They can be expensive (e.g., MRIs), and any test *might* be unnecessary (if the diagnosis is clear, tests are pointless). Furthermore, while tests are expensive, their costs usually fall within a high deductible, so that the patient might bear the cost. For example, some causes of back pain can be detected through an MRI, but those are unusual and not urgent problems. So it makes economic sense to treat the likelier causes and use an MRI only if that fails. But an anxious patient might think the test worth the cost.

In yet another consumerist category, patients need a treatment but can't afford it. This is a category many doctors know well and the category likeliest to expand with thorough-going consumerism. Preventing needed care is presumably not consumerism's goal. Who wants more arbitrary, inequitable, and inefficient rationing? Faced with such cases, doctors often become social workers, scrambling to help patients jury-rig treatments. This helps patients, but it misuses doctors' skills.

In sum, for consumerism to subdue costs, patients will need chances to economize. We have now asked how much choice will be available and how much scope for savings patients will have. The short answer is some of each, but not a lot of either.

⁴³ Paul Clay Sorum, *Ethical Decision Making in Managed Care*, 156 *Arch Intern Med* 2041 (1996).

⁴⁴ *Pegram v. Herdrich*, 530 US 211 (2000).

⁴⁵ A plan without burst appendices is performing unnecessary appendectomies, which have their own risks.

III. THE AVAILABILITY OF INFORMATION

As to Holmes, I observed that he sat frequently for half an hour on end, with knitted brows and an abstracted air, but he swept the matter away with a wave of his hand when I mentioned it. "Data! data! data!" he cried impatiently. "I can't make bricks without clay."

Arthur Conan Doyle
The Adventure of the Copper Beeches

Now suppose away the problems we've discussed. Consumers have enough choices of plans, providers, and treatments to suit their wants and their wallets. They next need information. They need to know what's on offer, its quality, and its cost. Does this information exist? Will it be forthcoming? From reliable sources? In brief: sometimes possibly, but not easily often.

A. DOES THE INFORMATION EXIST?

Nobody can be told what nobody knows. Much information consumers need for choosing plans or providers cannot practically be compiled, would not willingly be compiled, or has not been worth compiling. Consumers get *much* less information than they need. Reinhardt is blunt: "Only rarely, in a few locations, do American patients have access to even a rudimentary version of the information infrastructure on which the theory of competitive market and the theory of managed care rest."⁴⁶ Nor is managed care's experience inspiring. Organizations had every incentive to explain themselves. Yet they offered "patients a bewildering array of acronyms and concepts that even specialists sometimes have trouble characterizing" while doing "little to explain the concept" of managed care.⁴⁷

Might patients' demands induce providers to assemble information? Some, surely. But much information is hard to compile in a practical form. Take one indispensable datum - what doctors and hospitals charge. Prices are often unavailable in any form consumers could use to compare plans, providers, and treatments. They are often unavailable in any form *anyone* can readily use.⁴⁸

Hospitals' fees, for instance, are listed in a "charge master" - "a confidential list of charges made by the hospital for all its goods and services." It "is compiled and maintained by the hospital's chief financial officer on the hospital's computer system." Fifteen years ago, one hospital's charge master "contained approximately 295 pages and listed prices for approximately 7,650 items." It was "confidential proprietary information" and "not shown to anyone other than the officers and employees of the hospital and authorized consultants." It was adjusted weekly "to reflect current cost data; the hospital's costs are marked up by a mathematical formula designed to produce

⁴⁶ Reinhardt, 26 J Health Politics, Policy & L at 967 (cited in note 18).

⁴⁷ Jacobson, 47 SLU L Rev at 374 (cited in note 35).

⁴⁸ For a failure described at length, see Hall and Schneider, 106 Mich L Rev at 643 (cited in note 22).

a targeted amount of profit for the hospital.”⁴⁹ And today, charge masters may contain as many as 45,000 items.⁵⁰

If you could get a charge master and if you could understand it, you would still have to decide which charges to use comparing plans or providers (recalling that prices change frequently). Even if you knew what illnesses you would have, you would have to predict the treatments (something even doctors might not know) as the charge master coded their components. Then you would need similar success with other plans and providers.⁵¹ Even if you could do all this, would you?

Consumers run a pilot test of consumerism when they buy *in vitro* fertilization, cosmetic surgery, and dental crowns. These “[c]onsumers engage in little price shopping.” Most consumers accept other patients’ recommendations or physician referrals in choosing providers of IVF and rhinoplasty. “For dental crowns, virtually all patients choose to stay with their regular dentist rather than shop around.” Significantly, an “important reason why shopping takes place so infrequently for these procedures is that accurate price quotes can only be obtained after undergoing in-person screening exams, since costs vary according to patient characteristics and medical needs as assessed by each provider.”⁵²

Consumers usually learn best through experience, but experience is a sorry guide to hospital costs, since even long stays unlose only a drop in the Niagara of possible charges. Nor can you know how typical your experience is or what another hospital would charge. Nor will your bill teach you much, since you can’t decipher it. One expert, for example,

examined a hospital bill for a person who was charged more than \$30,000 for an outpatient procedure. Many of the services on the bill were written in a language that only a coding expert could understand. One of the items was a “Bairhugger upper body cov,” with a charge of \$77.55. The same hospital bill contained the following additional items and associated charges: Versed 1 MG/ML 2CC VIA-\$11.37; Lactated Ringers 2B2324-\$189.00; Valve IV-\$7.15; Pack Custom Cysto-\$58.00; Set Tur-\$35.35.⁵³

As the Aged Parent of one of us lamented, “every emergency room we’ve ever been in, every hospital stay we’ve had, particularly since our retirement, has reduced us to helplessness as far as costs were concerned, choice of

⁴⁹ *Doe v. HCA Health Services of Tennessee*, 46 SW3d 191, 194 (Tenn 2001).

⁵⁰ Hospital charge masters are described in Gerard Anderson, *From “Soak the Rich” to “Soak the Poor”: Recent Trends in Hospital Pricing*, 26 Health Affairs 780, 786 (2007); Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 Health Affairs 57, 58-59 (2006); Allen Dobson, et al, Medicare Payment Advisory Commission, *A Study of Hospital Charge Setting Practices* (2005), online at http://www.medpac.gov/publications/contractor_reports/Dec05_Charge_setting.pdf (visited Feb 10, 2009). For examples, see <http://www.treas.gov/offices/public-affairs/hsa/>.

⁵¹ On the impossibility of all this, see Hall and Schneider, 106 Mich L Rev at 643 (cited in note 22).

⁵² Ha T. Tu and Jessica H. May, *Self-Pay Markets In Health Care: Consumer Nirvana Or Caveat Emptor?*, Health Affairs w217, w223 (2007 – Web Exclusive), online at <http://content.healthaffairs.org/cgi/content/full/hlthaff.26.2.w217v1/DC1> (visited Feb 11, 2009).

⁵³ Anderson, 26 Health Affairs at 786 (cited in note 50).

hospitals, and choice of the physicians who treated us once we were immured.”

In short, prices are so complex and dynamic that information about them hardly exists. It has not been compiled, cannot easily be compiled, and cannot be reliably analyzed. No wonder it is little provided.⁵⁴ No wonder attempts have far to go before usable information is readily provided.⁵⁵

Quality information is as elusive as price information. Reinhardt gloomily concludes that “[i]nformation on the quality of care is generally unavailable or not trustworthy. Not even the infection or complication rates experienced in hospitals are publicly known.”⁵⁶ One study found that “[l]ess than one-third of adults in any plan type reported that their health plans provided them with information on either the quality or the cost of their doctors or their hospitals”⁵⁷ The scant information on quality in the media or on Internet sites “typically consists of mysteriously weighted aggregate indexes that obscure the detailed information patients would need in competitive market.”⁵⁸ There are only “very limited opportunities to learn about the health outcomes achieved by particular physicians and hospitals.”⁵⁹ For example, the Association of State Medical Board Executive Directors offers “information on physicians’ education, malpractice judgments, and disciplinary histories.” One employers’ group in the Northwest “publishes a study of patient satisfaction with medical groups and physician networks” which “ranks groups and networks on patient satisfaction, ease of getting referrals, and their records of keeping blood pressure and cholesterol under control and counseling patients on preventive care.”⁶⁰ This is better than nothing, but how much health would you wager on such spotty and delphic data?

Like price information, quality information is wickedly hard to assemble. Measuring quality is tricky. Many facts that look like evidence of a doctor’s proficiency or a hospital’s reliability turn treacherous on examination. Even mortality rates depend on much besides the quality of care. For instance, local hospitals often turf patients with ominous prognoses out to tertiary-care centers. So the Crooked Creek Community Hospital’s mortality statistics could look better than the Cleveland Clinic’s even while the former offered worse care.

⁵⁴ “[F]ew of these initiatives provide health plan enrollees the data they might need to make informed choices among available providers or treatments.” Mark Merlis, National Health Policy Forum, *Health Care Price Transparency and Price Competition* (2007), online at http://www.nhpf.org/library/background-papers/BP_PriceTransparency_03-28-07.pdf (visited Feb 11, 2009).

⁵⁵ Perhaps consumers shouldn’t even want this information published, since publication of prices might inhibit discounts. See Margaret K. Kyle and David B. Ridley, *Would Greater Transparency and Uniformity of Health Care Prices Benefit Poor Patients?* 26 *Health Affairs* 1384 (2007); Paul B. Ginsburg, *Shopping for Price in Medical Care*, 26 *Health Aff* w208 (2007); Symposium, 23 *Frontiers of Health Service Management* 3 (2007).

⁵⁶ Reinhardt, 26 *J Health Politics, Policy & L* at 987 (cited in note 18).

⁵⁷ Fronstin and Collins, 315 *EBRI Issue Brief* at 29 (cited in note 23).

⁵⁸ Reinhardt, 26 *J Health Politics, Policy & L* at 986-87 (cited in note 18).

⁵⁹ Deborah Haas-Wilson, *Arrow and the Information Market Failure in Health Care: The Changing Content and Sources of Health Care Information*, 26 *J Health Politics, Policy & L* 1031, 1040 (2001).

⁶⁰ *Id.* at 1041.

Even experts quarrel about measures of quality. For example, “the National Committee for Quality Assurance found that the ‘average’ health plan provided 61.9 percent of appropriate beta-blocker drugs to patients who suffered a heart attack. Plans ranged between 15 percent and 100 percent on this indicator.” So far so good. But is “a high favorable score on this count . . . evidence of overall high quality or of a shift of resources to this medical priority at the expense of others, perhaps those left unmeasured in formal surveys?”⁶¹

There is more. To seek out and interpret quality data, consumers must realize that quality varies. Many consumers do not. “[R]esearch suggests that most consumers do not believe clinical quality varies significantly across doctors, hence the low consumer demand for clinical quality report cards.”⁶² For example, “[m]any industry observers express concern that LASIK is regarded as a commodity by some consumers – leading them to shop only on price – when provider quality, in their opinion, varies considerably.” LASIK may be “relatively simple surgery with low complication rates, but for patients whose eyes have certain ‘problem’ characteristics (for example, abnormal topography, large pupils, thin corneas), quality differences can be critical.”⁶³

In short, even the most basic information consumers need to buy these expensive and vital products – information about cost and quality – is often inaccessible even to experts. Nor is adequate information readily compiled, given the obstacles to ascertaining and amassing it, the reluctance of sources of information to publish it, the Everest of relevant information, and the uncertainty about which information is actually useful, and how to use it.

Things get no better when we move from choosing plans and providers to choosing treatments. Even experts often lack good information about treatments. “Evidence-based medicine” is today’s watchword, but there is decent evidence for only a fraction (albeit a large fraction) of medicine. Indeed, the great fact about the “information” doctors reason from and present to patients is its insistent uncertainty. Uncertainty “is clinically commonplace.”⁶⁴ Medicine “is engulfed and infiltrated by uncertainty.”⁶⁵ Physicians practice “in a sea of doubt and uncertainty,”⁶⁶ so that “judgments must inevitably be made on the doctor’s personal experience of past cases; the comparison of the present size, sound or feel of something with what is remembered; and on what a clinician believes to be the problem, based sometimes on very scanty evidence.”⁶⁷

All this is uncertainty about how to treat patients. But consumerist patients need still another datum – treatments’ cost-effectiveness. This is

⁶¹ Brown, 56 Med Care Res & Rev at 160 (cited in note 36).

⁶² Ha T. Tu and Johanna R. Lauer, *Word of Mouth and Physician Referrals Still Drive Health Care Provider Choice*, 9 Center for Studying Health System Change 1, 5 (2008), online at <http://www.hschange.org/CONTENT/1028/> (visited Feb 11, 2009).

⁶³ Tu and May, *Health Affairs* (2007 – Web Exclusive) at w222 (cited in note 52).

⁶⁴ Charles L. Bosk, *Occupational Rituals in Patient Management*, 303 NEJM 71, 72 (1980).

⁶⁵ Jay Katz, *The Silent World of Doctor and Patient* 166 (Free Press, 1984).

⁶⁶ Eric J. Cassell, *The Changing Concept of the Ideal Physician*, *Daedalus* 185, 186 (1986).

⁶⁷ *Id.* at 191. On clinical uncertainty, see Schneider, *The Practice of Autonomy* at 48-75 (cited in note 20).

even less available than information about efficacy. Managed care organizations have been trying to generate and acquire such data for years, with incomplete success. Can patients inspire something better?

In sum, wise decisions depend on adequate information. In this section, we have seen that often such information does not exist, has not been gathered, is kept private, or cannot practically be collected.

B. WHENCE COMETH INFORMATION?

Once more suppose away all the problems we've been considering. Suppose consumers have real choices of plans, providers, and treatments. Suppose cost and quality information about plans, providers, and treatments is offered in useful form. Who will give consumers that information, and how might the messenger affect the message's availability, quality, and credibility?

Ordinary vendors advertise their wares. Unfortunately the incentives that inspire advertising also inspire hype. Furthermore, the beauties of our own work always outshine its flaws. Consumers expect and law tolerates some sales puffery. So when even scrupulous health plans and providers proclaim their virtues or relate their results, they accentuate the positive. "[N]o one denies that marketing agents [of medical plans], eager to boost a plan's enrollment, their own commissions, or both, sometimes put consumers' minds at ease by shading facts."⁶⁸ But how are consumers to discount for the hype?

Similar problems are inevitable when patients purchase treatments. One canary in this mine is LASIK surgery, which consumers buy directly from providers who advertise. "Misleading advertisements have been a recurring problem with some LASIK providers, most notably discounters; federal and state regulators have taken action against some providers – and investigated many more – for making unfounded claims about price and quality."⁶⁹

Another canary is direct-to-consumer drug advertising. One study concludes that these ads "have limited educational value and may oversell the benefits of drugs in ways that might conflict with promoting population health."⁷⁰ Similarly, Lyles believes that the "blend of promotion and information has produced more prescription drug awareness than knowledge – it has been largely ineffective in educating patients with medical conditions about the medications for those conditions."⁷¹ And not just ineffective in educating, but mis-educating. Advertisements for drugs are regulated, but their information "has frequently been found to be biased or misleading in

⁶⁸ Brown, 56 *Med Care Res & Rev* at 149 (cited in note 36).

⁶⁹ Tu and May, *Health Affairs* (2007 – Web Exclusive) at w221 (cited in note 52). LASIK "is widely regarded as the self-pay market with the most favorable conditions for consumer shopping: It is an elective, nonurgent, simple procedure," so consumers should have time and capacity to shop for it, "screening exams are not required to obtain initial price quotes, which keeps the dollar and time costs of shopping reasonable; and easy entry of providers (ophthalmologists) into the market has stimulated competition and kept prices down."

⁷⁰ Dominick L. Frosch, et al, *Creating Demand for Prescription Drugs: A Content Analysis of Television Direct-to-Consumer Advertising*, 5 *Annals Family Med* 6 (2007).

⁷¹ Alan Lyles, *Direct Marketing of Pharmaceuticals to Consumers*, 23 *Annual Rev Public Health* 73 (2002).

regulatory and academic evaluations.⁷² Consumers tested after seeing ads “correctly answered an average of 59 percent of the true/false questions,” fewer when the questions were about risk, and fewer “if the information had been given in text, with or without accompanying audio, rather than in audio only”⁷³

Hospital ads may be yet more vacuous (if blessedly rarer). An analysis of over 300 hospital websites said that their information was “rudimentary” and that “few of the designated measures were valid and reliable measures of quality.”⁷⁴

Even when providers are compelled to disclose information, they can usually beautify it. When health plans had to disclose the way their doctors were paid, “almost none” of their statements mentioned “the potential negative impact that incentive arrangements might have on physician behavior.” They more often put “incentives in a positive light,” by saying, for example, that the incentives rewarded better care (as perhaps they did).⁷⁵

All this makes vendors unreliable, as consumers know. But *how* unreliable? Vendors paint pretty portraits, but they also paint some warts, not least because they want repeat business and good word-of-mouth, neither of which comes from deceived customers. So how does the consumer distinguish reliable from dubious vendors? Discount favorable information from any vendor? Discount it they do. For example, “[s]everal focus groups have found that consumers particularly distrust information that comes from the plans themselves, or from their employers because they believe they are being ‘marketed’”⁷⁶ Yet too much discounting is as bad as too little.

Consumers of all kinds are especially moved by recommendations from friends and family. And so “when it comes to plan choice, consumers say they most trust the advice of their doctors, friends, and family”⁷⁷ However, those recommendations are unsystematic, and lay evaluations of technical services are unreliable.⁷⁸ So consumers may trust most those who evaluate quality worst.

⁷² Steven Morgan, et al, *The Economics of Direct-to-Consumer Advertising of Prescription Advertising of Prescription-Only Drugs: Prescribed to Improve Consumer Welfare?*, 8 J Health Services Res & Policy 237 (2003).

⁷³ Kimberly A. Kaphingst and William DeJong, *The Educational Potential of Direct-To-consumer Prescription Drug Advertising*, 23 Health Affairs 143, 145 (2004).

⁷⁴ David S. Zingmond, et al, *Information Superhighway or Billboards by the Roadside? An Analysis of Hospital Web Sites*, 175 Western J Med 385 (2001).

⁷⁵ Mark A. Hall, *The Theory and Practice of Disclosing HMO Physician Incentives*, 65 L & Contemp Prob 207, 227 (2002). Similarly, lending disclosure requirements may “create incentives for lenders to draft contract terms that . . . continue to obscure the actual contract terms.” Susan Block-Lieb and Edward J. Janger, *The Myth of the Rational Borrower: Rationality, Behavioralism, and the Misguided “Reform” of Bankruptcy Law*, 84 Texas L Rev 1481, 1560 (2005-2006).

⁷⁶ Amy B. Bernstein and Anne K. Gauthier, *Choices in Health Care: What Are They and What Are They Worth?*, 56 Med Care Res & Rev 5, 13 (1999).

⁷⁷ James S. Lubalin and Lauren D. Harris-Kojetin *What Do Consumers Want and Need to Know in Making Health Care Choices?*, 56 Med Care Res & Rev 67, 72 (1999).

⁷⁸ For example, B. McKinstry, et al, *Do Patients and Expert Doctors Agree on the Assessment of Consultation Skills?*, 21 Family Practice 75 (2004), found “no meaningful association” between patients’ and experts’ assessments of doctors’ skills. John T. Chang, et al, *Patients’ Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care*, 144 Annals Intern Med 665, 671 (2006), “found that patient reports about

Ideally, then, consumers need sounder sources. When you buy flooring, you check *Fine Homebuilding*. When you buy a bandsaw, you check *Fine Woodworking*. Will a *Fine Health Care* appear? *Consumer Reports* does rate health plans, *US News & World Report* does rate hospitals, and Internet sites are arising.⁷⁹ But when markets are so fragmented, could *Fine Health Care* evaluate each market thoroughly enough? *FHC* would also struggle with the complexities we've been describing. Furthermore, the institutions *FHC* evaluated would game the system, just as law schools do with *U.S. News and World Report*. Anderson, for example, says California has tried to proffer useful information by comparing "the prices of only twenty-five items on the chargemaster." However, "hospitals can lower prices for just those twenty-five items."⁸⁰ So is a really useful *FHC* possible? And if so, would consumers really use it?

Information about everything does bubble up everywhere on the Internet. But it must be (1) consulted, (2) reliable, and (3) workable: onerous requirements. For example, people over 75 "were much less likely to report use of the Internet for health than their juniors."⁸¹ And, for example, the best guide to Medicare drug cards in 2005 was the government's website. But three quarters of the prospective beneficiaries had never used the Internet, and "of the 23 percent who had used it, only 6 percent had visited the website."⁸²

Well, the Luddite old will eventually be replaced by the cyber young. But they still must locate sites and separate wheat-sites from chaff-sites. Inevitably, chaff proliferates; studies repeatedly find Internet information dicey.⁸³ "[O]nly a few of the web pages" one study reviewed "gave complete and accurate information for such a common and widely discussed condition as fever in children." The advice those sites gave parents about children's fevers was "often incomplete and partly misleading" and inadequate to overcome parents' "beliefs and established practices."⁸⁴

In addition, making Internet information usable is hard. One Medicare expert tried to help "a parent, who was taking four prescription drugs, use the [government] website to find the best card." It took "forty-two 'clicks' or word entries to get an answer." The expert had to supply data "about such things as each medication used and its dosage, current drug spending, and pharmacy

interpersonal quality were distinct from technical quality of care as measured by medical records and patient interviews."

⁷⁹ For a brief description, see J.D. Kleinke, *Vaporware.com: The Failed Promise of the Health Care Internet: Why the Internet Will Be the Next Big Thing Not To Fix the U.S. Health Care System*, 19 *Health Affairs* 57, 66-67 (2000).

⁸⁰ Anderson, 26 *Health Affairs* at 786 (cited in note 50).

⁸¹ Laurence Baker, et al, *Use of the Internet and E-Mail For Health Care Information: Results From a National Survey*, 289 *JAMA* 2400, 2402 (2003).

⁸² Yaniv Hanoch and Thomas Rice, *Can Limiting Choice Increase Social Welfare? The Elderly and Health Insurance*, 84 *Milbank Q* 37, 54 (2006).

⁸³ Baker, et al, 289 *JAMA* at 2405 (cited in note 81).

⁸⁴ Piero Impicciatore, et al, *Reliability of Health Information for the Public on the World Wide Web: Systematic Survey of Advice on Managing Fever in Children at Home*, 314 *British Med J* 1875, 1878 (1997). Similarly downbeat is Angela Fagerlin, et al, *Patient Education Materials About the Treatment of Early-Stage Prostate Cancer: A Critical Review*, 140 *Annals Intern Med* 721, 724 (2004).

preferences.⁸⁵ Not only is this laborious (and irksome, since entry errors are almost unavoidable), but who has such facts easy to hand?⁸⁶

Even were the Internet widely used, how consumerist would the results be? “Many have argued that patients using the Web to find providers will finally bring price-sensitivity to health care consumption The exact opposite is more likely to occur Not only will people never seek the lowest bidder when it comes to their own physical and emotional well-being; they will actively seek out and select the highest bidder, presuming (usually correctly) that higher cost connotes higher quality”⁸⁷ Furthermore, health care companies advertise because it moves their products, partly by increasing demand. Increased demand rarely lowers overall health care costs.

Another way to assess the Internet’s usefulness is to ask how it helps with other major choices. Try using the retirement-planning sites of Fidelity, Vanguard, TIAA and the like. Their instructions for entering data drip with ambiguity, their assumptions are unannounced, even a single program gives wildly different counsel with slight variations in entries, and different sites give different advice even when you try to keep entries consistent. If providing information on the Internet were easy, surely these well-motivated institutions could do better. And if they can’t, who can?

In the preceding section, we said that information about health purchases is often unavailable. In this section, we asked who will deliver the information that is available. Messengers are generally fewer than in other purchases and less reliable and harder to evaluate than consumers’ usual informants.

IV. WILL DOCTORS DISCUSS AND USE COST INFORMATION?

Should you begin by discussing fees, you will suggest to the patient either that you will go away and leave him if no agreement be reached, or that you will neglect him and not prescribe any immediate treatment For I consider such a worry to be harmful to a troubled patient, particularly if the disease be acute. For the quickness of the disease, offering no opportunity for turning back, spurs on the good physician not to seek his profit but rather to lay hold on reputation.

Hippocrates
Precepts

Once again, assume away all the problems we have discussed so far. Suppose the information consumers need is assembled and is proffered by trustworthy messengers consumers actually trust. Will doctors and patients then discuss costs, and will doctors help patients economize?

⁸⁵ Hanoch and Rice, 84 Milbank Q at 54 (cited in note 82).

⁸⁶ “Accessing health information using search engines and simple search terms is not efficient. Coverage of key information . . . is poor and inconsistent High reading levels are required to comprehend Web-based health information.” Gretchen K. Berland, et al, *Health Information on the Internet: Accessibility, Quality, and Readability in English and Spanish*, 285 JAMA 2612 (2001).

⁸⁷ Kleinke, 19 Health Affairs at 67 (cited in note 79).

A. STIMULATING DISCUSSIONS OF COSTS

Consumerism may seem especially plausible for treatment decisions, since doctors can help patients make them. Some patients – especially the poor – already get cost guidance. But for consumerism to work, doctors must routinely discuss costs, since otherwise patients cannot identify economies.

So will doctors and patients talk about the cost of treatment choices? They might. First, patients might take the initiative and ask about cheaper treatments or foregoing treatment. This happens. It should be encouraged. But patients often do not realize such a question makes sense. Furthermore, patients report a “wide variety of barriers” to discussing costs.⁸⁸ Who wants to bring up money? Even in an art gallery, embarrassment might inhibit you from asking about price. Partly this is because you probably can't afford the Paul Strand you want, just as you might not be able to afford the treatment the doctor proposes.

Furthermore, you come to the doctor “sick, anxious, and intimidated. So you let the doctor set the boundaries and tone of your relationship.”⁸⁹ You want doctors' approval, confidence, and concern. Questioning a recommendation and demanding a cheaper one rarely strike patients as canny tactics, especially when physicians are selling their own services. Thus in one study only 12% of the subjects had *ever* negotiated with a provider for a lower price.⁹⁰ One sophisticated patient we know thought it “a little difficult” to ask a doctor she had just met about price. She feared raising questions about “respect” for the doctor and getting “off on the wrong foot.” When we said that “you don't want your doctor thinking badly about you,” she replied, “Yeah, getting revenge somehow, perhaps.”⁹¹ Further, patients are notoriously bad at raising the subjects they really want to discuss. Finally, sickness can be painful, exhausting, debilitating, disorienting, terrifying, isolating. People so afflicted lack the energy and acuity to ask smart questions and demand smart answers.

If patients won't reliably bring up cost, will doctors? This is crucial, because physicians notoriously dominate conversations with patients.⁹² Yet physicians little relish conversations about prices.⁹³ Indeed, “the literature has only recently begun to address patient-provider communication about health care costs.” On “first pass, it appears that little communication of this type is going on.”⁹⁴ Physicians advertise rarely, advertise fees less, and post no

⁸⁸ G. Caleb Alexander, et al, *Barriers to Patient-Physician Communication About Out-of-Pocket Costs*, 856 J Gen Intern Med 19 (2004).

⁸⁹ Hall and Schneider, 106 Mich L Rev at 655 (cited in note 22).

⁹⁰ Sara R. Collins, et al, The Commonwealth Fund, *Gaps in Health Insurance: An All-American Problem* 20 (2006), online at http://www.commonwealthfund.org/usr_doc/Collins_gapshltins_920.pdf.

⁹¹ Hall and Schneider, 106 Mich L Rev at 655-56 (cite in note 22).

⁹² Even when doctors spoke with sophisticated patients (San Francisco AIDS patients) about an important topic (CPR), conversations were brief, doctors did most of the talking, and they “dominated the discussions.” James A. Tulsky, et al, *How Do Medical Residents Discuss Resuscitation with Patients?*, 10 J Gen Intern Med 436 (1995).

⁹³ For a historical view of the ethics and practice of fees, see Fridolf Kudlien, *Medicine as a “Liberal Art” and the Question of the Physician's Income*, 31 J History Med 448 (1976).

⁹⁴ Alex D. Federman, *Don't Ask, Don't Tell: The Status of Doctor-Patient Communication About Health Care Costs*, 164 Arch Intern Med 1723, 1723 (2004).

prices.⁹⁵ Dr. Hippocrates, quoted in our epigraph, set the example of reluctance to talk about money.⁹⁶ Stein describes a “taboo in official American health culture: namely, a prohibition upon allowing the physician to appear concerned with financial matters.” Stein thinks people “‘selling’ their services are loathe to affix a price tag to services at the time of the transaction or as an official precondition to ‘delivering’ them. Somehow it would be immoral to do so.”⁹⁷ And perhaps physicians (relatively rich) are embarrassed to reveal fees patients (relatively poor) may find incomprehensibly high and intolerably burdensome.

Research confirms that doctors and patients do not regularly discuss costs. “Four hundred eight patients (85%) reported they had never discussed their out-of-pocket costs with their physician. This group of 408 patients included 56 of the 77 patients (73%) who reported cost-related medication nonadherence during the previous 12 months.”⁹⁸ Likewise, only a tenth of another group of patients remembered being told what care would cost.⁹⁹

Some data look more encouraging. Fronstin and Collins found that people in consumer plans were likelier to talk with their doctor about treatment options and costs and to ask their doctor to recommend a cheaper drug: “[a]bout 2 in 5 said they had done this, compared with thirty percent of those in more comprehensive plans.”¹⁰⁰ Nevertheless, these patients were asked whether they had ever discussed cost, not whether such discussions were routine and productive.

Even if doctors balk at discussing their own fees, might they discuss the costs of services and supplies they order from others? Perhaps not. For instance: “Physician-patient discussions about new medication cost and other acquisition issues, especially medication affordability, occur infrequently.”¹⁰¹ This is true even where discussion seems needed: “Few chronically ill patients who are at risk of or experiencing problems related to prescription medication costs report that their clinicians had asked them about possible medication payment difficulties.”¹⁰²

⁹⁵ See, for example, Berkeley Rice, *How to Market Your Practice*, Med Econ 53 (Mar 4, 2005), online at <http://medicaleconomics.modernmedicine.com/memag/Medical+Practice+Management:+Practice+Pointers/Practice-Pointers-How-to-market-your-practice/ArticleStandard/Article/detail/148876> (visited Feb 13, 2009). “[P]hysician price advertising continues to be quite rare,” and “physicians are strongly opposed to price advertising.” John A. Rizzo & Richard J. Zeckhauser, *Advertising and the Price, Quantity, and Quality of Primary Care Physician Services*, 27 J Human Resources 381, 388-89, n 12 (1992).

⁹⁶ John Fabre, *Medicine as a Profession: Hip, Hip, Hippocrates: Extracts from The Hippocratic Doctor*, 315 British Med J 1669 (1997).

⁹⁷ Howard F. Stein, *The Money Taboo in American Medicine*, 7 Med Anthropology 1, 11 (1983).

⁹⁸ G. Caleb Alexander et al, *Patient-Physician Communication About Out-of-Pocket Costs*, 290 JAMA 953, 955 (2003).

⁹⁹ Thomas P. O’Toole et al, *Full Disclosure of Financial Costs and Options to Patients: The Roles of Race, Age, Health Insurance, and Usual Source for Care*, 15 J Health Care Poor & Underserved 52, 56 (2004).

¹⁰⁰ Fronstin and Collins, 315 EBRI Issue Brief at 33 (cited in note 23).

¹⁰¹ Derjung M. Tarn et al, *Physician Communication About the Cost and Acquisition of Newly Prescribed Medications*, 12 Am J Managed Care 657, 657 (2006).

¹⁰² Michele Heisler et al, *Clinician Identification of Chronically Ill Patients Who Have Problems Paying for Prescription Medications*, 116 Am J Med 753, 753 (2004).

One major problem is that doctors often do not know prices. Half a century ago doctors were “seldom informed about the price” of drugs.¹⁰³ A quarter of a century ago “doctors seldom ha[d] an accurate sense of drug costs” and when asked “about common drug prices, they reveal[ed] ignorance more often than knowledge.”¹⁰⁴ Today doctors “consistently overestimate[e] the cost of inexpensive products and underestimate[e] the cost of expensive ones.”¹⁰⁵ Even primary care and internal medicine physicians are “no more knowledgeable about costs than their family practice, geriatrics, pediatrics, and neurology colleagues were a decade ago.” Eighty percent of them “were often unaware of actual drug costs, and most underestimated the cost of common brand-name medications we inquired about.”¹⁰⁶

Furthermore, physicians cannot know what treatments cost until they know what treatments are required. But, for example, primary-care physicians often forward patients to specialists and hospitals with little idea what the cost will be.¹⁰⁷ Thus one national survey found primary-care doctors “unprepared to advise patients on the costs of medical care, particularly radiologic studies, specialty consultations, and hospitalizations.”¹⁰⁸

In addition, most doctors have patients with different insurers which negotiate fees “in a tumultuous market that regards prices as trade secrets. One Harvard surgeon’s group has a six-hundred page ‘master fee schedule’ with ‘twenty-four columns across the top, one for each of the major insurance plans, and, running down the side, a row for every service a doctor can bill for.’” Even a “superb office staff might not know who would pay what until the insurer completed claims ‘adjudication.’”¹⁰⁹ Yet

¹⁰³ Herman Miles Somers and Anne Ramsay Somers, *Doctors, Patients, and Health Insurance* 209, 209 (1961).

¹⁰⁴ Peter Temin, *Taking Your Medicine: Drug Regulation in the United States* 103, 105 (1980).

¹⁰⁵ G.M. Allan et al, *Physician Awareness of Drug Cost: A Systematic Review*, 4 *PLoS Med* 1486, 1486 (2007).

¹⁰⁶ Reichert et al, 160 *Arch Intern Med* at 2802 (cited in note 42). Nor did a third of them realize that Medicare did not (then) cover medications.

¹⁰⁷ See generally John D. Goodson, *Unintended Consequences of Resource-Based Relative Value Scale Reimbursement*, 298 *JAMA* 2308 (2007).

¹⁰⁸ Giridhar Mallya et al, 14 *Am J of Managed Care* at 666 (cited in 25).

¹⁰⁹ Mark A. Hall and Carl E. Schneider, 106 *Mich L Rev* at 657 (cited in note 22) (quoting Atul Gawande, *Piecework: Medicine’s Money Problem*, *New Yorker*, Apr. 4, 2005, at 44).

clearing a typical insurance claim involves, for starters, the following queries: (1) Is the patient a member of the plan? (2) Is this particular service covered by the patient's benefit plan? (3) Is there secondary insurance that should cover this service? (4) Is this service related to an incident that may be subrogatable to a workers' comp, disability, or accident event? (5) Is this service consistent with the patient's clinical diagnosis, history, age, and sex? (6) Is the service, if covered, medically necessary? (7) Has the service, if covered, been preauthorized? (8) Is this submitting provider qualified to provide this service? (9) Is the provider a member of the network? (10) How much do we pay this particular provider for this particular service? (11) Has the patient's deductible or major medical been met this year? (12) Did the patient pay upfront, and who are we reimbursing, patient or provider?¹¹⁰

Can doctors be persuaded to discuss money regularly? Altering doctors' preferences and practices is hard even where change would benefit patients clinically.¹¹¹ Most relevantly, managed care organizations have for years begged doctors to economize in exactly the ways consumerism contemplates. Those efforts provoked vehement resistance, disappointing improvement, and numerous retreats by health plans.

Can the law stimulate cost discussions? When the law wants to change sellers' interactions with consumers, it reaches first for mandated disclosure. Asked to change doctors' conversations with patients, the law reaches first for informed consent. But how would informed consent work here? Plaintiffs would be claiming that, properly informed, they would have foregone a test or chosen a cheaper treatment. But if doctors are giving reasonable advice, patients could not easily prove they would have rejected it. Nor will damages often be juicy enough to induce contingency fee lawyers to take such cases.¹¹²

Patients might refuse to pay for treatments they would have rejected if properly informed. The claim would resemble that of customers whose brokers churned their accounts. This is doctrinally neat but practically messy. Patients would have to realize that they had been denied information about cheaper care and would have chosen it. A lawyer would ordinarily have to help formulate the claim and make it stick, since no billing office would listen to that kind of whining from patients.¹¹³

¹¹⁰ Kleinke, 19 *Health Affairs* at 61 (cited in note 79).

¹¹¹ For an introduction to this unexpectedly challenging problem see Gro Jamtvedt et al, *Audit and Feedback: Effects on Professional Practice and Health Care Outcomes*, 1 *Cochrane Database Syst Rev* 259 (2006); Peter J. Greco and John M. Eisenberg, *Changing Physicians' Practices*, 17 *NEJM* 1271, 1271 (1993); Jacqueline Kosecoff et al, *Effects of the National Institutes of Health Consensus Development Program on Physician Practice*, 258 *JAMA* 2708, 2712 (1987); Lee A. Green and Colleen M. Seifert, *Translation of Research Into Practice: Why We Can't "Just Do It"*, *J Am Bd Family Prac* 541, 541 (2005); Lee Green and David R. Mehr, *What Alters Physicians' Decisions to Admit to the Coronary Care Unit?*, 45 *J Family Prac* 219, 223 (1997).

¹¹² For a helpful discussion of this issue, see E. H. Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 *Vanderbilt L Rev* 1207, 1224-32 (2006).

¹¹³ For more on the difficulties patients face resisting medical bills, see Hall and Schneider, 106 *Mich L Rev* at 643 (cited in note 22).

In sum, doctors and patients sometimes discuss costs, but not as often nor thoroughly as consumerism would need. Promoting such conversations is onerous, and the law is ill-suited to the task.

B. WILL DOCTORS EMBRACE THRIFT?

Suppose now that doctors and patients do discuss costs. Those conversations will be bootless if doctors aren't committed to economies, since doctors shape – often make – patients' choices about tests and treatments. As one court said, the doctor

dictates what brand [of drugs] the patient is to buy . . . [and] orders the amount of drugs and prescribes the quantity to be consumed. In other words, the patient is a captive consumer. There is no other profession or business where a member thereof can dictate to a consumer what brand he must buy, what amount he must buy, and how fast he must consume it and how much he must pay with the further condition to the consumer that any failure to fully comply must be at the risk of his own health [T]he patient then becomes a totally captive consumer and the doctor has a complete monopoly.¹¹⁴

And when patients enter a hospital, the doctor's influence over patients' expenditures intensifies. "Patients rarely abandon doctors, reject doctors' recommendations, or demand second opinions."¹¹⁵ So if doctors don't help patients economize – if they don't lead their patients to economize – patients will be sore pressed to economize intelligently.

Much in doctors' culture, training, and situation dulls economizing zeal. First, we got to consumerism because doctors had little reason to control costs and much reason to drive them up. The more services doctors sold and the more they charged for a service, the wealthier they got. In a simpler day, doctors had fewer services to offer and modest market power, and fee-for-service medicine could be kept within patients' ability to pay, especially since doctors charged the poor less than the rich.¹¹⁶ When health insurance became a basic benefit and when (over the "socialized medicine" laments of organized medicine) Medicare and Medicaid were instituted, fee-for-service remained standard. Fees, however, kept growing even while doctors' provision of services did not always correlate with need¹¹⁷ and doctors used some of their

¹¹⁴ *Magan Medical Clinic v. California State Board of Medical Examiners*, 57 Cal Rptr 256, 263 (Ct App 1967).

¹¹⁵ Hall and Schneider, 106 Mich L Rev at 652 (cited in note 22).

¹¹⁶ For this history, see Mark A. Hall and Carl E. Schneider, *Learning From the Legal History of Billing for Medical Fees*, 23 J Gen Intern Med 1257 (2008).

¹¹⁷ "[M]any studies have suggested . . . that physicians' decisions are influenced by a wide variety of factors that are unrelated to a patient's specific medical problem. These factors include practice setting, degree of specialization, and physician age." Lachlan Forrow et al, *Science, Ethics, and the Making of Clinical Decisions: Implications for Risk Factor Intervention*, 259 JAMA 3161, 3165 (1988). Furthermore, "[w]ide variations in the incidence of medical and surgical services are the norm, not the exception," Bradford H. Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals* 252 (Harvard U Press, 1991) (emphasis in original), although much of this variation is concentrated in areas where there is professional disagreement about the treatment. Further, "as much as 25 percent or more of expenditures for medical care is for unnecessary or inappropriate services."

market power to sustain their incomes.¹¹⁸ This dynamic drove us to managed care and still operates, even if less universally.

Furthermore, organized medicine and many physicians resented managed care's challenge to their authority, and they remain resentful.¹¹⁹ "Under cover of the managed care backlash, physicians and hospitals began to reassert their prerogatives. With the erosion of stringent cost controls, physicians gained greater leverage in clinical decisions."¹²⁰ As Hyman bluntly argues, "The medical profession wants to regain its ability to dictate the terms of trade with regard to cost and quality."¹²¹ In short, organized medicine and many doctors have fought long, hard, and bitterly to preserve their unconstrained authority in general and their ability to avoid cost controls particularly.¹²²

Dr. Bloche takes the point further. He writes that by the early 1960s, physicians had "won consumers' confidence" and that many physicians "took opportunistic advantage by acquiring ownership interests in hospitals, clinical laboratories, and other health care businesses." Doctors' "[a]nticommercial norms" eroded, so that doctors "now routinely advertise, accept discounted fees from managed health plans, take ownership interests in facilities financially affected by clinical utilization patterns, and sign contracts that reward them financially for withholding care."¹²³

Doctors, then, have interests that disincline them to make cost-containment a priority. These are only interests and only disinclinations. Many individual physicians lack or ignore those interests, and many restrain or reject the disinclination. Furthermore, organized medicine is more disorganized and various than ever, so its ultimate reaction to consumerism is unpredictable.

Doctors' doubts about cost-containment are reinforced by admirable aspects of their culture. Doctors are moved by craft pride. Their norms call them to provide the best care available, to follow the best practices, to apply the gold standard.¹²⁴ One reason many doctors loathe managed care is that

Id at 253. For vivid demonstrations of how much medical practices vary geographically, see John E. Wennberg et al, *Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?*, 1987 *Lancet* 1185; Mark R. Chassin et al, *Variations in the Use of Medical and Surgical Services by the Medicare Population*, 314 *NEJM* 285 (1986).

¹¹⁸ For the background, see Hall and Schneider, 106 *Mich L Rev* at 643 (cited in note 22).

¹¹⁹ "[P]hysicians provided some of the most vociferous opposition to managed care . . ." Jacobson, 47 *SLU L Rev* at 371 (cited in note 35).

¹²⁰ Id at 366.

¹²¹ David A. Hyman, *Accountable Managed Care: Should We Be Careful What We Wish For?*, 32 *U Mich J L Reform* 785, 801-02 (1999).

¹²² Nor can we count on organized medicine for constructive alternatives. "[P]roviders have spent too much of their time complaining about managed care and too little time considering whether alternatives to existing payment arrangements might make everyone better off." David A. Hyman, *Medicine in the New Millennium: A Self-Help Guide for the Perplexed*, 26 *Am J L & Med* 143, 147 (2000).

¹²³ M. Gregg Bloche, *The Market for Medical Ethics*, 26 *J Health Politics, Policy & L* 1099, 1108-09 (October 2001).

¹²⁴ The depth of their feeling is suggested by their occasional willingness to deceive insurance companies to obtain coverage. This superficially appealing but also destructive practice is discussed in Rachael M. Werner et al, *Lying to Insurance Companies: The Desire to Deceive among Physicians and the Public*, 4 *Am J Bioethics* 53 (2004); Victor G. Freeman et al, *Lying for Patients: Physician Deception of Third-Party Payers*, 159 *Arch Intern Med* 2263

they feel it prevents them from giving that care.¹²⁵ And doctors are trained in “Hippocratic individualism,”¹²⁶ a single-minded commitment to the interest of the patient seeking help. Much of this benefits patients, and in much of this doctors speak for patients. As individuals (if not as members of an insured group), patients want all the medical care their doctors think they need.

Furthermore, doctors' paternalism – less pejoratively, their role – accustoms them to persuade patients toward health. Patients often need persuading. They eat, drink, and smoke; they avoid doctors; they don't buy drugs they've been prescribed; they don't take drugs they've bought; they flee from burdensome treatment. Inducing patients to cooperate in their own care is part of the physician's stock-in-trade and part of what patients expect.¹²⁷

Little in all this inspires doctors to save money; much in this arms them to resist lowering standards. This commitment may bend to fit economic circumstances, but not easily.¹²⁸ Nevertheless, doctors are pragmatists. They want patients to receive the best care, but they are not flatly unwilling to help patients save money. Not at all. In our interviews and our work with medical colleagues, we encounter many physicians who are warmly anxious to help patients who have trouble paying for care.¹²⁹ Scholarship confirms this. For example, three-quarters of the doctors in one national survey routinely consider insured patient's out-of-pocket costs in some clinical situations, especially when prescribing drugs.¹³⁰ In one academic medical center, 88% of

(1999); Matthew K. Wynia et al, *Physicians Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 283 JAMA 1858 (2000).

¹²⁵ However,

we have tolerated a sharp dissonance between medical ethics' professed adherence to a rule of absolute patient loyalty and the reality of myriad violations of the rule. For example, physicians routinely make pragmatic decisions in public institutions operating under fixed budgets that may compromise individual patients' optimal medical benefit. In clinical practice, physicians regularly compromise individual patient welfare to a small but discernible extent because of competing demands for their time and limits on available specialized facilities and technology. They also comfortably adopt prudent clinical heuristics that avoid extravagant expenditures for very small increments of medical benefit.

Mark A. Hall and Robert A. Berenson, *Ethical Practice in Managed Care: A Dose of Realism*, 128 Ann Intern Med 395, 396 (1998).

¹²⁶ Robert Zussman, *Intensive Care: Medical Ethics and the Medical Profession* 192 (U Chicago Press, 1992).

¹²⁷ Schneider, *The Practice of Autonomy* 4-9 (cited in note 20).

¹²⁸ Gail Weiss, *A Patient's Coverage Takes a Back Seat to Clinical Factors, Say Most Respondents to our Ethics Policy*, Med Economics (Dec 1, 2006) online at <http://medicaleconomics.modernmedicine.com/memag/Physician+Surveys:+2006/What-would-you-do-Testing-and-insurance/ArticleStandard/Article/detail/387515> (visited February 25, 2009).

¹²⁹ See also Samia A. Hurst et al, *Physicians' Responses To Resource Constraints*, 165 Arch Intern Med 639, 641-42 (2005).

¹³⁰ Hoangmai H. Pham et al, *Physician Consideration Of Patients' Out-Of-Pocket Costs In Making Common Clinical Decisions*, 167 Arch Intern Med 663, 663 (2007). In one small survey, doctors considered patients' insurance status in 47% of patients' visits. David S. Meyers et al, *Primary Care Physicians' Perceptions of the Effect of Insurance Status on Clinical Decision Making*, 4 Ann Fam Med 399, 401 (2006). In another study, 31% of the doctors questioned sometimes or often did not offer “a useful service to patients because of health plan coverage rules.” Matthew K. Wynia et al, *Do Physicians Not Offer Useful Services Because Of Coverage Restrictions?*, 22 Health Affairs 190, 190 (2003).

the physicians thought patients' costs were important in prescribing, and 71% would sacrifice some efficacy to save some money.¹³¹

What is more, doctors may see more realistically than patients that a treatment is futile or ineffective. Nor is economy always inimical to health. Thus we found in interviews with a convenience sample of seven primary-care physicians that doctors are most willing to save money when it promotes optimal care, as when a patient is likelier to take prescribed medication if the doctor chooses a cheaper even if less effective drug.¹³²

In sum, foregoing care to conserve costs conflicts with much that is elemental in the training and culture of doctors. It also conflicts with much that is elemental in the feelings of patients. They want to save money, but they don't want minky short-term economies at major long-term expense. All the conflicting traditions and principles and interests and emotions may leave doctors unsure when to press patients to economize and when to press them to spend. Pragmatic doctors will, for instance, accede more readily to patients' thrift where the goal is controlling symptoms the patient can perceive and where long-term harm is unlikely. After all, patients ordinarily are motivated by their illness itself to control arthritis pain, or to take medications that slow the onset of dementia.

But where symptoms aren't obvious and where mistakes may be irreparable (controlling blood pressure, cholesterol, and blood sugar are classics) doctors more readily urge treatments on patients. Doctors we interviewed gave examples that ranged from persuasion to manipulation to coercion. One doctor told a woman who balked at a mammogram that he was scheduling one anyway. Another called a taxi to take a patient to the hospital to prevent her from going home. Yet another doctor enlisted family members in convincing recalcitrant patients. Still another doctor asked a patient who wouldn't leave her grandchild to come in for an exam, "Who will take of your grandchild if you die?" In sum, doctors dance a delicate dance to accommodate patients' ambivalent wants and ambiguous needs.

But if consumerism prevailed, might doctors decide that a reputation for economy would attract patients? Might doctors recognize a social duty to cabin costs? Perhaps, but managed care's experience is not encouraging. Even doctors who tolerated managed care did not respond as consumerism expects. They did not so much adjust recommendations to each patient's individual situation as change their style of practice across the board.¹³³ Economists celebrated this "spill-over effect," but consumerism expects

¹³¹ Reichert et al, 160 Arch Intern Med at 2800 (cited in note 42).

¹³² Elizabeth A. Mort et al, *Physician Response To Patient Insurance Status in Ambulatory Care Clinical Decision-Making: Implications For Quality Of Care*, 34 Med Care 783, 783 (1996), for example, finds that patients' insurance status influences doctors' clinical decisions more for discretionary than for necessary services.

¹³³ Sherry Glied and Joshua Graff Zivin, *How Do Doctors Behave When Some (But Not All) of Their Patients are in Managed Care?*, 21 J Health Economics 337, 353 (2002). See also Rajesh Balkrishnan et al, *Capitation Payment, Length of Visit, and Preventive Services*, 8 Am J Managed Care 332, 332 (2002) (finding that "[p]hysicians spent 5.6% less time . . . with patients in capitated plans than with those in noncapitated plans.").

patients and doctors to make efficient decisions tailored to each patient's circumstances and preferences.¹³⁴

Suppose now that doctors expect to help patients economize. Even such doctors face many practical problems in the examining room. For example, when should doctors propose thrifty treatments if thrifty means less effective? How much should doctors know about patients' financial situations? How much should doctors ask? The problems doctors will face become clearer when we realize that many patients need help not just with individual medical decisions, but with managing their financial situation when medical costs pressure their budgets. But a national survey found that "while physicians are generally ready to discuss issues of cost with patients, they are less ready to discuss medical budgeting . . ."¹³⁵ The problem is not just that cost information is hard even for doctors to ascertain; it is also that budgeting discussions require doctors to understand something of patients' financial situation. But doctors cannot master the insurance programs of all their patients, and doctors are misinformed about those programs even in general terms. For example, the same national survey found that "many physicians may not know that less than half of employers make contributions to their employees' medical savings accounts."¹³⁶ Furthermore, medical budgeting raises issues not just of finance, but of the quality of medical care. Yet patients may find it difficult to articulate their ideas on this subject, and "primary care physicians do not generally trust the quality-of-care information that patients in [consumer-directed health plans] may increasingly utilize."¹³⁷

This brings us to a problem with informed consent and all other kinds of mandated disclosure in medicine – time. Doctors often complain that managed care robbed them of time with patients. In fact, doctors apparently spend slightly *more* time with patients than they used to.¹³⁸ But doctors *feel* hurried because so much more is asked of them: Medicine can do more things, treatments are more complex, chronic diseases requiring elaborate care proliferate, and medicine's jurisdiction has broadened as problems are medicalized.

So discussions of cost must jostle for time with other urgent matters. "The ever-expanding repertoire of interventions, screening tests, vaccines, and devices has dramatically increased the work of patient care for all physician specialties." For a general practitioner to provide "all recommended preventive services to a panel of 2500 patients could require up to 71/2 hours a day of physician time. Generalist physicians report that roughly 4 separate problems are addressed at each office visit for patients older than 65 years and

¹³⁴ Similarly, the designers of Medicare's "diagnostic-related groups" imagined that they would cause hospitals to treat more and less profitable services differently. Instead, hospitals essentially economized across the board, even for non-Medicare patients. David M. Frankford, *The Medicare DRGs: Efficiency and Organizational Rationality*, 10 Yale J Reg 273, 293-96 (1993).

¹³⁵ Mallya et al, 14 Am J Managed Care at 665 (cited in note 25).

¹³⁶ Id at 666.

¹³⁷ Id at 665.

¹³⁸ David Mechanic and Donna D. McAlpine, "Fifteen Minutes of Fame": Reflections on the Uses of Health Research, the Media, Pundits, and the Spin, 20 Health Affairs 211, 213 (2001).

even more issues are addressed for patients with chronic illnesses such as diabetes.¹³⁹ One study concluded that doctors cannot “deliver all of the services recommended by the USPSTF [U.S. Preventive Services Task Force] to a representative panel of patients.” Nor is reducing the doctor’s panel “a very practical or realistic solution,” since “a 50% reduction in panel size is needed to reduce the time requirement to approximately 4 hours a day.”¹⁴⁰ To put the problem differently: “Current practice guidelines for only 10 chronic illnesses require more time than primary care physicians have available for patient care overall.”¹⁴¹ All this threatens consumerism and its dream of adding another topic – cost – to already overtaxed discussions.

Consumerist patients must learn enough about the risks, benefits, and costs of tests and treatments to make economical choices. This already happens somewhat. But it must happen much more for consumerism to flourish, and many obstacles make that unlikely: Patients make few medical decisions on their own. Once they consult a physician, they enter a relationship which disposes them to follow doctors’ orders. Under any kind of insurance, patients and doctors are reluctant to discuss costs, doctors know too little about costs, and doctors are not driven to economize. Consumerism has depreciated these realities, but they menace its prospects.

V. “CUMBERSOME, COMPLEX, AND DETAILED”: CAN INFORMATION BE PRESENTED EFFECTIVELY?

*Warum soll es einfach sein, wenn es so leicht kompliziert sein kann?*¹⁴²

German witticism

In assessing the prerequisites of consumerism, we have reached several conclusions. First, medical markets often offer fewer choices than markets need. Second, much information is unavailable and hard to assemble. Third, sources of information are often hard to evaluate. Fourth, doctors may be ill-situated and even undisposed to help patients save money. But suppose, *arguendo*, that information about plans, providers and treatments could practically be assembled by trusted and trustworthy sources and that doctors want to help patients economize. Can that information be put into a form consumers can use to make good decisions?

A. LITERACY AND NUMERACY

The first problem in presenting health care choices is that *many* people read and cipher poorly. Most information about health plans, much information about providers, and swaths of information about treatments are in writing. Yet the “1992 National Adult Literacy Survey . . . , the most

¹³⁹ Goodson, 298 JAMA at 2308 (cited in note 107).

¹⁴⁰ Kimberly S. H. Yarnall et al, *Primary Care: Is There Enough Time for Prevention?*, 93 Am J Public Health 635, 637 (2003).

¹⁴¹ Truls Ostbye et al, *Is There Time for Management of Patients With Chronic Diseases in Primary Care?*, 3 Ann Fam Med. 209, 209 (2005).

¹⁴² “Why should it be simple, when it can so easily be complicated?”

accurate portrait of English language literacy in the United States, found that 40 to 44 million Americans, or approximately one quarter of the US population, are functionally illiterate, and another 50 million have marginal literacy skills.¹⁴³ Illiteracy matters in health care: A “third of English-speaking patients at 2 public hospitals could not read and understand basic health-related materials,” and 42% of the patients studied could not “comprehend directions for taking medication on an empty stomach, 26% could not understand information on an appointment slip, and 60% could not understand a standard consent form.” Patients’ incomprehension of “information about disease management, prevention, and informed consent . . . [means that] physicians are not successful in communicating essential health care information to their patients, particularly to those with inadequate health literacy.”¹⁴⁴ Furthermore, many literate people cannot manage complicated material. For example, to reach the 80th percentile in literacy you need only comprehend a (straightforward) definition of “peremptory challenge” given jury pools.

Consumers are also hobbled by innumeracy:¹⁴⁵ “Numeracy, or the ability to process basic probability and numerical concepts,¹⁴⁶ influences “comprehension of important health information.”¹⁴⁷ Numeracy “is related to health literacy, but makes an independent contribution to comprehension and choices” and can even be “a stronger predictor of these outcomes than health literacy.”¹⁴⁸

Numeracy is increasingly important because patients “are increasingly being exposed to quantitative information about risks for disease and benefits of treatment.” Yet “many persons do not work well with numbers.”¹⁴⁹ For example, people were asked to: (1) guess how often a flipped coin would come up heads in 1,000 tries, (2) asked to calculate 1% of 1,000, and (3) turn a proportion (1 in 1000) into a percentage. “Thirty percent of respondents had 0 correct answers, 28% had 1 correct answer, 26% had 2 correct answers, and 16% had 3 correct answers.” This innumeracy hobbled women given “quantitative risk reduction data” about mammography. Few of them could “apply quantitative information about the benefit of mammography to their perceived risk for death from breast cancer.”¹⁵⁰

Similarly, innumeracy confounds consumers making many kinds of purchases. For example, picking and using credit cards are simpler than understanding and buying health care. Yet “[w]hen thousands of adults from across the country were given tests of basic math and basic literacy, a

¹⁴³ Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, *Health Literacy: Report of the Council on Scientific Affairs*, 281 JAMA 552, 552 (1999).

¹⁴⁴ Id.

¹⁴⁵ On the word and the problem, see John Allen Paulos, *Innumeracy: Mathematical Illiteracy and Its Consequences* (Hill and Wang, 2001).

¹⁴⁶ Judith H. Hibbard et al, *Consumer Competencies and the Use of Comparative Quality Information: It Isn't Just About Literacy*, 64 Med Care Res & Rev 379, 388 (2007).

¹⁴⁷ Id at 380.

¹⁴⁸ Id at 388.

¹⁴⁹ Lisa M. Schwartz et al, *The Role of Numeracy in Understanding the Benefit of Screening Mammography*, 127 Ann Intern Med 966, 966 (1997).

¹⁵⁰ Id.

significant portion of the population was unable to make the comparisons necessary to assess the cost of credit card debt.¹⁵¹

It is thus inevitable that one study “found that comprehending key differences between a CDHP and a conventional PPO was challenging for consumers, particularly those with lower numeracy.” They understood “less about the CDHP and reported having more difficulty understanding plan differences than those higher in numeracy; yet they were substantially more likely to select the CDHP.” The study’s authors suggest that “once enrolled, less numerate enrollees also may have more difficulty making the type of cost-effective decisions that CDHPs were developed to foster.”¹⁵²

In sum, anyone presenting information to consumers climbs a high barrier – many people read badly and cipher worse. Yet much health care information must be presented in writing and numbers, and much of it is inherently complex, dense, and obscure.

B. PRESENTATION

Now assume away literacy and numeracy problems. How well can information be presented? We begin by asking what consumers need to know about health plans. Consumers say they want to know about:

- (1) access (to chosen doctor, to specialists, length of time to get an appointment, ability to get care when needed, telephone access);
- (2) amount of paperwork; (3) benefits; (4) choice of provider (of doctors, of hospitals, ability to keep one’s own doctor);
- (5) communication/interpersonal skills/caring of provider;
- (6) convenience (of choosing doctor, getting care, location);
- (7) coordination of care; (8) costs; (9) courtesy and manner of physicians and staff; (10) hospital ratings; (11) good value for the money; (12) plan administrative hassles; and (13) quality (of care overall, of particular types of care, of providers).¹⁵³

Well, sure. Each item is reasonable, but the list is wickedly long and could easily be expanded. And most of the items comprise multiple elements. For example, “access” includes the “ability to get care when needed.” This in turn subsumes things like how the plan decides when a treatment is covered (an issue that provoked bitterness about and lawsuits over managed care). That issue, again in turn, is a fountain of questions about who decides what treatment is excluded on what grounds and how patients challenge exclusions.¹⁵⁴

All these things could – perhaps should – influence consumers’ choices. But consumers *cannot* mean what they say. They often ignore even simple disclosures. For example, Blue Cross of California posted plan enrollees’ ratings of hospitals’ costs. It used the Zagat method, “where ‘\$’ is assigned to

¹⁵¹ Block-Lieb and Janger, 84 Texas L Rev at 1538 (cited in note 75).

¹⁵² Jessica Greene et al, 14 Am J Managed Care at 374 (cited in note 26).

¹⁵³ Lubalin and Harris-Kojetin, 56 Med Care Res & Rev at 72 (cited in note 77).

¹⁵⁴ Worse, people’s view of the information they need for choosing a health care plan or treatment changes rapidly as they acquire information.

the lowest-cost hospitals and ‘\$\$\$\$’ to the highest.” Great idea. But “the plan discontinued this feature” for lack of use.¹⁵⁵

Wanting much but using little is normal. For example, patients fabulously over-estimate how much information they want in choosing treatments. In one large study, “[m]ost subjects (76.2%) responded that they would want to hear of *any* adverse effects [of a treatment], no matter how rare.” And 83% wanted to know about *any* “serious adverse effect, no matter how rare.”¹⁵⁶ Do people really want WebMD’s whole list of one drug’s side effects: excess stomach acid secretion, irritation of the stomach or intestines, nausea, vomiting, heartburn, stomach cramps, bronchospasm, stomach ulcers, intestinal ulcers, hepatitis, stomach or intestinal bleeding, inflammation of skin, redness of skin, itching, hives, rash, wheezing, trouble breathing, life-threatening allergic reaction, giant hives, rupture in the wall of the stomach or intestines, hemolytic anemia, large skin blotches, decreased blood platelets, decreased white blood cells, and decreased appetite? Will people still want the list when they learn that this alarming drug is Aspirin?

But suppose we winnow out the information that most helps consumers. How do we present it? Many have tried. Many have failed. For instance, California posted a sample charge master. But, Reinhardt concludes, “prospective patients would be hard put to make sense of these price lists.”¹⁵⁷ For another instance, “the Minnesota Health Data Institute distributed a 16-page, statewide report card that featured comparison tables and color-coded graphs of consumer satisfaction within categories of health plans and compared 38 plans based on 20 performance measures.” However, “less than half of those seeing the report thought it was helpful for deciding on a plan. Consumers found the report cards cumbersome, complex, and detailed.”¹⁵⁸

So why are report cards “cumbersome, complex, and detailed”? Why not just make them handy, straightforward, and simple? We again consult experience in related areas. Institutional review boards must approve all “human-subject” research, and they notoriously make informed consent their *summum*, perhaps *solum*, *bonum*. Commissions and commentators, researchers and institutional review boards, have long demanded handy, straightforward, and simple consent forms. Nevertheless, IRBs persistently insist on adding information to forms, and they can be tens of (repellent) pages long.

Why don’t IRBs practice what they preach? Partly because in a given case no one can deny that one more datum might be crucial to someone’s decision. As we saw, if you ask patients how much they want to know, they say “everything.” If patients think they “want to hear of any serious adverse effect, no matter how rare,”¹⁵⁹ the slippery slope to interminable disclosure is slick.¹⁶⁰

¹⁵⁵ Ginsburg, 26 Health Affairs at w213 (cited in note 55). This disclosure was also abandoned because it created “pressure for price increases from hospitals identified as low cost.” *Id.*

¹⁵⁶ Dewey K. Ziegler et al, *How Much Information About Adverse Effects of Medication Do Patients Want from Physicians?*, 161 Arch Intern Med 706, 708 (2001) (emphasis added).

¹⁵⁷ Reinhardt, 25 Health Affairs at 59 (cited in note 39).

¹⁵⁸ Judith H. Hibbard et al, *Informing Consumer Decisions in Health Care: Implications from Decision-Making Research*, 75 Milbank Q 395, 398 (1997).

¹⁵⁹ Ziegler et al, 161 Arch Intern Med at 708 (cited in note 156) (emphasis added).

And bad as the information problem has been when IRBs review research, the problem is worse when consumers choose plans and providers because much more information can be relevant. Research subjects are told the risks of one experiment; health care consumers may need any kind of treatment for any kind of ailment.

So with health care information, less is not more. But perversely, more is too much. First, who reads long forms?¹⁶¹ Second, the longer the form, the harder it is to understand. A “large body of empirical work suggest[s] that the integration of different types of information and values into a decision is a very difficult cognitive process.” For example, “people can process and use only a limited number of variables.” In one nifty study, Slovic asked expert handicappers to predict horse races using “from 5, 10, 20, and, later 40 variables.” The more information the experts had, the more confident they were. “However, predictive ability was as good with 5 variables as with 10, 20, or 40.” Worse, “reliability of the choices *decreased* as more information was made available. That is, when individuals had more information, their ability to use it ‘consistently’ declined.”¹⁶²

Not only does adding information not reliably improve and may impair understanding, it can *reduce* the amount of information people use. “An increase in the number of alternatives (three, six, and nine) being considered in this research has been shown also to increase the number of participants (21 percent, 31 percent, and 77 percent, respectively) who rely on elimination strategies . . . leading to a reduction in the amount of information used.”¹⁶³

The hopeless choice between less and more information pervades health care decisions. Plans are irreducibly complex – they either cover or exclude every human ailment. They allocate unpredictable costs among many players in elaborate ways. They are confusingly structured and mysteriously administered.¹⁶⁴

Even a single aspect of a single plan can be too complex to be explained to people of ordinary patience. For example, a notoriously upsetting feature of managed care is capitation – paying providers a fixed sum per year per patient. This creates an incentive to under-treat patients. Explaining why this may be sensible is an uphill battle, but that’s just the beginning, because “capitation” is exhaustingly complicated. Its effects are “mediated by such variables as size of the patient panel, amount of the capitation sum, refinement of risk adjustments, dollar value of stop-loss provisions, and scope of risk (does it extend, for example, to specialist referrals and drugs?), not to mention such relative intangibles as the force of professional ethics and fear of

¹⁶⁰ On the travails of IRBs with informed consent, see Simon Whitney and Carl E. Schneider, *The Stop of Truth: The Case Against the IRB System* (forthcoming).

¹⁶¹ Apparently this is an old problem. “According to the statutes of the university, every student before he is matriculated must subscribe his assent to the Thirty-nine Articles of the Church of England, which are signed by more than read them, and read by more than believe them.” Edward Gibbon, *The Autobiography of Edward Gibbon* 82 (Meridian Books, 1961).

¹⁶² Hibbard et al, 75 *Milbank Q* at 397–98 (cited in note 158) (emphasis added).

¹⁶³ Hanoach and Rice, 84 *Milbank Q* at 41 (cited in 82).

¹⁶⁴ The complexity to which health-insurance can descend is exemplified by Medicaid, a “horribly complicated law” that is “almost unintelligible to the uninitiated.” So unintelligible that “millions of eligible people are not enrolled.” Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 *Brooklyn L Rev* 453, 467–68 (2004).

malpractice suits.” So there “is no obvious informational middle ground between demonizing capitation and turning consumers into incipient health service researchers.”¹⁶⁵

One of us (Hall) tried to solve this problem with “extensive efforts at disclosure.” Even then, disclosing incentives had “limited or no impact on patient trust of physicians and health plans.” No wonder plan representatives said that disclosures “have been a ‘big yawn,’ ‘useless,’ and have not caused ‘even a ripple’ of a reaction. One large plan which, like others, invites members to call if they have questions or want additional information, received only two inquiries in the first two years.”¹⁶⁶

Complexity has another aspect. Consumers need baselines. You can rate the Ritz because you’ve stayed at the Marriott and the Hôtel Misère. But people know little and misunderstand much about health care and health care financing. Professor Sage is mild – “the American public is poorly informed about modern health care financing and delivery.”¹⁶⁷ People misperceive even their own coverage. “Previous research has indicated that consumers do not understand many of the key concepts of managed care; our study results indicate that this lack of understanding also applies to their own health plan.”¹⁶⁸ Although plan members’ “accuracy of reporting on some individual attributes was fairly high, fewer than one-third of respondents (30.3 percent) correctly reported all four attributes . . . [J]ust over half of respondents (56 percent) accurately reported both network attributes, while just under half (48.8 percent) accurately reported both gatekeeper attributes.”¹⁶⁹

This is not reprehensible; people have better things to do than become health care experts. Nevertheless, consumers lack “baseline information that could provide context for required disclosure,” and they therefore “can easily misinterpret even accurate data. In one example, potential enrollees regarded report card data showing high hospitalization rates of health plan enrollees for pneumonia as showing leniency in approving inpatient treatment rather than demonstrating failure to administer vaccinations.”¹⁷⁰

¹⁶⁵ Brown, 56 *Med Care Res & Rev* at 161 (cited in note 68) (footnotes omitted). “We can tell people whether we have a withhold, bonus payments or capitation,” remarked Paul Langevin, president of the New Jersey HMO Association, “but there are literally over 100,000 ways to pay, and these systems are very proprietary. And, quite frankly, the plans change them all the time.” *Id.*

¹⁶⁶ Mark A. Hall, *The Theory and Practice of Disclosing HMO Physician Incentives*, 65 *L & Contemp Prob* 207, 229 (2002). “Similarly, under the Medicare rules, regulators and plans reported that beneficiaries who are told that they have the right to request information about physician incentives rarely or never do so.” *Id.*

¹⁶⁷ William M. Sage, *Accountability Through Information: What the Health Care Industry Can Learn from Securities Regulation* 22 (Milbank Memorial Fund, 2000).

¹⁶⁸ Peter J. Cunningham et al, *Do Consumers Know How Their Health Plan Works?*, 20 *Health Affairs* 159, 165 (2001).

¹⁶⁹ *Id.* at 163. Another example: “approximately one-third of patients correctly identified their physicians’ payment method, one-third were incorrect, and one-third did not know.” Tracy E. Miller and Carol R. Horowitz, *Disclosing Doctors’ Incentives: Will Consumers Understand and Value the Information?*, 19 *Health Affairs* 149, 150 (2000) (describing Audrey C. Kao et al, *The Relationship Between Method of Physician Payment and Patient Trust*, 280 *JAMA* 1708 (1998)). Another study agreed that most patients know “little about how their health plan” compensates doctors. Anne G. Pereira and Steven D. Pearson, *Patient Attitudes Toward Physician Financial Incentives*, 161 *Arch Intern Med* 1313, 1316 (2001).

¹⁷⁰ Sage, *Accountability Through Information* 22 (cited in note 167).

In sum, consumers must learn forbiddingly much and make forbiddingly hard comparisons. This is why comprehensible report cards are so necessary, and so hard to write. We again consult similar problems in related areas. The “readability” of many kinds of mandated disclosures has been much studied, and the news is bad: It is almost impossible to put complicated information in written language that most people can understand. For example, two-thirds of the privacy disclosure forms academic medical centers used “were written beyond the 12th grade reading level, and almost the entire sample (90%) fell in the difficult range of reading ease.”¹⁷¹ A similar study of hospitals found the forms “beyond the reading capacity of the majority of American adults.”¹⁷² Even the model forms IRBs distribute are often well below IRBs’ own “readability standards.”¹⁷³

So, you say, if report cards are unreadable, make them readable. If language is complex, simplify it. If text is dense, prune it. If pages are dull, brighten them. But people have been trying to do exactly this for decades. Attempts to improve the information consumers receive about health insurance, like attempts to improve informed consent, have had some success, but not enough success to equip patients and consumers to make good decisions. For example, there were only “modest gains in Medicare-related knowledge” in both “a local and a national study.”¹⁷⁴ In short, nothing in the experience of mandated disclosure in other areas suggests that information about health plans can be presented to consumers in a way that will bring them up to consumerist standards. And nothing in the experience of telling consumers about health plans or patients about treatments suggests otherwise.¹⁷⁵

We have asked whether consumers will learn enough about their choices to select plans, providers, and treatments shrewdly enough to buy the best coverage, choose the best doctors and hospitals, select the thriftiest treatments, and thus help control health care costs. We have charted a long list of reasons consumers cannot find or understand the information they need. No doubt some progress can be made in some places in some ways. But strenuous efforts both in health care and in analogous areas have barely budged the meter, and we should not expect much better in any foreseeable future.

¹⁷¹ S. Walfish and K.M. Watkins, *Readability Level of Health Insurance Portability and Accountability Act Notices of Privacy Practices Utilized by Academic Medical Centers*, 28 Eval Health Prof 479, 479 (2005).

¹⁷² M.K. Paasche-Orlow et al, *Notices of Privacy Practices: A Survey of the Health Insurance Portability and Accountability Act of 1996 Documents Presented to Patients at US Hospitals*, 43 Med Care 558, 558 (2005).

¹⁷³ M.K. Paasche-Orlow et al, *Readability Standards for Informed-Consent Forms as Compared with Actual Readability*, 20 NEJM 348, 348 (2003).

¹⁷⁴ Lauren A. McCormack et al, *Measuring Beneficiary Knowledge in Two Randomized Experiments*, 23 Health Care Financing Rev 47, 60 (2001).

¹⁷⁵ On some of the barriers to success, see Michele Heisler, *Helping Your Patients With Chronic Disease: Effective Physician Approaches to Support Self-Management*, 8 Seminars Med Prac 43, 49 (2005); Kimberley Koons Woloshin et al, *Patients’ Interpretation of Qualitative Probability Statements*, 3 Arch Fam Med 961, 965 (1994).

C. *DEUS EX MACHINA*: EDUCATION

Consumerists defend consumerism by invoking the same “Great Solution” that will rescue us from so many other problems – education. If only patients can be taught more facts and more skills. As Kapp says, the champions of informed consent place “much faith . . . in . . . patients to comprehend and manage adequately the basic information needed to satisfy informed consent aspirations.” These tools include “more sophisticated decision aids in the form of information technology; the provision of written handouts to patients; presentation of information in qualitative, quantitative, and graphic formats, simplified to reach the lower literate patient; and the showing of videotapes.”¹⁷⁶

This is the triumph of hope over experience. Educating consumers to thrifty and intelligent choices has been part of the health care ethos for years. Yet the results are dispiriting. For example, a decade ago Medicare beneficiaries chose between a fee-for-service plan and managed care plans. When asked about their choice, “few” beneficiaries were well informed. Even those who used “multiple information sources . . . often . . . [had] less-than-adequate knowledge.”¹⁷⁷ Thirty percent knew almost nothing about HMOs. Thirty-one percent of HMO respondents and 30 percent of traditional Medicare respondents “failed to pass the screening questions and could not go on to take the knowledge test.”¹⁷⁸ Of those who passed the screening test, “only 16 percent had adequate knowledge . . . to choose between traditional Medicare and an HMO. More than 41 percent scored in the ‘inadequate’ range . . . [, and] 7 percent scored in the lowest quartile (equal to or worse than guessing).”¹⁷⁹ In short, these consumers knew far too little to make good choices. As Cunningham puts it, “A considerable body of evidence indicates that early efforts to educate consumers have not been very effective . . .”¹⁸⁰

What, though, of the tools Kapp lists? With skill and struggle, they can produce statistically significant improvements in understanding. But they have not brought and will not bring patients to *adequate* understanding. Take one vital consideration for consumers. Lubalin writes, “With appropriate education, over time consumers may begin to understand the role that plan structure plays relative to doctor performance in affecting their care and plan experiences.”¹⁸¹ But researchers have long striven to create that “appropriate education” – with dismal results. And see how cautious Lubalin is. This education will take time. All this education over time “may” teach consumers something, but that “something” is only “beginning” to understand the subject.

Consumers remain poorly informed, even about their own plans, even after extraordinary efforts to educate them. One study, for example, “surveyed adults a year after they were enrolled in a New York State pilot project aimed

¹⁷⁶ Marshall B. Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice*, 28 *J Legal Med* 91, 102 (2007).

¹⁷⁷ Judith H. Hibbard et al, *Can Medicare Beneficiaries Make Informed Choices?*, 17 *Health Affairs* 181, 190-91 (1998).

¹⁷⁸ *Id.* at 185.

¹⁷⁹ *Id.* at 186.

¹⁸⁰ Cunningham et al, 20 *Health Affairs* at 165 (cited in note 168).

¹⁸¹ Lubalin and Harris-Kojetin, 56 *Med Care Res & Rev* at 73 (cited in note 77).

at expanding health care coverage for the uninsured.” The five plans “made extensive efforts to educate enrollees about the plans,”¹⁸² including “individual in-person enrollment meetings, during which staff describe eligibility and benefits; brochures or videotapes; detailed enrollment contracts; question-and-answer documents in Spanish and English; and, at one plan, a required educational seminar.”¹⁸³ Nevertheless, “fewer than a third of enrollees could answer all three questions correctly; for four of the five plans, fewer than one-fifth could answer all three questions correctly.” Discouragingly, for example, “as few as 29.2 percent of respondents in Brooklyn understood that their plan covered out-of-area emergency care despite explicit wording in the Health Insurance Plan of Greater New York (HIP) handbook,” and except “in Manhattan, fewer than 42 percent of respondents knew that their plan limited their choice of hospitals.”¹⁸⁴

Nor do the lessons of related areas make education a convincing Great Solution. Informed consent may be the closest comparison, and decades of striving show that while skillfully created and energetically administered education can nudge up understanding, it regularly fails to prepare patients to make truly informed choices about complex issues. Nor has education worked wonderfully better in other areas in which consumers labor. For example, “investment education does not significantly change investment behavior among 401(k) plan participants.”¹⁸⁵

Another crucial point is regularly overlooked. Education is the Great Solution not just to this problem, but to many problems. People are daily admonished to become better consumers and be more responsible for more decisions in more areas. An ever-more complex world generates ever-more things to learn. Choices about even standard products proliferate.¹⁸⁶ Who, for example, can really buy a telephone? Corded? Wireless? Cellular? Internet? Which phone company, or cell phone company, or Internet company? Which manufacturer? Which bells? Which whistles? A camera? Internet? What’s cheapest? Most useful? Best? And what other questions are we too elderly to know about?

Consumers must do more than buy goods and services intelligently. For example, defined-contribution pensions oblige us to manage retirement accounts (and “privatizing” Social Security would exacerbate things nicely). Other financial issues proliferate, like handling debt.¹⁸⁷ And think of all the (often changing) lessons about health and safety everyone should learn. No

¹⁸² Deborah W. Garnick et al, *How Well Do Americans Understand Their Health Coverage?*, 12 *Health Affairs* 204, 206 (1993).

¹⁸³ *Id.* at 207.

¹⁸⁴ *Id.* at 209.

¹⁸⁵ Colleen E. Medill, *Challenging the Four “Truths” of Personal Social Security Accounts: Evidence From the World of 401(K) Plans*, 81 *NC L Rev* 901, 947-48 (2003). On the scant knowledge about Social Security benefits, see Ruth Helman et al, *Encouraging Workers to Save: The 2005 Retirement Confidence Survey*, 280 *EBRI Issue Brief* 1, 27 (2005).

¹⁸⁶ One literature suggests that people are happier and choose better when options are not too numerous. See e.g., Sheena S. Iyengar and Mark R. Lepper, *When Choice is Demotivating: Can One Desire Too Much of a Good Thing?*, 79 *J Personality & Social Psych* 995 (2000).

¹⁸⁷ These things are complicated enough that high schools now teach courses covering them. Alas, with dismal success. See Block-Lieb and Janger, 84 *Texas L Rev* at 1561 (cited in note 75).

wonder it has taken so many decades of so much effort to bring home the information that has gradually convinced many people not to smoke.

We are no enemies of education. Gladly would we learn, and gladly teach. But fifty professorial years have taught us that both teaching and learning are humbly difficult. This is a lesson consumerists seem not to have learned.

VI. ANALYZING INFORMATION

The human understanding is not a dry light, but is infused by desire and emotion, which give rise to 'wishful science'. For man prefers to believe what he wants to be true. He therefore rejects difficulties, being impatient of inquiry; sober things, because they restrict his hope; deeper parts of Nature, because of his superstition; the light of experience, because of his arrogance and pride, lest his mind should seem to concern itself with things mean and transitory; things that are strange and contrary to all expectation, because of common opinion.

Francis Bacon
Novum Organum

Again suppose away *all* the problems we've traversed. Imagine we have adequate choices. We have reliable information. We have selected the right information to present. We have decided how to present it. Doctors have cooperated. We have presented it. Consumers have received it. Consumers have understood it. We have at last reached the goal – consumers situated to choose health plans, providers, and treatments intelligently. How willingly and well will consumers do so?

On the whole, people reason less willingly and well than sound consumerist decisions require. This may conflict with ordinary intuitions. It certainly conflicts with consumerism's assumptions. But those intuitions and assumptions rest on misconceptions about human nature. In this section we criticize those misconceptions. Then we present evidence that people make unfamiliar decisions generally, and medical decisions particularly, less adroitly than consumerism requires.

A. HOMO ARBITER

Consumerism misconceives human nature. Understandably. Its misconceptions fit conventional intuitions about how people make decisions. Its misconceptions are shared by the field that treats the ethical problems of health care – bioethics. And its misconceptions underlie the law of mandated disclosure. Consumerism, bioethics, and much law rest on a plausible assumption and plausible inferences from the assumption about human nature. Both the assumption and the reasoning from it are partly correct. Nevertheless, they both fail in ways that mislead policy-makers and rule-writers.

The plausible assumption is that people demand “control.” The plausible inferences are that therefore people: (1) want to make all the decisions that could affect their lives, and (2) make those decisions skillfully. In other

words, consumerism, bioethics, and much law expect a world populated by *homo arbiter*, by people whose *raison d'être* is making decisions. *Homo arbiter* cherishes decisions, reaches out to make decisions, relishes decisions. There is obviously crucial truth in the assumption, the inferences, and even this view of human nature. But the truth is only partial and leaves out much in human nature that is necessary for establishing workable policies.

First, the assumption. "Control" matters. But most people don't want control of everything, at least if that means mastering difficult subjects to reach difficult conclusions. Control may be comforting, and impotence is misery. But people routinely acquiesce in decisions with relatively little information about them.

Next, the inferences. The first inference is that wanting control means wanting to tackle every decision in sight. But, ironically, seeking plenary control is inimical to enjoying the things that really matter to you. Complete control means making choices, and making choices well enough to achieve "control" is soul-sucking and time-absorbing. You can't exercise plenary control and still devote yourself to, as Freud put it, "work and love." Furthermore, who likes decisions? The drudgery of learning, the agonies of indecision, the risks of responsibility – these are charms cheerfully foregone.¹⁸⁸

The second inference is that people make decisions capably. Making good decisions is harshly harder than it looks. The process is less rational and less under our control than we think. Our decisions are driven by intuitions that are almost invisible to us. And "an enormous body of psychological evidence tells us that a person (such as you or I) has no reliable insight into the roots of his own intuition."¹⁸⁹ In fact, what seems like making a decision is often finding a rationale for a choice we have made unknowingly.

When we say people are less avid to make decisions and make them less well than consumerism hopes, we are easily misunderstood. Our meaning will become apparent as we show how consumers actually analyze purchases of health plans, providers, and treatments. However, two clarifications may avert misunderstandings. First, while people are reluctant to take on all kinds of dicey decisions, they certainly care what happens to themselves. Some choices almost everyone wants to make personally (marriage, for example), and some choices we make by individual preference. But people resist making many critical decisions, and often for excellent reasons.

Second, we are not saying that people rarely make good decisions. People manage their lives just fine because most decisions concern familiar subjects. When you make the same decision repeatedly you learn what your options are, see choices work out or fail, and practice making decisions more shrewdly. You build up reliable intuitions. Experience *is* a great teacher. But you lose all these advantages when you make unfamiliar decisions. And choosing health plans, providers, and medical treatments swamps you in the unfamiliar.

¹⁸⁸ Barry Schwartz, *The Paradox of Choice: Why More is Less* (HarperCollins, 2004), develops many of these points.

¹⁸⁹ Howard Margolis, *Dealing With Risk: Why the Public and the Experts Disagree on Environmental Issues* 33 (U Chicago Press, 1996).

B. LET THIS CUP . . .

If people refuse to ponder a choice, nobody can make them. And if people are reluctant to make a fully pondered choice, they won't collect and analyze information adequately. But unstudied and unanalyzed choices can be disastrous. Medical information is often elusive, obscure, unfamiliar, messy, and uncertain. If consumers do not energetically master this confusion, they cannot make well-founded purchases. They will not ferret out information, read it, grapple with it, survey alternatives, probe preferences, or bring themselves to a conclusion. Consumerism demands willing consumers.

Consumerism will only find them sporadically. In area after area of life, people say and show that they are less thirsty to choose than consumerists expect. Some of the richest evidence of this reluctance is in studies of a decision patients *must* make – the choice about medical treatments. We study this example in detail because if people don't seize treatment decisions, they are unlikely to seize other medical decisions.

The evidence that patients do not long to make medical decisions is compelling. One study can stand for many.¹⁹⁰ Ende and his colleagues concluded that “patients’ preferences for decision making in general were weak.” Where 0 meant no desire to make decisions and 100 meant an intense desire to do so, the mean score was 33. Worse, “as patients were asked to consider increasingly severe illnesses, their desires to make decisions themselves declined.”¹⁹¹

The example of medical decisions suggests why people yearn less for “control” than consumerists imagine. Patients have excellent reasons for accepting guidance, especially from experts. Illness corrodes the crafts and arts needed to learn novel and knotty things. Patients are exhausted, rattled, discouraged, harried, and hurried. They are absorbed by the problems of getting through the day that illness exacerbates and by the large questions about life that illness thrusts before them. Rarely can they spare time and attention to collect information thoroughly, assimilate it properly, and analyze it soundly. Rather, they turn with relief to people with expertise and experience for guidance.

People who avoid medical decisions should *a fortiori* resist choosing health plans. That choice turns on scaling mountains of daunting data. It requires anticipating unpredictable needs too dreadful to imagine. Medical decisions generally can be made with less information and more help than decisions about health plans. So who wants to choose a plan? We ourselves do not, and we have met only one person who might (maybe). And as all teachers know, unwilling learners are poor learners.

There is yet more evidence that people approach health care purchases diffidently. Decades ago, before widespread health insurance, patients had every reason to buy care carefully. Nevertheless,

¹⁹⁰ This reluctance to make medical decisions is discussed and defended in Schneider, *The Practice of Autonomy* (cited in note 20). Chapter 2 scrutinizes the empirical data with tiresome thoroughness.

¹⁹¹ Jack Ende et al, *Measuring Patient's Desire for Autonomy: Decision Making and Information-Seeking Preferences Among Medical Patients*, 4 *J Gen Intern Med* 23, 26-27 (1989).

few patients either knew or tried to discover whether their health care could be purchased at different prices; prices were never published or advertised. Patients generally had faith in their physicians and assumed the fees were fair and valid – whether or not they could afford to pay them. They obediently entered whatever hospital they were sent to and took their prescriptions to the pharmacy or provider that the physician suggested. Experience indicates that few patients, even those who complained about the costs, did any shopping around for better prices.¹⁹²

If consumers thought consumerism wonderfully advantageous, they might overcome their aversion to intimidating decisions. But “individuals with comprehensive health insurance were significantly more satisfied with their health plan than individuals” with consumer plans. They were “more likely than those with a [consumer plan] to report that they were extremely or very likely to recommend their health plan to a friend or coworker.” And people in consumer plans were “less likely than those with more comprehensive health insurance to report that they were likely to stay with their current plan if they had the opportunity to change plans.”¹⁹³

Furthermore, consumerist decisions almost invite evasion because they are both distressing and avoidable. Consumerism forces patients to (1) choose and (2) economize. But choosing is labor, and economizing is sacrifice. In addition, consumerism must convince people that health care costs them money. Making the flight of money out the door visible is not exhibiting something pleasant. Not only is assessing health care choices distasteful; it is delightfully easy to neglect. If you are working with a doctor, follow the doctor’s advice. If you are choosing a health plan, select one or two plan attributes and rest your decision on them. Or just follow your colleagues’ lead. Check a box. File and forget.

We said earlier that if people don’t want to make decisions, they won’t make them well. There is direct evidence that in making medical choices people do not do the things they themselves say they need to do. People acknowledge that information is crucial: even the same studies that say patients are reluctant to make medical decisions say that patients want information. For example, in the Ende study, “the mean score for information seeking was [on the 0-to-100 scale] 79.5 ffl 11.5.”¹⁹⁴

But while consumers insist that they want loads of information, they shrug most of it off. For example, only about half of the people in consumerist plans “indicated that they had made use of the information about quality and cost of their doctors” and “had tried to use information on the quality of hospitals.”¹⁹⁵ For another example, a national study of Medicare beneficiaries

¹⁹² Benson B. Roe, *The UCR Boondoggle: A Death Knell for Private Practice?*, 305 NEJM 41, 43 (1981). And twenty years ago Judith H. Hibbard and Edward C. Weeks, *Consumerism in Health Care: Prevalence and Predictors*, 25 Med Care 1019 (1987), questioned whether patients would be willing to be consumers.

¹⁹³ Fronstin and Collins, 315 EBRI Issue Brief at 15 (cited in note 23).

¹⁹⁴ Ende et al, 4 J Gen Intern Med at 26 (cited in note 191). This remarkable contrast between an information score of 80 and a participation score of 33 is typical.

¹⁹⁵ Fronstin and Collins, 315 EBRI Issue Brief at 29 (cited in note 23).

who had undergone high-risk surgery (abdominal-aneurysm repair, heart-valve replacement, or resection of the bladder, lung or stomach for cancer) reported that only “10% of respondents seriously considered going elsewhere for surgery. Few respondents (11%) looked for information to compare hospitals. Almost all respondents thought their hospital and surgeon had good reputations (94% and 88%, respectively)”¹⁹⁶

The theory of consumerism is that people will shop for the best combination of cost and quality. But the evidence suggests that quality tends to get ignored in decisions. “Literature suggests that patients do not engage in rational or ‘consumerist’ behavior when searching for or choosing physicians. They instead rely heavily on recommendations from family and friends and engage in limited searches for alternative physicians”¹⁹⁷ The Harris study “confirm[ed] the image depicted in the previous literature of patients as passive consumers of physician services” and concluded “that, in the current market, physicians do not have to compete to maintain the loyalty of established patients.”¹⁹⁸ Similarly, a recent study found that “[f]ew of the consumers who needed new providers reported using either price or quality information in choosing those providers”¹⁹⁹

One reason that people underuse quality information is (as we said earlier) that people do not realize how wide the range of quality can be. Another is that people are not competent to evaluate quality and thus base choices on things they can evaluate. Thus when focus groups were asked what they looked for in a doctor, the “majority of responses focused on the interpersonal aspects of care - communication, respect, and caring.” Those aspects of care are surely crucial. But people do not seem to have made a considered decision that those aspects are the *only* crucial ones: when “a cogent framework was used to present quality information,” the group members “changed their minds about what was important in selecting health plans and providers and indicated a desire to use indicators of evidence-based care when making health care choices.”²⁰⁰

We have presented evidence that people make medical choices less willingly than consumerism assumes and needs. That evidence is confirmed by evidence that people avoid other consequential decisions. For example, in financial planning, “passive decision-making” is the norm. “[M]any households appear to passively accept the status quo.”²⁰¹ Thus, companies that used different default choices for employee contributions to retirement plans found employees simply sticking with whatever position they had been assigned.

¹⁹⁶ Lisa M. Schwartz et al, *How Do Elderly Patients Decide Where to Go for Major Surgery?*, 331 *BMJ* 821, 821 (2005).

¹⁹⁷ Katherine M. Harris, *How Do Patients Choose Physicians? Evidence from a National Survey of Enrollees in Employment-Related Health Plans*, 38 *Health Services Res* 711, 712 (2003).

¹⁹⁸ *Id.* at 729.

¹⁹⁹ Ha T. Tu and Johanna R. Lauer, *Word of Mouth and Physician Referrals Still Drive Health Care Provider Choice*, 9 *Center Studying Health System Change* 1, 5 (2008).

²⁰⁰ Judith Hibbard and L. Gregory Pawlson, *Why Not Give Consumers a Framework for Understanding Quality?*, 30 *Joint Commission Journal Quality & Safety* 347, 349 (2004).

²⁰¹ James J. Choi et al, *Defined Contribution Pensions: Plan Rules, Participant Choices, and the Path of Least Resistance*, prepared for *Tax Policy and the Economy* 32 (2001).

Retirement planning provides a close and fruitful comparison to buying health-care plans. The former is relatively easy, since most people are too poor to have elaborate investment choices and need only a few simple principles – like “diversify!” – that are ceaselessly repeated everywhere. Nevertheless, many people have not even tried to plan for their retirement. “Only 42 percent of workers report they and/or their spouse have *tried* to calculate how much money they will need to have saved by the time they retire so that they can live comfortably in retirement.”²⁰² Gloriously unrealistic expectations about retirement abound. For example, “[t]wo-thirds of workers say they expect to work for pay after they retire (66 percent). . . . However, just one-quarter of retirees report having actually worked for pay at some time during their retirement. . . .”²⁰³

Furthermore, many people misunderstand the most basic facts and principles of retirement investing. A “1995 survey by John Hancock Financial Services found that a majority of respondents thought money market funds were riskier than government bonds, and felt that their own company stock was safer than a diversified portfolio.”²⁰⁴ People often invest in notoriously perilous ways. For example, people who can buy company stock for retirement accounts allocate “nearly 42 percent of the assets [to it], more than any other type of investment,”²⁰⁵ thus dangerously flouting the “diversify!” principle (think Enron). Nevertheless, “investors often do not recognize how difficult these choices are and instead rely on a belief that their innate abilities will lead to a good investment result.”²⁰⁶ (Human self-confidence is marvelous to behold.)

In sum, consumerism needs willing consumers, but *many* people are generally unengaged consumers who resist making decisions in the full-throated way consumerism assumes. And many people are unengaged health-plan consumers. Brown writes wryly: “The public is not running to government demanding longer lists of plans and therewith more chances to ask more probing questions, sift more information, and wage a more valiant inner struggle against their suspicions of purchasers, plans, and providers.”²⁰⁷

This should not seem strange when we think more attentively about how people actually live their lives. What people most fundamentally want is not so much “control” as doing the things that are important to them – working at rewarding jobs with congenial colleagues, spending time with the people they love and like, enjoying their leisure, and so on. People have better things to do than make risky decisions about alarming subjects which require burdensome

²⁰² Ruth Helman et al, 280 EBRI Issue Brief at 6 (cited in note 185).

²⁰³ Id at 25.

²⁰⁴ Shlomo Benartzi and Richard H. Thaler, *Naive Diversification Strategies in Defined Contribution Saving Plans*, 91 Am Econ Rev 79, 79 (2001).

²⁰⁵ Id at 95. “Perhaps the most disturbing aspect of 401(k) participants’ asset allocation choices is the large fraction of balances invested in employer stock. . . . For firms that offer company stock in their plans . . . about 33 percent of plan assets are held in this asset class.” Choi et al, *Defined Contribution Pensions* at 27 (cited in note 201). Investing heavily in your employer’s stock flouts the diversification principle, partly because you already rely on your employer for your economic welfare. (The consequences are sadly shown by the fate of the Enron employees whose pensions were invested in Enron stock).

²⁰⁶ Stephen J. Choi and A.C. Pritchard, *Behavioral Economics and the SEC*, 56 Stanford L Rev 1, 12 (2003).

²⁰⁷ Brown, 56 Med Care Res & Rev at 151 (cited in note 68).

work with scant visible reward. Furthermore, if people really tried to make independent decisions about everything in their lives, they'd do little else. Who wants to live in a world in which everybody must choose everything about everything? So, we are increasingly freed from paternalism, for we have proliferating choices about proliferating things, but we are increasingly prisoners of the need to learn enough to handle decisions that we make badly, that we would like to escape, and that divert us from things we would rather devote ourselves to. Getting and spending we truly lay waste our powers.

This doesn't mean, of course, that people want or expect to avoid choices altogether. But people confide themselves to experts (like doctors, of course). They hope (and they expect) that they will be protected against disaster, that they will not be offered dangerous options. They expect doctors to lead them to medical prudence. They expect employers to offer them safe pensions. They expect credit card terms to be fair. They expect cars to be safe. They expect to be offered safe mortgages.

So too with health plans, providers, and treatments. As Brown rightly says, people want "assurance that the plans they choose will not treat them badly and that some accountable body puts consumers' protection high on its agenda."²⁰⁸ When people's expectations are disappointed, they want action. Brown describes a common pattern. "[C]hoice' – process, symbol, theoretical linchpin of market visions – is now ubiquitous" in health policy. But it

is also richly ambiguous. Talk about "protecting and promoting consumer choice" often means two different things, namely, ensuring that consumers have the power to make appropriately abundant choices and ensuring that the products (health plans and providers) from among which consumers choose are safe and reliable. The first meaning expands the range of choices, depends on consumers to shop and buy prudently, and invigorates the market. The second eliminates harmful choices, invokes regulation to protect consumers, and expects government to police and discipline the market.²⁰⁹

So "health policy debates tend to start out with hearty affirmations of the first version of choice, only to discover that many problems beset its realization. Reformers then look to the second set of connotations to discern the protections consumers need in order to reap the benefits of expanded choice"²¹⁰ But this reduces the range of choice and drives up costs.

So people want what they can't have. They want choice when they want it, but they want protection against over-reaching vendors and improvident decisions. They want cheap mortgages, but they want to be rescued when the terms that made the mortgages cheap backfire. They want "that consoling plenitude of option in which modern satisfaction really consists."²¹¹ But they expect that all their options will be good ones. This is not wicked; it is human. But it bodes ill for the consumerist vision of the vigilant, vigorous, and victorious consumer.

²⁰⁸ Id.

²⁰⁹ Id at 145.

²¹⁰ Id at 146.

²¹¹ Philip Rieff, *The Triumph of The Therapeutic: Uses of Faith After Freud* 26 (Harper & Row, 1966).

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We have argued that consumerism specifically and the law of mandated disclosure generally rest on the *homo arbiter* misconception of human nature. *Homo arbiter* makes decisions willingly and well. But people are less ardent and attentive consumers than that. How well then, do people reason their way through the decisions consumerism presents?

In their normal lives, in their normal spheres, normal people normally make normal decisions adeptly. But weighing health plans, providers, and treatments is not a normal activity (except to some extent for the chronically ill). A lovely literature now catalogs the ways people working outside their normal spheres disserve their goals. That people choose crudely and clumsily does not, of course, mean that they should not be allowed to choose. But it has consequences for consumerism's prospects and for pressuring people into making consumerist decisions.

What, then, would it take for people to pick plans, providers, and treatments as shrewdly as consumerism demands? The standard formula for medical decisions is that people should "critically assess their own values and preferences; determine whether they are desirable; affirm, upon reflection, these values as ones that should justify their actions; and then be free to initiate action to realize the values."²¹² This placidly hides a maelstrom of problems.

A scholar of medical decisions wrote years ago that "the stresses of making major decisions and the various ways people deal with those stresses . . . frequently result in defective forms of problem solving that fail to meet the standards of rational decision making."²¹³ Since then, psychologists have ingeniously shown how strangely we all perceive and parse the world. A new subfield – behavioral economics – incorporates into traditional economics this revised view. People are not the utility maximizers of traditional economics. Because they have limited resources for making decisions, people do not even try to make optimal ones. They "satisfice." They take shortcuts in getting and using information; they settle for the adequate instead of the best. Satisficing and shortcuts usually, well, satisfice. However, "[s]ome of these shortcuts systematically color and bias the decisions that individuals reach . . ."²¹⁴ And the more exotic, arcane, and momentous a decision, the worse satisficing is. Consumerist decisions often are exotic, arcane, and momentous. Satisficing may not suffice.²¹⁵

²¹² Arthur L. Caplan, *Informed Consent and Provider/Patient Relationships in Rehabilitation Medicine*, in *If I Were a Rich Man Could I Buy a Pancreas? and Other Essays on the Ethics of Health Care* 245 (Indiana U Press, 1992).

²¹³ Irving L. Janis, *The Patient as Decision Maker*, in W. Doyle Gentry, ed, *Handbook of Behavioral Medicine* 326, 333 (Guilford, 1984).

²¹⁴ *Id.* at 1531.

²¹⁵ The vast literature on the sadly abundant defects in human reasoning is still well described in two classics: Richard Nisbett & Lee Ross, *Human Inference: Strategies and Shortcomings of Social Judgment* (Prentice-Hall, 1980); Daniel Kahneman et al, *Judgment Under Uncertainty: Heuristics and Biases* (Cambridge U Press, 1982). A more recent summary of evidence that was written for lawyers is Paul Slovic, *Rational Actors and Rational Fools: The Influence of Affect on Judgment and Decision-Making*, 6 *Roger Williams U L Rev* 163 (2000). Daniel Gilbert, *Stumbling on Happiness* (Alfred A. Knopf, 2006), surveys the issues with welcome wit. Barak Richman, *Behavioral Economics and Health Policy: Understanding Medicaid's Failure*, 90 *Cornell L Rev* 705 (2005), applies the literature to

A sampling suggests the gravity of these problems. The standard formula for making medical decisions assumes consumers *have* preferences. Not just preferences – “a set of preferences which are clearly-defined, well-understood, and rank-ordered so that people can make logical tradeoffs among them.”²¹⁶ But, as Slovic warns, preferences are not “simply read off some master list.” We have no set of pre-formed preferences for all occasions. More than we know or like, we create preferences as we go along, preferences shaped by the very process of decision. As Slovic explains, “Preferences appear to be remarkably labile” and “are often constructed – not merely revealed – in the elicitation process.”²¹⁷

So as Hibbard puts it, “individuals may not have existing preferences or beliefs about self-interest, but, rather, construct them in the process of deciding.” This is particularly true of “choices among options that are important, complex, and unfamiliar, like those consumers face in the current health care environment.”²¹⁸ Thus while consumers *do* have preferences about familiar purchases, “it appears that . . . medical care consumers have no well-formed preferences.”²¹⁹ No wonder: Few of us have worked out *any* beliefs so systematically, much less beliefs about things both distant and dreadful.

Evidence of people’s inchoate and unsettled preferences is that people’s choices about even momentous medical topics are unstable. For example, in a group of chronically ill elderly patients, “preferences for potentially life-sustaining treatment, assessed in terms of participants’ willingness to endure high-burden treatment for a given chance to avoid death or risk disability to avoid death, were frequently inconsistent. Many participants became more and then less willing (or vice versa) over time to undergo future high-burden therapy or to risk severe disability.”²²⁰ A famous study investigated a natural-childbirth class. It had well worked-out beliefs about anesthesia and pain, but at “the beginning of active labor . . . there was a shift in the preference toward avoiding labor pains.” But “the mothers’ preferences shifted again at postpartum toward avoiding the use of anesthesia during the delivery of her next child.”²²¹

Instability affects choices of health plans too. Buying insurance requires imagining how you will feel about possible futures. Not only do “focus group studies with health care consumers suggest that preferences are not stable,”

health care policy. Block-Lieb and Janger, 84 *Texas L Rev* 1481 (cited in note 75), applies this literature to a problem with important parallels to the consumerism question. Howard Margolis, *Dealing With Risk: Why the Public and the Experts Disagree on Environmental Issues* 33 (cited in note 189), applies the literature to a broader set of issues.

²¹⁶ Lee Clarke, *Context Dependency and Risk Decision Making*, in James F. Short, Jr., and Lee Clarke, *Organizations, Uncertainties and Risk* 28 (Westview, 1992).

²¹⁷ Paul Slovic, *The Construction of Preference*, 50 *Am Psychologist* 364, 365 (1995).

²¹⁸ Hibbard et al, 75 *Milbank Q* at 402 (cited in note 158).

²¹⁹ Frank A. Sloan, *Arrow’s Concept of the Health Care Consumer: A Forty-Year Retrospective*, 26 *J Health Politics, Policy & L* 899, 899 (October 2001).

²²⁰ Terri R. Fried et al, *Inconsistency Over Time in the Preferences of Older Persons with Advanced Illness for Life-Sustaining Treatment*, 55 *J Am Geriatrics Society* 1007, 1010 (2007). Angela Fagerlin and Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 *Hastings Center Rep* 30, 33 (March/April 2004), reviews the literature on the instability of patient’s preferences.

²²¹ Fagerlin and Schneider, 34 *Hastings Center Rep* at 33 (cited in note 220) (quoting J. J. Christensen-Szalanski, *Discount Functions and the Measurement of Patients’ Values: Women’s Decisions during Childbirth*, 4 *Med Decision Making* 47 (1984)).

but “preference shifts have been observed even within the time frame of a focus group”²²²

Satisficing is risky for other reasons. People succumb to a cavalcade of well-studied failures in perception, anticipation, and reasoning. Several examples: First, the “availability heuristic” leads people to over-estimate the likelihood of memorable and under-estimate the likelihood of mundane occurrences. Second, people’s reasoning is skewed by the “anchoring heuristic,” by having a starting point, however arbitrary. For example, estimates of an item’s cost are changed by giving people an arbitrary number – like the last two digits of their Social Security number. Third, people are notoriously influenced by the way choices are “framed.” For instance, treatment looks better if described in terms of its chance of success rather than its chance of failure (even though both statistics describe the same likelihood). Fourth, once people have made up their minds, they ingeniously interpret new evidence – however damning – as confirming their choice. Fifth, despite all these infirmities, people are invincibly confident that they make good decisions. “Doth any man doubt, that if there were taken out of men’s minds vain opinions, flattering hopes, false valuations, imaginations as one would, and the like, but it would leave the minds of a number of men poor shrunken things, full of melancholy and indisposition, and unpleasing to themselves?”²²³

Decisions are distorted more oddly. Decisions turn on how people expect to respond in possible futures, but people chronically mispredict those responses. This is the problem of hedonic forecasting, about which a bemusing literature is blooming. People mispredict even mundane feelings, mispredict what they will want and how they will like what they get. They mispredict which snacks they will prefer over the next three weeks, how happy election results will make them, how much happier living in California instead of Michigan will make them, how much criticism will wound them, and how painful visiting dentists and other tormenters will be.²²⁴ Predicting reactions to insurance coverage, providers, illness, and treatment is surely harder.²²⁵

We all suffer these defects in reasoning, although experience making a decision moderates them. This suggests another concern. It takes intelligence, sometimes much intelligence, to make sense of what you are learning, organize it in your mind, anticipate your future, and dissect your choices. “[I]ntelligence is manifested in generic thinking skills such as efficient learning, reasoning, problem solving, and abstract thinking. High intelligence is a useful tool in any life domain, but especially when tasks are novel, untutored, or complex and situations are ambiguous, changing, or unpredictable.”²²⁶ Medical decisions fit that description, and “being a patient requires the same cognitive skills that . . . most jobs require for good

²²² Ellen Peters et al, *Less Is More In Presenting Quality Information To Consumers*, 64 *Med Care Res & Rev* 169, 170 (2007).

²²³ Francis Bacon, *Of Truth*, in *The Essays* 61 (Penguin, 1985).

²²⁴ Garrison and Schneider, *The Law of Bioethics* at 306-307 (cited in note 27), reviews this research.

²²⁵ For fascinating applications of these ideas to medical situations, see Peter Ubel, *You’re Stronger Than You Think* (McGraw-Hill, 2006).

²²⁶ Linda S. Gottfredson & Ian J. Deary, *Intelligence Predicts Health and Longevity, But Why?*, 13 *Current Directions Psych Sci* 1, 2 (2004).

performance: efficient learning, reasoning, and problem solving.”²²⁷ Many people lack the intellectual skills needed to choose unfamiliar things well, since even people rich in intellectual advantage flinch and fail in making health care choices.

People, in sum, do not select plans, providers, and treatments in the methodical, meticulous way consumerism intends. They do not use the full range of relevant information, or evaluate information meticulously, or scrutinize their preferences. One way we know this is that people often choose so rapidly that they *cannot* be surveying, assessing, and weighing options. In one typical study, almost two-thirds of kidney donors made “an immediate choice.” They “*volunteer[ed] immediately upon hearing of the need* without any time delay or any period of deliberation, and they themselves regard their choice as no decision at all.” Only “25% of the donors . . . seem to have approximated a classical decision-making pattern,” since they “had done some *deliberating* and weighing of costs and gains.”²²⁸

How can people treat serious things so brusquely? They almost must: “Making trade-offs to integrate conflicting dimensions into an overall choice is such a complex cognitive task that people tend to use heuristic shortcuts that may not produce optimal decisions. These simplified strategies include selecting only one dimension and ignoring others or focusing on concrete, easy to understand concepts such as cost rather than more complicated and less precise factors such as quality indicators”²²⁹ The more overwhelming a decision seems, the likelier radical shortcuts are taken.²³⁰

For example, patients often base even classically controversial decisions on a single factor. Thus, one illuminating study of breast cancer patients concluded that the leading “influence on decision-making behavior” was “perceived salience.” In other words, one aspect of the treatment determined the whole decision. These patients “did not report conflict about what course to take or the need for further information or deliberation.”²³¹ Schneider observed “similarly truncated courses of decision” in prospective dialysis patients. They listened “until they heard some arresting fact and then based their decision on it. For instance, as soon as some patients hear that hemodialysis requires inserting two large needles into an arm thrice weekly, they opt for whatever the alternative is. When some other patients hear peritoneal dialysis means having a tube protruding from their abdomen, they choose ‘the other kind of dialysis.’”²³²

Snap decisions are not confined to treatment choices; health plans seem often to be similarly chosen. Consider this powerful *a fortiori* example. Hibbard et al. say that even employers’ health care specialists make decisions poorly. “Half of the purchasers in our survey thought that it was difficult or

²²⁷ Linda S. Gottfredson, *Intelligence: Is It the Epidemiologists’ Elusive “Fundamental Cause” of Social Class Inequalities in Health*, 86 J Personality & Social Psych 174, 175 (2004).

²²⁸ Roberta G. Simmons, et al, *Gift of Life: The Social and Psychological Impact of Organ Transplantation* 241 (Transaction Books, 1987) (emphasis in original).

²²⁹ Lubalin and Harris-Kojetin, 56 Med Care Res & Rev at 88 (cited in 77).

²³⁰ Hanoch and Rice, 84 Milbank Q at 41 (cited in note 163).

²³¹ Penny F. Pierce, *Deciding on Breast Cancer Treatment: A Description of Decision Behavior*, 42 Nursing Res 20, 23 (1993).

²³² Schneider, *The Practice of Autonomy* 94-95 (cited in note 20). For an extended development of these points, see id at 92-99.

very difficult to bring all of the variables together into a decision.”²³³ Only about a fifth used “some kind of system for making trade-offs and identifying high-performing, cost-effective plans,” and the “system” could be as primitive as a four-cell matrix.²³⁴ “Twelve percent reported that they made their choices on the basis of a single dimension such as cost or geographic access.”²³⁵ Purchasers depended on inferior information about hospital quality. They used the best information (outcomes data) only about a quarter of the time it was available, for example.²³⁶ “Purchasers do not always understand the intent of the quality indicators and do not always interpret them correctly.”²³⁷ If this is how professionals fare, what hope for us amateurs?

Again, this is characteristic of how people operate in other contexts. For example, loan terms differ scarily, but “the basic rule of thumb for borrowing seems to be: ‘Can I afford the monthly payment?’” This simplifies choice, but it obviates “any calculation or awareness of the cost of credit. It also obscures any comparison between the cost of credit and the cost of paying . . . out of savings, and any comparison of competing credit offers. Most importantly, it renders disclosure of APR and related credit terms interesting but irrelevant.”²³⁸

Ultimately, what matters is whether patients can choose plans, providers, and treatments with the combination of quality and cost that best suits them and thus helps restrain medical costs. Can they? Consumerism sometimes produces some of its intended effects in some ways in some measure. Patients with less insurance and patients spending their own money behave differently from patients spending insurance money. Fronstin and Collins report that 60 to 74 percent of people enrolled in consumerist plans strongly or somewhat agreed that the terms of their health plans made them consider costs when deciding to see a doctor when sick or fill a prescription. By comparison, “fewer than half (47 percent) of those in more comprehensive plans felt this way” Similarly, sixty percent of those enrolled in consumerist plans said that they had checked whether their health plan would cover their costs prior to receiving care, while 50 percent “of those in comprehensive plans had checked whether their plans would cover care” and 21 percent had checked the price of a service.²³⁹ While this suggests that consumerism can change people’s behavior, it is far from showing that enough people “consider costs” regularly enough and correctly enough to reduce costs significantly without impairing patients’ health.

But do patients economize undesirably? There is *some* encouraging news on this front. Almost two decades ago, the RAND experiment found that “reduced service use under the cost-sharing plans had little or no net adverse effect on health for the average person”²⁴⁰ However, that experiment’s

²³³ Judith H. Hibbard et al, *Choosing a Health Plan: Do Large Employers Use the Data?*, 16 *Health Affairs* 172, 177 (1997).

²³⁴ *Id.* at 177.

²³⁵ *Id.*

²³⁶ *Id.* at 175.

²³⁷ *Id.* at 179.

²³⁸ Block-Lieb and Janger, 84 *Texas L. Rev.* at 1539 (cited in note 75).

²³⁹ Fronstin and Collins, 315 *EBRI Issue Brief* at 33, 40 (cited in note 23).

²⁴⁰ Joseph P. Newhouse, *Free For All?: Lessons from the Rand Health Insurance Experiment* 339 (Harvard U Press, 1993).

deductibles were lower than the upper range of deductibles today (inflation-adjusted, around \$2500-3000). And crucially, “[h]ealth among the sick poor — approximately the most disadvantaged 5 percent of the population — was adversely affected”²⁴¹

There is also disquieting evidence about how well patients negotiate between underuse and wasteful use of medical care. For example, a recent attempt “to assess whether CDHP enrollees are more likely to make cost-effective, evidence-based care choices than those who are enrolled in a PPO” similarly found “that enrollment in CDHPs resulted in a reduction of both high-priority and low-priority care (cost-effective and less cost-effective care).”²⁴² Distinguishing between the two is difficult. Consider one kind of under-use — postponing consultation with a doctor. People often do so unwisely and expensively. “Over 30 percent of cancer patients . . . postpone seeking a diagnosis for three or more months after they first notice growths or other symptoms that they know could be danger signs.”²⁴³ Many people having heart attacks delay calling a doctor for four or five hours because “the decision making process gets jammed by the patient’s inability to admit that he is mortally sick.”²⁴⁴

Some of the problem is medical ignorance, but only some. For example, people who know cancer’s danger signs are *likelier* to postpone seeing a physician than people who do not.²⁴⁵ Cost deters some patients from seeking care, but again this is not the whole story. Over one-third of the English families with free health care had a member who was “suffering from pain or discomfort but was not receiving medical treatment.”²⁴⁶ Much of the story is fear, which can lead to seeking care both too aggressively and too timidly. As one man ruefully wrote, “In full health, I imagine minor ailments to be dangerous symptoms, or else, from fear, ignore them away. I do not submit routinely to preventive medicine. What may it not show up?”²⁴⁷

Most significantly, there is plentiful evidence that cost pressure on patients can lead them to damaging economies. For example, “incentive-based formularies are associated with lower costs and smaller increases in drug utilization and expenditures compared with control groups.” However, those formularies are also “associated with undesirable effects.” Patients confronted “with higher copayments are more likely to switch medications or to discontinue medications entirely. Moreover, studies have found that cost sharing may be followed by reductions in the use of ‘essential’ drugs, higher rates of serious adverse events, and increased use of emergency department visits and hospital days.”²⁴⁸

²⁴¹ Id.

²⁴² Judith H. Hibbard et al, *Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?*, 65 *Medical Care Research and Review* 437, 445 (2008).

²⁴³ Irving L. Janis and Leon Mann, *Decision Making: A Psychological Analysis of Conflict, Choice, and Commitment* 230 (Free Press, 1977).

²⁴⁴ T.P. Hackett and N.H. Cassem, *Psychological Management of the Myocardial Infarction Patient*, 1 *J Human Stress* 25, 27 (1975).

²⁴⁵ This is long established. See, e.g., B. Kutner et al, *Delay in the Diagnosis and Treatment of Cancer: A Critical Analysis of the Literature*, 7 *J Chronic Diseases* 95 (1958).

²⁴⁶ Janis and Mann, *Decision Making* at 230 (cited in note 243).

²⁴⁷ Richard P. Brickner, *My Second Twenty Years: An Unexpected Life* 197 (Basic Books, 1976).

²⁴⁸ Peter J. Neumann et al, 12 *Am J Managed Care* at 30 (cited in note 41).

One study of Medicare+Choice beneficiaries is typical and telling enough to be described in block quotes:

[L]imits on drug benefits had consistently negative consequences. Beneficiaries whose benefits were capped used fewer prescription drugs overall and fewer drugs for the treatment of chronic diseases than those whose benefits were not capped. The differences in consumption between beneficiaries with and those without caps on their benefits were substantially larger during the months after the subjects exceeded the cap than during earlier months. . . . Overall, subjects whose benefits were capped had higher rates of non-elective hospitalizations, visits to the emergency department, and death. In addition, subjects whose benefits were capped had lower pharmacy costs but higher hospital and emergency department costs, with no significant difference in total medical costs between the two groups.²⁴⁹

These findings were

consistent with those of previous survey-based studies. Nearly a third of Medicare beneficiaries reported taking fewer drugs than were prescribed in order to save money, and less generous drug benefits were associated with lower rates of drug adherence. In non-Medicare, low-income populations, drug limits increased nursing home admissions. High patient cost-sharing levels in Canada were associated with a lower rate of use of essential drugs and higher rates of visits to the emergency department and hospitalizations. The lack of any drug coverage has been associated with poor outcomes.²⁵⁰

Rice and Matsuoka summarize the literature similarly: “Nearly all of the 22 relevant studies examined that have been published since 1990 – 16 focusing on cost-sharing for prescription drugs and 6 on cost-sharing for medical services – conclude that increased cost-sharing reduces either or both the [appropriate] utilization and health status of seniors.”²⁵¹

Are these patients simply too poor to buy all the care they need? Or are they economizing improvidently? Surely both. But given such hard decisions, it would be surprising if the latter answer did not explain a good deal.

We have asked how well even knowledgeable consumers make decisions. Contemporary scholarship finds a festival of ways people stumble in making decisions. This is true, but it is easily misunderstood. So, three reminders. First, we are *not* saying that nobody ever makes good decisions. We are saying that people have trouble with unfamiliar and complex choices, like selecting health plans, providers, and treatments.

Second, we are *not* implying that people’s decisional reluctance justifies usurping their decisional authority. On the contrary, we are evaluating a

²⁴⁹ John Hsu et al, *Unintended Consequences of Caps on Medicare Drug Benefits*, 354 NEJM 2349, 2356 (2006).

²⁵⁰ Id at 2356-2357.

²⁵¹ Thomas Rice & K.Y. Matsuoka, *The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors*, 61 Med Care Res & Rev 415, 415 (2004).

program – consumerism – intended to compel people to make decisions willy-nilly.

Third, consumerism, like the law of mandated disclosure generally, is misled by its *homo arbiter* model of human nature. That model assumes that people want to make all the decisions that affect their lives and that they will be motivated and able to make those decisions well. Both assumptions contain important truth and important misconceptions. Many people will shrug off the burden consumerism would impose on them. We all have trouble making many of those decisions well and with a good chance of reaching results that serve our own goals. And that sets consumerism on an uphill road.

VII. CONCLUSION

Of course, this is a somewhat vague conclusion. But in a question of significance, of worth, like this, conclusions can never be precise. The answer of appreciation, of sentiment, is always a more or a less, a balance struck by sympathy, insight, and good will. But it is an answer, all the same, a real conclusion. And in the course of getting it, it seems to me that our eyes have been opened to many important things.

William James
What Makes a Life Significant

A. CONSUMERS ON THE CLATTERING TRAIN

Consumerism inspires zeal in a few proponents²⁵² and hope in a few quarters. To return to our clattering-train metaphor, consumerists want us consumers in charge of the providers and insurers who seem to run the train. We have not tried to evaluate consumerism globally, to survey every kind of issue it raises. Rather, we have singled out one crucial question: What would the consumer's world and the patient's life be like in a consumerist system? Would people succeed at the tasks they would have to perform for consumerism to subdue health care costs and to help patients get the care they want?

We have answered those questions by identifying consumerism's prerequisites and asking if they can be met. The prerequisites are disconcertingly many. First, consumers must be offered the coverage, caretakers, and care they need. Second, reliable information about those choices must be available. Third, information must be put before consumers, especially by doctors. Fourth, consumers must receive the information. Fifth, the information must be adequately complete and comprehensible. Sixth,

²⁵² As one reviewer says of one zealot and her book, "She and the majority of her 92 contributors . . . are convinced that a new age is dawning. As a consequence, this book projects an almost messianic fervor; it brims with the confidence and enthusiasm of converts to a great cause." Arnold S. Relman, Review of Regina E. Herzlinger, ed, *Consumer-Driven Health Care: Implications for Providers, Payers, and Policy-Makers* (2004), 350 NEJM 2217, 2217 (2004).

consumers must understand what they are told. Seventh, consumers must be willing to analyze the information. Eighth, consumers must actually analyze the information and do so well enough to make good choices.

Each prerequisite must be met; a failure at any stage can preclude accurate decisions. Can *all* these prerequisites be met? Not reliably; they are too numerous and too often too demanding.

Two kinds of evidence tended to confirm this conclusion. First, we frequently have drawn parallels between consumerism and the legal device of mandated disclosure. As we have seen, mandated disclosure has often betrayed the hopes entertained for it. Second, consumerism rests on misleading assumptions about human nature. People often resist proffers of decisional authority, and they often stumble in making unfamiliar decisions. This too dims the prospects of meeting consumerism's prerequisites.

When we recall our clattering train, the consumer's situation looks even worse. The train is impelled by forces strong and many. Consumerism leaves most of them unaltered. It directly addresses the moral-hazard problem, but most other dynamics of the health care system remain unaffected. Insofar as consumerism addresses those dynamics, it is by us all to manage them. This task overwhelmed managed care. Like consumerism, managed care counted on market forces. Will consumers fare better with those forces?

Partly, this depends on the politics of consumerism. For example, consumerism needs the cooperation and even commitment of both employers and employees. But a "recent study of employers' attitudes toward such programs suggests some ambivalence on their part. They are uncertain about the effect of such programs on costs and quality, and most significantly, perhaps, whether such programs will in fact be popular with employees"²⁵³ The Community Tracking Study recently found "deep skepticism" among a full range of market participants that consumerism can "produce urgently needed improvements in the efficiency and quality of the nation's health care system. As much as these predominantly private-sector leaders dread the prospect of deeper interventions by government, few of them seem to be able to imagine other alternatives."²⁵⁴

Discouragement, distrust, and dislike are not conclusive, but they are critical. First, the history of managed care teaches that a detested health policy is a dead one. Managed care was less culpable than people thought and deserves more esteem than it enjoys. Yet like St. Sebastian it twists in agony as it is pierced from all sides with arrows. The revolt against managed care was remarkable: legislation attacking particular cost-saving measures (including so-called "drive-by deliveries"),²⁵⁵ legislation prohibiting "gag-rules" said to restrict what doctors could tell patients,²⁵⁶ patients' "bills of rights,"

²⁵³ Callahan and Wasunna, *Medicine and the Market* at 77 (cited in note 12).

²⁵⁴ Nichols et al, 23 *Health Affairs* at 8 (cited in note 19).

²⁵⁵ For an acidulous argument that Congress had it wrong, see David A. Hyman, *Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?*, 78 *NC L Rev* 5 (1999).

²⁵⁶ "After condemnation of such clauses by every member of Congress who spoke on the subject, the General Accounting Office determined that there were no true gag clauses in any of the 1,150 contracts they examined Opponents of managed care also have yet to produce a single true gag clause" David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 *Vill L Rev* 409, 409 n142 (1998). Nor have providers

legislation and litigation inhibiting managed care plans from excluding doctors from their networks, legislation to “amend ERISA and permit patients to sue their MCO and states to regulate managed care,”²⁵⁷ and so on. The number, scope, stringency, and success of these attacks on managed care suggest how powerfully doctors and patients can insist on the control over medicine they have recently enjoyed, despite a consensus that health care costs must be constrained.

To be sure, the public has itself (partly) to blame for consumerism and may well have boxed itself into a consumerist corner. That public can't bear government regulation of expenditures. It can't agree on universal health care. It helped sabotage managed care. In other words, “as the 1990s' HMO debate showed, [the public] wants fine health care benefits with no bureaucratic cost-control measures to limit that care”²⁵⁸ but not to pay what such benefits cost. So “[g]overnment, booed off the field, handed the ball to market forces,” Brown says dryly. Those forces did “what they are supposed to do – squeeze waste, change payment systems, redefine necessary and appropriate care, favor primary care, and the rest. Yet the general public and special groups increasingly demand closer regulation of the new system,” a demand government is “ever more willing to meet.”²⁵⁹

This is all understandable; *tout comprendre, beaucoup pardonner*. Health care organization, regulation, and finance are so Byzantine and baroque that a sober and sophisticated political discussion of them is unimaginable.²⁶⁰ Faced with illness (their own or someone else's), people reflexively say damn the price (especially since the price has so long been so obscured by insurance). And the public has been incited to misunderstanding and indignation by institutions less easily pardoned – particularly the medical establishment. Organizations like the AMA have served their members' economic interests and demands for professional autonomy by resisting managed care and other promising attempts to control medical costs, not least physicians' fees.²⁶¹ And doctors have shown as a profession that they exalt their guild interests at the expense of their patients' welfare.²⁶² This matters because, as we have shown, patients' spending usually is directed by doctors. If doctors do not wholeheartedly help patients economize, consumerism cannot cool health care costs

We have tested consumerism against its proponents' claims. Would consumerism look better if those claims were moderated? Surely. First, any plausible approach to American health care finance will use some consumerist

presented any “proof that any of these provisions are being enforced in a way that systematically restricts communications between providers and patients.” David A. Hyman, *Managed Care at the Millennium: Scenes from a Maul*, 24 J Health Politics, Policy & L 1061, 1064 (1999).

²⁵⁷ Jacobson, 47 SLU L J at 381 (cited in note 35).

²⁵⁸ Callahan and Wasunna, *Medicine and the Market* at 50 (cited in note 12).

²⁵⁹ Brown, 56 Med Care Res & Rev at 151-52 (cited in note 68).

²⁶⁰ For a sobering example, see Theda Skocpol's analysis of the collapse of the Clinton reform – *Boomerang: Health Care Reform and the Turn Against Government* (Norton, 1997).

²⁶¹ For the history, see Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (Harper Collins, 1982).

²⁶² As the dying Cardinal Wolsey famously lamented, “[b]ut if I had served God as diligently as I have done the King, he would not have given me over in my grey hairs. Howbeit this is the just reward that I must receive for my worldly diligence and pains that I have had to do him service, only to satisfy his vain pleasures, not regarding my godly duties.”

devices. Such devices already proliferate in the form of shared premiums, co-payments, and deductibles.

Second, patients care about and can evaluate some aspects of care. In particular, patients want respect and solicitude.²⁶³ Prudent providers might respond to consumerism by trying to accommodate them. “The healthcare industry – as ironic as it may seem – has not functioned as a true customer-oriented service industry. It is now seeking to shift models and to better understand the phenomenon of patient satisfaction.”²⁶⁴ Some providers are using “survey research methods to obtain customer (patient) feedback with respect to service, process, and facilities. This is especially true within the fastest growing sector associated with the family-centered practice.”²⁶⁵

Third, at least consumerism brings *some* costs home to patients, however clumsily. Could this at least help consumers realize that costs won’t be controlled until they get help persuading doctors to attack costs systematically and until they accept a system that does not give them everything they want?²⁶⁶ People do realize now that, in various ways, health costs are a severe problem.²⁶⁷ Can consumerism help them see that better cost-control might be possible with managed care run in the patients’ interests? Can consumerism induce them to apply enough political pressure for such a reform?²⁶⁸ We dearly hope so.

B. RICHER RICH AND POORER POOR

Consumerism embodies two of the central preoccupations of contemporary health law and policy – controlling costs and extending patients’ authority over their care. We have shown that many unlikely things have to happen for consumerism to achieve its advocates’ expectations. But there is another problem with consumerism. It fails to address the continuing scandal of American health policy – the fact that almost 50 million people are uninsured and at least as many are poorly insured²⁶⁹ and that much evidence shows “large health disparities between the disadvantaged in the United

²⁶³ For a discussion of what patients want and what they get in today’s bureaucratized medicine, see Schneider, *The Practice of Autonomy* at 181–231 (cited in note 20).

²⁶⁴ Barry Eisenberg, *Customer Service in Healthcare: A New Era*, 42 *Hospital & Health Services Admin* 17, 20 (1997).

²⁶⁵ Raj Arora et al, *Influence of Key Variables on the Patients’ Choice of a Physician*, 13 *Quality Management Health Care* 166, 166 (2004).

²⁶⁶ This argument is made in detail in Mark A. Hall and Clark C. Havighurst, *Reviving Managed Care With Health Savings Accounts*, 24 *Health Affairs* 1490 (2005).

²⁶⁷ Asked to describe the few “most important health care problems,” people first mentioned the “cost of health care services, the lack of or inadequate health insurance coverage, and the cost of prescription drugs. In combination, costs were the top issue for approximately half of respondents.” Robert J. Blendon et al, *Americans’ Health Priorities: Curing Cancer and Controlling Costs*, 20 *Health Affairs* 222, 227–228 (2001).

²⁶⁸ People praise health care reform. But their support can “be quickly tempered by messages implying that personal sacrifices might be required to deal with the broader problems.” Support “plummeted if Americans heard that reform would limit their choice of doctors or hospitals, would require rationing, would reduce the quality of care most persons now receive, or would require more than a modest tax increase.” Robert J. Blendon et al, *What Happened to Americans’ Support for the Clinton Health Plan?*, 8 *Health Affairs* 7, 12 (1995).

²⁶⁹ For some specifics, see Jessica H. May and Peter J. Cunningham, *Tough Trade-Offs: Medical Bills, Family Finances and Access to Care*, 85 *Issue Brief Center Studying Health System Change* 1, 1 (2004).

States and those who are more privileged²⁷⁰ Worse, it moves in the opposite direction; it benefits most those who least need help and most disadvantages those most in need.

Of course it does. The prosperous do better in markets than the impecunious. The poor, the illiterate, the elderly, the really sick, profit least from consumerism, while to profit substantially, it helps to be well off, well educated, and healthy. For example, the federal government's way of promoting consumerism specially benefits the wealthy, healthy, and childless: Health savings accounts are tax-advantaged, but that is useless to people with modest income. HSAs can accumulate from year to year, but the sick and families with children rapidly spend each year's allotment. And consumerism leaves to their fates the unemployed and the under-insured. Even people whose employers provide good insurance often struggle with high deductibles. Many of them are economically marginal and barely make it from paycheck to paycheck.²⁷¹ But what are high deductibles to wealthier patients?²⁷²

Consumerism's favors are for the well off in another way. Like mandated disclosure generally, it serves "the well educated and well situated far more than the illiterate and poor. Disclosures are more useful to the former than the latter because the former are better able to understand them and understand how to use them."²⁷³ Consumerism puts a premium on fending for yourself and negotiating for the best deal. The well-off have experience and resources to do so that the badly off lack. This can be true even where attempts have been made to simplify information. For example, "Peters and colleagues found that using a traffic light symbol helped highly numerate consumers select better-quality hospitals. However, it reduced the ability of less numerate consumers to select the best-quality hospital."²⁷⁴

For example, "functional health literacy was worse among the elderly and individuals who reported poor overall health. Thus, groups with the highest prevalence of chronic disease and the greatest need for health care had the least ability to read and comprehend information needed to function as a patient."²⁷⁵ There were "striking differences between the Medicare and the younger sample in ability to use information accurately. Medicare beneficiaries made almost three times as many errors as the younger respondents did (25 percent versus 9 percent)"²⁷⁶ People in "poorer

²⁷⁰ David Mechanic, *Disadvantage Inequality and Social Policy: Major Initiatives Intended to Improve Population Health May Also Increase Health Disparities*, 21 *Health Affairs* 48, 49 (2002).

²⁷¹ The 2006 median household income was \$48,201. U.S. Census Bureau, *Current Population Survey*, online at http://pubdb3.census.gov/macro/032007/hhinc/new04_001.htm (visited Mar 16, 2009).

²⁷² For a forceful statement of ways the health care system already favors the well-to-do, see Havighurst and Richman, 69 *L & Contemp Prob* at 7 (cited in note 1).

²⁷³ Carl E. Schneider, 41 *Wake Forest L Rev* at 443 (cited in note 30).

²⁷⁴ Jessica Greene et al, 14 *The American Journal of Managed Care* at 370 (cited in note 26).

²⁷⁵ Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, *Health Literacy: Report of the Council on Scientific Affairs*, 281 *JAMA* 552, 553 (1999).

²⁷⁶ Judith H. Hibbard et al, *Is The Informed-Choice Policy Approach Appropriate For Medicare Beneficiaries?*, 20 *Health Affairs* 199, 200 (2001).

health” and people “with less education” also “tended to make more errors.”²⁷⁷ The people who understood Medicare information least were also the people most likely to want to delegate decisions and to see “more information and options as unwelcome burdens.”²⁷⁸ In another study, the people who knew the least about Medicare choices “were older, had lower incomes, lower education, more nights in the hospital, and fewer doctor’s office visits.”²⁷⁹ Similarly, “less than half of the uninsured (48%) – or about 18 million people – use or are aware of a safety net provider in their community,” suggesting “that many uninsured people do not know of an affordable source of care to turn to when they need medical attention.”²⁸⁰ Yet “the least educated users of health care often have the greatest health needs and are vulnerable both to risk-selection in insurance and to substandard provision of care.”²⁸¹

As we have seen, the problem is not just in understanding; it is in results. For example, in the Rand experiment the poorest people were the worst affected by consumerism. And as a more recent study reports, consumerism’s “impact on utilization appears to be strongest for those with less education and income (hourly workers). That is, the observed effect is more prominent for those who have fewer resources. This suggests that the CDHP approach to cost sharing may further disadvantage those who are already less advantaged.”²⁸² Likewise, “[c]ost-sharing is perhaps the most studied aspect of the Medicaid program: a plethora of research concludes that even modest co-payments . . . cause Medicaid patients to forego necessary, not just excess, medical care.”²⁸³ This is consistent with long experience. For instance, “prevention efforts often attract those who least need them and fail to reach those most disadvantaged.”²⁸⁴

Thus we come to a final observation. We are grateful to live in a market economy. We cherish the market’s ability to provide – so often – good things at good prices. If consumerism could deliver what its apostles promise, we would cheer. Any successful health care system will use market devices.²⁸⁵ But when a resource so basic to human well-being – to human life – is so scarce for so many people, we need to think more broadly about our social responsibilities. The attempt to give individuals more control over their health care – whether through the market or through various mandated disclosures – has its moral merits. But it has come to dominate the ethics and law of health care to the detriment of a decent sense of our responsibilities to

²⁷⁷ Id at 200-01.

²⁷⁸ Id at 201.

²⁷⁹ Hibbard et al, 17 *Health Affairs* at 185 (cited in note 177).

²⁸⁰ Jessica H. May et al, *Most Uninsured People Unaware of Health Care Safety Net Providers*, 90 *Center for Studying Health System Change Issue Brief* 1, 1 (2004).

²⁸¹ Sage, *Accountability Through Information* at 23 (cited in note 167).

²⁸² Judith H. Hibbard et al, 65 *Medical Care Research & Review* at 447 (cited in note 242).

²⁸³ Sidney D. Watson, *The View from the Bottom: Consumer-Directed Medicaid and Cost-Shifting to Patients*, 51 *Saint Louis University Law Journal* 403, 430 (2007).

²⁸⁴ David Mechanic, 21 *Health Affairs* at 51 (cited in note 270).

²⁸⁵ “All health care systems are a mixture of public and private elements: the rise of the market in healthcare involves an incremental shift and the selected application of various market ‘tools’ or instruments to different parts of the health system, rather than a wholesale move from one kind of system to another.” Callahan and Wasunna, *Medicine and the Market* at 42 (cited in note 12).

our fellow citizens. “By its emphasis on choice, its eschewing of visions of the common good (much less social solidarity), and its focus on individual preferences as the (almost) final arbiter of political acceptability,”²⁸⁶ consumerism shares the moral failing of much contemporary health policy. It speaks powerfully to the claims we make for ourselves but barely whispers about the claims others make on us.

²⁸⁶ Id at 261.