Health Care's Market Bureaucracy

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Health Care’s Market Bureaucracy
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Allison K. Hoffman

The last several decades of health law and policy have been built on a foundation of economic theory. This theory supported the proliferation of market-based policies that promised maximum efficiency and minimal bureaucracy. Neither of these promises has been realized. A mounting body of empirical research discussed in this Article makes clear that leading market-based policies are not efficient—they fail to capture what people want. Even more, this Article describes how the struggle to bolster these policies—through constant regulatory, technocratic tinkering that aims to improve the market and the decision-making of consumers in it—has produced a massive market bureaucracy.

To illustrate the growth of market bureaucracy, this Article traces the origin and development of several market-based theories that have been central to the modern era of health law. The first, called managed competition, looks to consumerism in insurance markets and contends that people will choose wisely among health plan options, and their choices will drive higher value health care. The second relies on consumerism when using medical care. Sometimes called consumer-driven health care, the notion is that when people are subject to a share of the costs, they will more selectively choose when and where to use medical care and will avoid low-value care. The final example considers the application of antitrust to health care mergers, ostensibly to create a competitive field on which consumerism can flourish.

This Article shows that, in application, none of these ideas has, nor will ever, deliver as imagined in a world that deviates from theory. Nonetheless, they continue to spawn a vast web of health law regulation in their support. The cost of this market bureaucracy includes the scaffolding to hold up an ineffective market-based structure and, more importantly, the opportunity cost of driving out better alternatives to solving important health care challenges.

Health care’s market bureaucracy endures in light of this failure in part due to politics and political economy, a point others have illuminated well. Yet, this Article suggests that it persists equally because of its elevation of values of individualism and choice. Choice is especially appealing when it comes to decisions about our health, where we want to believe we are in control, but choice has proven empty as conceived. Understanding that markets do not actually enhance choice—and are as bureaucratic as any other approach—can clear the way to ask how to design health law and policy that better produces what the polity genuinely values.

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INTRODUCTION

Health policy and law is in flux. For most of its history, health law focused on the doctor, and his patient, guided primarily by the goal of fostering the medical profession and protecting physician autonomy. The law gradually took equal interest in patients’ autonomy, increasingly in recent decades in their role as consumers in a health care marketplace, as economic theory has emerged as the guiding light of health policy and regulation.¹

Patients as consumers are now charged with using their purchasing power to solve what are considered healthcare’s most intractable problems: high spending and relatively poor outcomes.² The United States spends nearly one-fifth of its Gross Domestic Product on health care,³ more than all other peer nations and over 50 percent more than France, Germany, or Canada.⁴ Yet, we fall comparatively and embarrassingly short on key health outcomes, including life expectancy and infant mortality, as well as on subjective patient experience.⁵

Another way in which the U.S. is unique is that we have looked to competition and consumer choice as the guiding mantra to fix this mismatch in spending and outcomes. Market-based solutions enticingly promise patients control of their care, instead of deferring to doctors or insurers to call the shots, as was the mark of earlier decades.⁶ With the right incentives, theory predicts, consumers will select the care that they value the most.

¹ JACOB S. HACKER, THE ROAD TO NOWHERE 156 (1997) (“In the health policy community, the most influential ideas have been associated with economists.”).


⁵ Id. at 8-9. Marian F. MacDorman et al., Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues, 128 OBSTAT. GYNECOL. 447, 453 (2016). There is no neat explanation for this divergence. Poor outcomes remain after adjusting for demographics. And, higher spending is not easily justified by investing in innovation. Evidence in many areas suggests that we have reached the flat of the curve, where “innovation” and more spending does not improve outcomes. Jonathan S. Skinner et al., Is Technological Change in Medicine Always Worth It? The Case of Acute Myocardial Infarction, 25 HEALTH AFFAIRS w34 (2006), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.25.w34.

⁶ Schneider & Hall, supra note 2, at 10 (“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.”); William M. Sage, Regulating Through Information, 99 COLUM. L. REV. 1701 (1999).
and root out the rest. In turn, health regulation has become a tool to define and lubricate markets, and a profession and field that was once exempt from competitive concerns became all about it.

Market-based approaches have dominated all U.S. regulatory fields since the Reagan revolution. In this Article, I focus on the particular dysfunction that has resulted in health care regulation, where conditions are especially unconducive to consumerism and where getting regulation right is critically important for a massive industry that deals with life and death.

The turn to markets in health law and policy has been widespread and partisan, favored by the Reagan and Clinton Administrations alike. When President Obama assembled his health reform team, he turned predominantly to economists and economic theories. Along with these advisors came market-based ideas, which formed the bedrock of the Patient Protection and Affordable Care Act (ACA) and thousands of pages of rules and regulations to direct market dynamics. Likewise, after the election of President Trump, the Republican Congress sought to scale back comprehensive insurance coverage on the theory that if people have their own money at stake in the market, they will spend more judiciously. Scholars and think tanks, in turn, have become laser focused on regulating markets through constant technocratic tinkering, rarely reevaluating or challenging their prominence.

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7 As Deborah Stone, a skeptic, describes: “[M]arket reforms invite people to treat their health as a consumer good and to approach diagnostic, curative, preventive, and rehabilitative services as if they were part of the family market basket.” The False Promise of Consumer Choice, 51 ST. LOUIS L. J. 475, 477 (2007).


9 See K. SABEEL RAHMAN, DEMOCRACY AGAINST DOMINATION 5-7 (2017) (describing the managerialist approach from the New Deal to the present and its reliance on expertise that co-exists with the centrality of markets). Even health law literature that recognizes the problems with consumerism often works within its paradigm. See, e.g., Mark A. Hall & Carl E. Schneider, Patients as Consumers: Courts Contracts, and the New Medical Marketplace, 106 MICH. L. REV. 643 (2008) (describing doctrinal approaches that give patients the benefit of the doubt because of their compromised bargaining position for medical care); Russell Korobkin, Comparative Effectiveness Research as Choice Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis, 523 MICH. L. REV 523, 526-27 (2014) (acknowledging problems people have making insurance decisions but proposing an alternative that requires they do so). But see, e.g., Lindsay F. Wiley, Health Law as Social Justice, 24 CORNELL J. L. & PUB. POL’Y 47, 51-52 (2014) (noting increased attention to collective needs and social determinants of health, rather than just individual preferences); Stone, supra note 7 (critiquing the rise of consumer choice and free markets in health case).
Market-based policies are hailed as offering two main advantages: being first more efficient and second less bureaucratic than alternatives. They are held up as the *singular* way to honor autonomy and choice. Although historically not the case, individual choice has emerged as a sacred value in health care decisionmaking—where decisions are often scientifically imprecise, deeply personal, and potentially very expensive. Promises of market choice now pervade all corners of health care: You can choose your own insurance plan. You can choose your own doctor. You can choose your hospital, imaging center, pharmacy, urgent care facility, lab, and outpatient surgical center. You can choose your own procedures, drugs, and course of treatment. You can get your care at CVS, or in India. Market choice is sold as equivalent to freedom or autonomy.

Regulation, in ironic contrast, is critiqued as ill-suited to provide what people want. In Richard Epstein and David Hyman’s words: “No administrative agency or committee of experts, no matter how well intentioned and highly credentialed, will be able to do a better job of meeting consumer demands than the private market.” In the private health care

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10 There are softer and harder versions of pro-market arguments, which vary in level of commitment to an unregulated market. Harder versions argue that government should be reduced to zero, or close to zero. MURRY N. ROTHBARD, FOR A NEW LIBERTY (1973); EDWARD PETER STRINGHAM, PRIVATE GOVERNANCE: CREATING ORDER IN ECONOMIC AND SOCIAL LIFE (2015). Softer versions concede government regulation for limited functions, such as to provide public goods that private providers might undersupply. See, e.g., F.A. HAYEK, THE ROAD TO SERFDOM 45 (1944) (rejecting the elimination of government); MILTON FRIEDMAN, CAPITALISM AND FREEDOM (1962) (arguing that the government role includes enforcing law and order, diminishing “neighborhood effects” and controlling money); ROBERT NOZICK, ANARCHY, STATE, AND UTOPIA (1974) (arguing for a minimalist state, arising from anarchy). In health care, pro-market arguments universally recognize some role for regulation, primarily to correct for market failures. See, e.g., CHARLES SILVER AND DAVID A. HYMAN, OVERCHARGED: WHY AMERICANS PAY TOO MUCH FOR HEALTH CARE (2018) (arguing that consumer control over spending is the only way to control health care spending); CLARK. V. HAVIGHURST, Deregulating the Health Care Industry: Planning for Competition (1992) (arguing for deregulation to create a competitive market); Mark V. Pauly, Mercatus Center, Giving Competition in Medical Care and Health Insurance a Chance 2019); James F. Blumstein & Michael Zubkoff, Perspectives on Government Policy in the Health Sector, 51 MILBANK MEMORIAL FUND Q., HEALTH & SOC’Y 395, 401 (1973) (describing the public finance criteria for government intervention—externalities, public goods, monopoly, and market imperfections—and how they apply in health). Richard A. Epstein & David A. Hyman, Fixing Obamacare: The Virtues of Choice, Competition, and Deregulation, 68 NYU ANN. SURVEY OF AM. L. 493, 485, 517-536 (2013) (mapping out health care deregulation yet yielding the possible need for some price control). For a health care version closer to complete deregulation, see RICHARD EPSTEIN, MORTAL PERIL (1997).


12 Epstein & Hyman, supra note 10, at 537.
market, competition among businesses, who are already intractably embedded, will in theory generate an array of options so people can make individualized decisions.

The second promise of market-based policy is limited government and, in turn, less opportunity for government failure. Even though most experts concede markets need some regulatory structuring to exist, proponents claim government regulation can and should be more limited in a market-based system, in turn lessening the influence of bureaucrats, who are criticized as both paternalistic and also captured by vested and powerful interests.

This Article draws from a mountain of empirical evidence to document the irrefutable failure of health care’s most popular market-based policies to live up to both of these promises. To the contrary, despite decades of efforts, these policies produce exactly the opposite as the theory predicts: a myth of choice and what this Article calls a market bureaucracy. Rather than helping people get what they want, market-based policies produce a maze of obligations and decisions that confuse people and burden them when they are sick.

Furthermore, efforts to fix flailing competition-based policies have required armies of health regulators, reams of regulation, and seemingly endless evaluation and adjustment by technocratic experts—to no avail. The result is a market-lubricating regulatory scaffold—a governmental bureaucracy that may be as large or larger than what would have grown out of more direct regulatory approaches and also vulnerable to capture.

Even more, in addition to the public regulatory infrastructure, health care’s market bureaucracy amasses equally within the walls of private industry. The U.S. has lower public social expenditures, relative to other countries, but total social expenditures—public plus mandated private expenditures (those that serve redistributive purposes but are not directly government administered)—are higher in the U.S. than in all other countries except for France. In other words, the U.S. relies heavily on private industry to achieve social welfare goals. In health care, the market bureaucracy deeply embeds private industry in the implementation of public programs, which means that high private industry profits and salaries, including as one small example the recently reported $19.2 million compensation for the CEO of Blue Cross Blue Shield of Michigan (just one insurer in one state), is all

13 ROBERT I. FIELD, MOTHER OF INVENTION: HOW THE GOVERNMENT CREATED “FREE-MARKET” HEALTH CARE (2014); Stone, supra note 7, at 477 (“Indeed, the health sector has been more dramatically reconfigured according to market theory than any other sector of social policy.”)


15 Id. at 10.

16 Ryan McMaken, ‘Social Expenditures’ in the US are Higher Than all Other Countries, Except France, Mises Wire (Oct. 30, 2015).

17 Jay Greene, Blues CEO’s Compensation Rises 43 Percent to $19.2 Million, Crain’s Detroit Business (March 1, 2019).
part of the cost of market-based bureaucracy. It is unsurprising that the administrative costs of the U.S. health care system well outpace its peers.¹⁸

The popular narrative about the benefits of markets over other forms of regulation is empirically, and clearly, wrong in key areas of health care regulation. They do not enable effective consumer choice and yet they have generated a sizeable public-private bureaucracy.

Consider, for illustration, one of the many examples discussed in Part II below. A recent study of lower-leg MRIs—a service with very little variation in quality—showed that patients with high deductible plans and easy access to price data (the best-case scenario to motivate consumerism) passed six lower-priced imaging centers on the way to get an MRI, resulting in average excess cost of $80 to the patient and $250 to the health plan.¹⁹ They could have choose much lower-priced services without a negative health effect, but instead went to the provider their doctors recommend.

As another example, when selecting an insurance plan among options, people struggle to choose, dread the shopping experience, and often do not choose well. One study that aimed to simulate plan choice under an ACA marketplace created an objectively better health plan option yet resulted in a relatively informed group of participants choosing that better plan only half of the time.²⁰ Behavioral economics inspired attempts to educate and nudge participants to better results were mostly ineffective.²¹ These are just two of the myriad examples described below that illustrate how market choice works better in concept than in practice.

As they fall short, these efforts are accreting sizeable bureaucracy. To set up and run these ACA exchanges—a structure that sets people up for failure and creates anxiety—the federal government has spent tens of billions of dollars and states have spent additional billions of dollars; California estimates annual costs of $350 million to run its exchange.²² Under the Obama Administration alone, the Department of Health and Human Services (DHHS) issued 24 new rules and 64 guidance documents on the exchanges.²³ Scholars,


²⁰ Eric J. Johnson et al., Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture, 8 PLOS ONE e81521.

²¹ Id. at 3.


news outlets, and policymakers obsess over every twist and turn on the exchanges, from an insurer joining or dropping out of participation to the ups and downs of premium prices. The New York Times alone published over 300 articles on the ACA exchanges from 2010-2016. All of this expensive, time-intensive tinkering and scrutiny serves to bolster a market structure that provides insurance for a mere 3 percent of the population, many of whom make poor plan choices for reasons discussed in Part II. The fiscal and opportunity costs of this flawed market bureaucracy are too high to justify the result.

Let me be clear on what this Article does not intend to argue. I do not intend to imply that there is no role for economics in health policy but want to make clear that any role that depends on effective patient consumerism will be thwarted. The role of economic analysis in health care has focused over time on microeconomics and mathematical modeling as policy tools. Even if these models have been misapplied, economic theory might be useful in other modes. Further, by elucidating the inefficiency and bureaucracy of market-based policies, I do not intend to imply that the aim of social policy should be economic efficiency or minimalist government. Others have offered compelling critiques of these aims, and have made explicit the hidden normative agendas of neoliberalism, obscured by the objective tone of the language of economics. This Article moves these critiques to the

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24 Original research (on file with author).


26 Id. There are more examples than I could possibly cite here, but I list a few from different disciplines. Robert Evans and Tom Rice describe market-based policies as a form of American exceptionalism that replicates inequitable access and unusually high system administrative costs and prices. THOMAS RICE, THE ECONOMICS OF HEALTH RECONSIDERED (1998); Robert G. Evans, Going for the Gold: The Redistributive Agenda behind Market-Based Health Care Reform, 22 J. HEALTH POL., POL’Y, & L. 427, 432 (1997) (“Distributional questions may be suppressed in economic analysis, but they remain at the forefront of public policy debates”). Tim Jost has aptly observed: “Even though the foundations and conclusions of neoclassical economics as a science are questionable and the ideological inclinations of the discipline render its normative prescriptions suspect, economics retains great influence on policy making in the United States, more so than any of the other social sciences.” Jost, supra note 2, at 177. Much of Deborah Stone’s work critiques the overinfluence of economics on policymaking. See, e.g., Beyond Moral Hazard: Insurance as Moral Opportunity in EMBRACING RISK (Tom Baker & Jonathan Simon, eds. 2002). Jacob Hacker critiques the rise of the idea of personal responsibility as part of the neoliberal project and how it has contributed to economic insecurity. THE GREAT RISK SHIFT (2006). For normative critiques of neoliberalism in other fields, see Amy Kapczynski, Intellectual Property’s Leviathan, 77 L. & CONTEMP. PROBLEMS 131; Anne L. Alstott, Neoliberalism in U.S. Family Law: Negative Liberty and Laissez-Faire Markets in the Minimal State, 77 L. & CONTEMP. PROBLEMS 25 (2014).

27 David M. Frankford, Scientism and Economism in the Regulation of Health Care, 19 J. OF HEALTH POL., POL’Y, & L. 773 (1994); See also, e.g., Suzanne Mettler, Reconstituting the Submerged State: The Challenges of Social Policy Reform in the Obama Era, 8 803, 804 (2010) (summarizing the notion Mettler
side for the most part to show that even when measured on their own terms, market-based policies have fallen short in health care and will continue to do so.

This Article has two primary objectives. The first is to draw on empirical evidence to critique this recent era of health law as overly reliant on economic ideas—both neoclassical and behavioral—in the adoption of market-based approaches. Proponents of these approaches were overoptimistic about the ability to correct failures both in the markets and in patient decisionmaking. There is no singular reason why health care’s market-based solutions have failed. If there were, it might be fixable. Rather, the failures arise from a range of problems deeply-embedded in what health care is a good and in how people are as patient consumers.

The Article’s second objective is to consider why market-based approaches persist, even as evidence of their shortcomings amasses, and how to begin to conceive of a new path forward. There is no simple regulatory path to high-value health care and happy patients. Yet, there are some concrete ways to make progress toward this goal, including in part, I argue, by reexamining how markets have elevated and defined choice in an unproductive way.

These arguments proceed in three Parts. The first Part describes fundamentally why health care is especially inhospitable to market-based policies. There is no one reason why health care consumerism does not work. Rather, the failures arise from multiple levels of structural problems—problems with neoclassical assumptions, behavioral economic assumptions and interventions, and policy design in real-world conditions. Health care breaks all of the rules of neoclassical economics’ markets. From the time Kenneth Arrow brought health care into mainstream modern economics, he warned that it defied many of the assumptions of neoclassical economics including, the most basic ideas that people have well-ordered preferences and the agency to make meaningful decisions.28 Fixing all of these problems is inscrutable, yet Arrow’s caution did little to slow the eager adoption of microeconomic market-based approaches in health care. Health care also defies the recipes of behavioral economics, ascribing to all of the cognitive ills and responding to few of the prescriptions for cure. Finally, even without these failing, health care markets are deeply flawed and do not respond as models predict and policies are crafted in a manner blissfully ignorant of this fact.

The second Part traces the arc of microeconomic influence, through three market-based ideas that have deeply shaped the regulation of health care financing and delivery. Although financing—how we pay for health care—and delivery—how we use and provide health care—are distinct concerns in some ways, the core regulatory challenges are the same: providing access to good care at a reasonable cost. Solutions to both have been cast

from the same intellectual mold and fail for the same reasons: patients do not have the preferences, capacity, or desire, to choose as these solutions demand.

The first example looks at consumerism and health insurance with the theory of managed competition, made famous by Alain Enthoven and Richard Kronick. They argued that when people make good choices among health plans in a carefully regulated health insurance market, their choices will send signals to stimulate higher-value health care delivery. This idea undergirds the ACA and its health insurance exchanges and was influential for decades prior, as part of President Clinton’s failed Health Security Act of 1993, Massachusetts’ health reform in 2006, Medicare Advantage (Medicare’s managed care marketplace), and the creation of Medicare’s prescription drug program in 2003. The second example looks at patient decisions at the point of care and the trend toward what is often called “consumer-driven” or “consumer-directed” health care (CDHC), whereby higher out-of-pocket responsibility for medical expenses is supposed to motivate patients to economize more wisely. This pervasive trend is often described, somewhat crassly, as consumers having “skin in the game.” The final example focuses on antitrust law and oversight of mergers, which has seen a recent resurgence.

Each of these ideas spawned a regulatory structure built on a simple blueprint—the idea that if health law and regulation support a functioning market, people can make meaningful choices that will, in turn, improve the value of health care spending. These ideas transform the role of health regulation into fixing market failures and “flawed” decision-makers. Yet, despite intensive regulatory tinkering, markets are still not delivering as promised.

The final Part of this Article examines why market-based approaches garner continued loyalty, even in light of growing evidence of their inescapable failure. The persistence of market-based policies is in part a story of conflict avoidance and political economy. Policymakers and regulators can avoid dealing with hard normative tradeoffs around how much care we use, who uses it, and how much we pay for it. Instead, rationing occurs implicitly and usually without collective deliberation. Policymakers thus punt decisions that could directly harm the bottom line of the healthcare industry, leaving the dirty work to consumers. The market-based bureaucracy is, in part, the price we pay to avoid wrestling collectively with hard moral or political challenges.29

Yet, I suggest that an equal reason that market-based solutions endure is that the intellectual dominance of economic theory has elevated the idea of choice and claimed ownership to it, defining it in microeconomic terms. This has translated into using markets—and individual purchases in them—as the means for determining what people

29 Cf. Dan Kahan, The Secret Ambition of Deterrence, 113 Harv. L. Rev. 413, 417 (1999) (“Citizens of diverse commitments converge on the deterrence idiom to satisfy social norms against contentious public moralizing; public officials likewise converge on it to minimize opposition to their preferred policy outcomes.”).
value or want. Market-based solutions have been sold as the epitome of choice, even when the choice they produce is empty.

This Article concludes by arguing that to develop more productive foundations for health policy, we must revisit both the privileging of choice and the way we have understood choice, including the idea that people reveal what they value, or want, by how they spend their dollars in a market. In some cases, the value of choice has been overemphasized. We may be better off if simply handed the best available health plan, or, more controversially, if denied treatments and therapies that are low value or do not work.

Even when individual choice is not worth preserving, which I argue is the case in most but not all circumstances, rejecting market-based approaches does not preordain eschewing choice for regulatory paternalism; rather, it demands seeking proxies other than purchases in a market to understand what people most value. In many ways, what people value most in a health care system is not so complicated or varied. People want to be able to see a good doctor when they are sick. They want the drugs or treatment that will make them well. They do not want to have to go broke to stay healthy. Most people expressly do not want to spend their time wading among health insurance plans, health care prices, or medical care options. And, as the evidence outlined below shows, most people are not particularly good at making these decisions anyway. For all of these reasons, we must avoid the temptation to continue to build reflexively on a foundation of market-based policies in the next era of health policy and regulation.

I. PERFECT CONDITIONS FOR A MARKET BUREAUCRACY

The gap between economic theory and successful application in health care is often vast. In an economist’s terms, health care markets suffer from countless sources of market failure. For this very reason, for many years economists did not see health care as an industry appropriate for economic analysis. And the early health economists who worked on health policy saw economic tools at best as one among many and inappropriate for making normative decisions. As economist Rashi Fein, who served on the Council of Economic Advisers under President Kennedy wrote, “it is important that our political leaders listen to the wishes of society, not just the analyses of economists.”

Increasing economist attention to health care microeconomics came with skepticism. Kenneth Arrow said at the nascence of modern health economics and economist Tom Rice clearly articulated in detail decades ago, health care lacks many of the conditions necessary for a competitive market. In one study done in the late 1980s, as market policies were gaining steam in the field, half of all economists agreed that competition does not

30 Fox, supra note 25.
31 Rashi Fein, Commentary, From Reform to Relativism: A History of Economists and Health Care, 57 MILBANK MEMORIAL Q., Summer 1979, at 353, 357.
32 Arrow, supra note 28.
33 Rice, supra note 26.
work in health care. Yet, over time, some scholars, policymakers, and commentators have lost this skepticism. Others seem to know that getting health care markets to work is a Sisyphean task, but they keep at it.

This Part provides the groundwork for understanding why health care is uniquely challenging for market-based policies, as context for understanding the failed policies discussed in Part II. Although market-approaches can, and have been, critiqued in many fields, health care is an especially problematic case story. The challenges are multi-layered, and some have proven insurmountable. First, basic assumptions of neoclassic economics, like well-ordered preferences, evade patients. Second, patient consumers experience a range of problems of cognitive biases—from information overload to anchoring to deference—that have proven tough to correct. Finally, even if consumers were perfectly rational beings, the health care markets themselves are also flawed and difficult to mend, so that even when consumers signal clearly and accurately, markets often will not respond in turn.

In short, nearly every condition necessary for a well-functioning market evades most health care decisions. Most simply, economic theory assumes, first, that consumers have well-ordered, predetermined preferences and second, they have or can acquire enough knowledge to make choices in line with their preferences. Yet, everything from economic theory to empirical work to anecdote and personal experience suggests that these assumptions fall short when it comes to making medical care and health insurance decisions.

Consider the most basic assumption of economic theory—that people have well-ordered preferences or “tastes” that are genuinely aligned with their interests. For this to be true, people must be able to judge what is in their best interest, but they routinely fail to do so with respect to medical care or health insurance choices. Instead of starting from some sense of self-interest, people form preferences based on what they have experienced in the past, which economist Tom Rice describes as “wanting what they got rather than getting what they want.” He offers the example of Americans accustomed to high use of

34 Rice, supra note 2628, at 22.
37 The Rand Health Insurance Experiment should that with less insurance they equally reduce what is considered by experts to be the most effective and least effective types of treatment. KATHLEEN N. LOHR ET AL., USE OF MEDICAL CARE IN THE RAND HEALTH INSURANCE EXPERIMENT: DIAGNOSIS- AND SERVICE-SPECIFIC ANALYSES IN A RANDOMIZED CONTROLLED TRIAL 31 (1986).
38 Rice, supra note 36, at 400.
medical technology and wanting more of it, whether beneficial or not.\textsuperscript{39} Even if someone did have an accurate sense of self-interest, the most basic economic concept of “willingness to pay” is hard to understand in the context of decisions that can be life or death.

Furthermore, interests must be reasonably stable and endemic to inform meaningful decisions, which studies show is absent in many health care decisions, even across short time frames and on critically-important issues.\textsuperscript{40} Women change their preferences about pain treatment throughout their pregnancy, during labor, and after labor.\textsuperscript{41} People’s views about whether they would want life-saving treatment if it comes with a high risk of physical or cognitive disability change over even relatively short periods of time.\textsuperscript{42}

People change their minds in light of changing circumstances, social pressure, or addiction, which might cause someone to smoke, use illegal drugs, forgo a helmet, or gamble, any of which but not be a person’s own long-run best interest.\textsuperscript{43} We simply do not have defined and consistent preferences about medical care and health in the way that economic theory envisions.

The other critical prerequisite—that someone does (or could) possess and understand information regarding options—also fails in most cases. The health care system is notoriously opaque. Patients rarely know the price of medical care.\textsuperscript{44} Even if they did, patients do not understand basic aspects of the medical system, including that a doctor might recommend unnecessary surgery, that a doctor can only admit a patient to a hospital where she has privileges, or that doctors are not reexamined routinely prior to licensure.

\textsuperscript{39} Id.


\textsuperscript{41} Christen-Szalanski, supra note 40.

\textsuperscript{42} Fried et al., supra note 40, at 1008 (When asked about willingness to risk physical or cognitive disability for survival, half of all participants responses were inconsistent over time).

\textsuperscript{43} Rice, supra note 27, at 22.

\textsuperscript{44} Hall & Schneider, supra note 2, at 647-62 (describing the opacity of pricing in health care and the reticence of doctors to discuss or patients to ask about prices).
renewal. Understanding these facts would make a rational person approach medical advice and decisions with some skepticism.

More information is not the answer. Reams of studies show that health care consumers lack the basic skills to process more information. Low population wide levels of numeracy, health literacy, and financial literacy impede good health care decisions. Over half of American adults have only basic or below basic quantitative skills. This means, for example, that they are unable to determine whether their car has enough gas to get to the next gas station, knowing all of the relevant inputs (the distance to the next station, the reading on their gas gauge, and how many miles per gallon their car gets). Or even more pertinent, they cannot determine what time to take a prescription medicine, based on the drug label instructions for timing of doses to eating. Even college educated patients, doctors, and medical students show surprisingly high levels of error on numeracy

45 Joseph P. Newhouse et al., RAND, How Sophisticated Are Consumers About the Medical Care Delivery System? 6, 10 (1981).

46 On numeracy, see, e.g., Wendy Nelson et al., Clinical Implications of Numeracy: Theory and Practice, 35 ANN. BEHAV. MED. 261 (2008) (providing an overview of research on health numeracy and the clinical implications for patients); Valerie F. Reyna et al., How Numeracy Influences Risk Comprehension and Medical Decision Making, 135 PSYCH. BULL. 943, 945-46 (2009) (reviewing studies showing links between innumeracy and poor health decisions); Stacey Wood et al., Numeracy and Medicare Part D: The Importance of Choice and Literacy for Numbers in Optimizing Decisions Making for Medicare’s Prescription Drug Program, 26 PSYCH. & AGING 295, 296 (2011) (summarizing studies showing that low numeracy impedes health-related decision-making); Ellen Peters & Irwin P. Levin, Dissecting the Risky-Choice Framing Effect: Numeracy as an Individual-Difference Factor in Weighing Risky and Riskless Options, 3 JUDGMENT & DECISION MAKING 435 (2008) (showing that lower levels of numeracy led to higher loss aversion). On health literacy, see, e.g., Zsofia Parragh & Deanna Okrent, Health Literacy and Health Insurance Literacy: Do Consumers Know What They Are Buying (2015), http://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit_163.pdf (describing health literacy and summarizing studies on health and health insurance literacy); Tentine Sentell, Implications for Reform: Survey of California Adults Suggests Low Health Literacy Predicts Likelihood of Being Insured, 31 HEALTH AFF. 1039, 1045 (2012) (finding that low health literacy is higher among the uninsured and that people with low health literacy are likely to be sicker); Helen Levy & Alex Janke, Health Literacy and Access to Care, 21 J. HEALTH COMM’N 34, 45-46 (2016) (reporting that individuals with low literacy are more likely to forgo needed care or to self-report difficult in finding a healthcare provider). On financial literacy, see generally Annamaria Lusardi, Financial Literacy: An Essential Tool for Informed Consumer Choice? 2 (Nat’l Bureau of Econ. Research, Working Paper No. 14084, 2008) (explaining that financial “[i]literacy is widespread among the general population and particularly acute among specific demographic groups, such as women, African Americans, Hispanics, and those with low educational attainment.”).


48 Id. at 7

49 Id.
assessments and simple arithmetic tests. Many patients do not understand simple and important information, such as when their next appointment was scheduled.

People especially lack health insurance literacy. Repeatedly, studies affirm that people do not understand the technical terms that describe their health insurance policy, how much it costs, and what benefits are covered. Most people do not understand even the basic structure of their health insurance, including whether they are in a plan where they can see any doctor or in a managed care plan that restricts whom they can see. In a survey of insured adults, only 14 percent correctly answered four simple multiple-choice questions to elicit their understanding of cost-sharing features, such as a deductible. Yet, people overestimated the extent to which they understand insurance concepts, which suggests many would not seek more information even when needed and if offered. These gaps in capacity and understanding should be disqualifying, in and of themselves, of approaches that look to patients as consumers.

In a recent study of a large firm by economists Benjamin Handel and Jonathan Kolstad, a majority of people incorrectly answered questions about benefit design,

50 Nelson et al., supra note 46, at 263.
51 Id. at 262.
52 eHealthinsurance, EHEALTH (2008), http://phx.corporate-ir.net/phoenix.zhtml%3Fc=201232%26p=irol-newsArticle%26ID=1090963 (reporting that less than one-quarter of respondents to a phone survey were sure of the terminology in their health insurance policy and only half knew how much they paid for monthly premiums or annual deductible); M. SUSAN MARQUIS, RAND, CONSUMERS’ KNOWLEDGE ABOUT THEIR HEALTH INSURANCE COVERAGE 12, 15-16 (1981) (showing in survey that many people do not understand what their insurance covers, underreporting especially when their insurance covers outpatient care, and that with higher cost sharing and more complicated insurance structures, more people incorrectly report that physician services and prescription drugs are not covered); Deborah W. Garnick et al., How Well Do Americans Understand their Health Coverage, 12 HEALTH AFF. 204, 206 (1993) (finding that even though consumers largely understood whether their plans covered hospitalization or doctors’ visits, they underreported that their plans covered services including mental health, alcohol and drug abuse treatment, or prescription drug and over-reported that their plans covered long-term care).

53 David E. Nelson et al., What People Really Know About their Health Insurance: A Comparison of Information Obtained from Individuals and their Insurers, 90 AM. J. PUB. HEALTH 924, 926 (2000) (reporting that 84.2% of people in fee-for-service plans incorrectly believed they were in managed care plans); Peter J. Cunningham et al., Do Consumers Know How Their Health Plan Works, 20 HEALTH AFF. 159, 161-62 (2001) (finding over-estimation of the need to sign up with a primary care provider and to get approval for specialty care).

54 George Loewenstein et al., Consumers’ Misunderstanding of Health Insurance, 32 J. HEALTH ECON. 850, 855 (2013).
55 Id. at 850, 855 (2013); Kathryn A. Paez & Coretta J. Mallery, A Little Knowledge is a Risky Thing: Wide Gap in What People Think They Know About Health Insurance and What They Actually Know (American Institutes for Research Issue Brief, 2014).
including the amount of plan deductibles, or their own spending. The employees had a choice between two health plans: a high deductible health plan (HDHP) or a preferred provider option (PPO), the latter with higher premiums and lower cost sharing. Both offered access to the same benefits and medical network, which is a critically important feature for choosing a plan but which over half of the employees did not understand, despite this fact being emphasized in information given to them. A large majority of people also incorrectly estimated their spending from the prior year, yet a majority were confident in their estimates—more evidence that people do not understand their shortcomings enough to seek to remedy them.

A lack of understanding of health insurance concepts causes people to make poor choices among health plans, either choosing plans that are dominated—objectively worse than alternatives in all scenarios of health spending—or that are contrary to their own stated preferences, as illustrated in Part II.A. Furthermore, without understanding the basic structure of their plans, it is simply impossible that people will gauge the incentives embedded in the structure of those plans to shape their use of medical care, as illustrated in Part II.B.

To make good medical care choices, people must also understand what might have happened if they made a different choice. As one expert explains, “[w]hat a buyer wants to know is the difference between his state of well-being with and without the commodity being considered … Thus, a consumer of such services who gets better after the purchase does not know whether the improvement was because of, or even in spite of, the ‘care’ that was received. Or if no health care services are purchased and the problem becomes worse, he is generally not in a strong position to determine whether the results would have been different, and better, if he had purchased certain care.” In short, people cannot judge their decisions against foregone alternatives.

The vast gap between this reality of what health care consumers know and understand and an idealized informed consumer cannot be bridged, even if it could be somewhat narrowed. Often, solutions to these problems focus on better real-time education on


57 Id. at 2465.

58 Id. at 2468.


60 Rice, supra note 27, at 72.

options, chipping away at the tip of an iceberg. One might imagine more literate and numerate decisionmaking if everyone in the United States got a basic education that was far superior than what they do, but that reality is unlikely to manifest in the name of producing better healthcare consumers. Even with the best structured just-in-time education, most consumers will never be able to navigate many choices in health care in the way models predict.

Finally, for market-based policies to work, patients must be in control of their choices. Yet, many people cannot afford to make good clinical decisions, even when the right decision is clear—sometimes referred to as “financial toxicity.” Even more, health care decisions are replete with what economists call principal-agent problems because they are often strongly influenced by employers, who choose a menu of health plans and design benefits, or by doctors.

In many cases, there is evidence that people want to farm out decisions to their doctors. Studies suggest that half of the time patients simply do, and in fact a majority prefer to do, what a physician recommends. Sometimes physicians’ recommendations align with a patient’s preferences, but physicians are influenced as well by other factors, including lack of time to assess preferences and their own conflicting profit motives.

62 See Johnson et al., supra note 20, at 3 (showing that education interventions only made a small change in the number of people choosing a dominated health plan).

63 COMM. ON CONSEQUENCES OF UNINSURANCE, INST. OF MEDICINE, CARE WITHOUT COVERAGE: TOO LITTLE TOO LATE 27-28 (2002) (describing studies showing that the uninsured lack access to necessary care); Stone, supra note 7, at 478-481 (describing the many ways that people make poor decisions for their own health when operating within budgetary constraints). See also studies cited in Part II below.

64 See generally Peter Henry Huang, Happiness Studies and Legal Policy, 6 ANN. REV. L. SOC. SCI. 405 (2010) (“people often prefer not to make decisions by procrastinating, leaving decisions to others, making second-order decisions, or avoiding decisions.”

65 Wendy Levinson et al., Not All Patients Want to Participate in Decision Making, 20 J. GEN. INTERNAL MED. 531, 532 (2005) (52% of respondents preferred for physicians to make final treatment decisions, even if they were offered choices. 44% preferred to rely on physicians for medical knowledge rather than seek it themselves); See also Neeraj K. Arora & Colleen A. McHorney, Patient Preferences for Medical Decision Making: Who Really Wants to Participate? 38 MED. CARE 335, 338 (2000) (finding that 69% of patients prefer to leave medical decisions to their physicians, with rates increasing among older, less-educated, and sicker patients). But see Betty Chewning et al., Patient Preferences for Shared Decisions: A Systematic Review, 86 PATIENT EDUCATION & COUNSELING 9 (2012) (reviewing studies on shared decisionmaking from 1980-2007 and finding mixed results on patients’ preferences for an active role). See also CARL E. SCHNEIDER, THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS (1998).

66 See John McKinlay et al., Non-medical Influences on Medical Decision-making, 42 SOC. SCI. & MED. 769 (1996) (describing a range of non-medical factors that influence physician decision making); Amitabh Chandra et al., Who Ordered That? The Economics of Treatment Choices in Medical Care, 2 HANDBOOK OF HEALTH ECONOMICS 397, 412-8 (Mark V. Pauly et al. eds., 2011) (describing financial influences over physician decision-making).
Finally, even in the extraordinary situation where these conditions are all met—well-ordered, stable preferences, good information and understanding of both choices and counterfactuals, agency to decide, and the financial resources to make the best decision—a patient must then act consistently and rationally in line with her preferences and understanding. The abundant work in cognitive psychology and behavioral economics has made clear that decisionmakers are far from the rational archetype.67

Even in the best decision-making conditions, health care consumers often make choices that are not in their own stated interests.68 The conditions scholars identify as ripe for error are heightened in the medical care or health insurance context. Decisions are often scientifically and technically complex.69 People are overly optimistic about their own health, especially since the health consequences of decisions are often delayed (e.g., skin cancer develops years after the pleasure of warm sun on your face).70 People tend to anchor too strongly on low probability but scary facts or possibilities (e.g., a spot that a doctor says has a very small probability of being cancerous) when making a decision.71 Emotional responses, such as disgust, are overly influential.72 People struggle deeply to comprehend and factor risk into decisions73—an element central, of course, to choices of health


68 Redelmeier et al., supra note 40, describing reasons, based on studies in cognitive psychology, why patients are flawed decision makers); Korobkin, supra note 9, at 532-538 (summarizing some of the key factors that contribute to bounded rationality in health care decisionmaking, such as complexity, novelty of the decision evaluability problems, and emotion).

69 Schneider & Hall, supra note 2, at 54.


71 Cf. Korobkin & Ulen, supra note 67, at 1100 (describing “anchoring” errors); Amos Tversky & Daniel Kahneman, Judgment Under Uncertainty: Heuristics and Biases, 185 SCI. 1124 (1974); Redelmeier et al., supra note 40, at 75 (“sudden problems with short deadlines tend to be most compelling, whereas intermittent problems of insidious onset are often overlooked.”).

72 Redelmeier et al., supra note 40, at 75 (describing a study showing that people are averse to wearing clothing of people with disease, disfigurement, or moral faults after that clothing has been sterilized).

73 Id. at 71-72 (describing how people tend to categorize something as safe or dangerous, without regard for the level of risk, and overvalue reducing risk to zero). For an overview of cognitive biases with respect to risk and uncertainty, see Daniel Kahneman & Amos Tversky, Prospect Theory: An Analysis of Decision Under Risk, 47 ECONOMETRICA 263, 264 (1979) (showing then people tend to make choices inconsistent with their own expected utility when dealing with risky options); Daniel Ellsberg, Risk, Ambiguity, and the
insurance and medical care (e.g., what does it mean for something to increase or decrease your risk of heart attack by ten percent?). When people are making decisions about major medical care, they are often dealing with questions of first impression. Even when not, people do not accurately remember past medical experiences. For example, duration of past pain is less memorable than intensity of pain. Framing can significantly affect decisions, as when people make different decisions when told survival rates versus mortality rates.

Medical care decisions often must be made when ill and vulnerable or, in the case of emergency care, unconscious. For most big-ticket items, health care spending does not feel discretionary. Consider the case of a patient with advanced cancer, who must decide between expensive, intense treatments with no chance of cure yet some probability of prolonging life for months or years, on one hand, and less expensive, less invasive treatment (or no treatment) that will mean a better quality of life in the remaining time but less likelihood of prolonged survival, on the other. The patient is sick and scared, perhaps under the pressure from family to make certain choices, and she knows that no choice will save her life. These are impossible conditions for decisionmaking and are routinely present in medical care decisions.

It is unsurprising with these barriers separating theory from reality in health care that a mounting body of empirical evidence, discussed in detail in Part II, has shown little effective “consumerism” in the health care space; people do not seek out information and comparison shop, even when they would benefit from doing so. For example, among expectant mothers who felt they had a choice in prenatal providers, only 24 percent seriously considered another provider and only 14 percent had contact with another provider. See Schneider & Hall, supra note 2, at 650-651 (describing how illness affects patient, pulling quote from literature describing people’s experience as ill patients and consumers).


74 Redelmeier et al., supra note 40, at 75.

75 Id. at 73.

76 See Farzon A. Nahvi, Don’t Leave Health Care to a Free Market, N.Y. TIMES (July 10, 2017), https://www.nytimes.com/2017/07/10/opinion/health-insurance-free-market.html (op-ed contribution describing treating patients in the emergency room, who don’t have ability to choose whether to take on expensive treatment).

77 See Schneider & Hall, supra note 2, at 650-651 (describing how illness affects patient, pulling quote from literature describing people’s experience as ill patients and consumers).

78 See, e.g., Zarek C. Brot-Goldberg et al., What Does a Deductible Do? The Impact of Cost-Sharing on Health Care, Prices, Quantities, and Spending Dynamics, Q. J. ECON. 1287-89 (2017) (finding that among employees with access to leading technology for price comparison, there appeared to be no price shopping at all and that a minority of employees reported that they knew of (33%), used (22%) or benefitted from (4%) the tool). See also Part III. B. below.
provider. These low rates belied the authors’ expectations because of the importance of the decision and the relative ease of searching for a prenatal care provider.

The widespread academic response to this evidence, motivated by the rise and deep influence of behavioral law and economics, has been to try to nudge imperfect consumers to better answers through choice architecture. Yet, addressing all of these barriers would demand Herculean effort and, even then, falls short, as the studies described below show.

Economic theory and competition can undoubtedly serve positive ends in health care. For example, there is evidence that in more competitive provider markets, hospitals compete on price, and when price is fixed, on quality. The threat of disruption by retail clinics or medical tourism can prompt doctors and hospitals to lower their prices, even if patients have not yet begun to flee. These supplier-level dynamics seem to have the potential to produce some benefit, even without effective patient consumerism. Even in some very limited situations, consumer-focused competition may have moved the needle. An oft-cited example is laser eye surgery, or Lasik, which costs one-tenth today what it did twenty years ago, in nominal terms. Similar results have been shown with plastic surgery, fertility services, and, most recently, hearing aids. But it is fallacious to extrapolate from these examples of mostly elective care that more closely resembles other consumer products to the more common, complicated decisions that today’s policies are asking


80 Id. at 348.


82 E.g., Marah Noel Short & Vivian Ho, Vertical Integration Versus Market Concentration on Hospital Quality, 0 MED. CARE RES. & REV. (2019) (increased market concentration is strongly associated with reduced quality, based on patient satisfaction); Martin Gaynor et al., Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service, 5 Am. Econ J.: Econ. Pol’y 134, 150 (2013) (finding market concentration has a positive effect on mortality); Daniel P. Kessler & Mark B. McClellan, Is Hospital Competition Socially Wasteful?, 115 Q. J. ECON. 577, 601 (2000) (finding that Medicare patients receiving care for heart attacks in less competitive areas experienced higher rates of mortality).

83 Silver & Hyman, supra note 10, at 331-32, 352-53.

84 Some people, like Silver & Hyman, draw a logical fallacy from the success of trends like CVS minute clinics and the threat of medical tourism to the need to push decisions and payments onto individual patients. In these very situations, services in new settings are often reimbursed by insurers (not cash pay) and are encouraged by insurers or employers at a systems level, rather than leaving it to individual patients to compare among and choose among various delivery channels.

85 Brooks, supra note 29. See also Silver & Hyman, supra note 10, at 318-319.

86 See also Silver & Hyman, supra note 10, at 318-325.
patients to make. The patient earning just over minimum wage with a plan with a $500 deductible and a chronic disease is in a wholly different decisionmaking situation than a cash-pay patient seeking out elective breast augmentation or Lasik surgery so that she does not have to fuss with glasses.

The following Part illustrates what should be an unsurprising result of policymaking on a shaky foundation: decades of market-reliant policies are not producing as promised.

II. THE PRODUCTION OF HEALTH CARE’S MARKET BUREAUCRACY

Economic concepts when translated into law and policy can fall short for various reasons. Some theories are wrong conceptually, even if applied perfectly. Alternately, even if the theory is good, the assumptions underlying the theory may not prove true in application, or in application in a particular field, for reasons such as those outlined above in Part I. Policymakers, lawyers, and judges might extend a theory beyond its usefulness, or undermine benefits that can be derived from the theory. This Part illustrates how all of these types of shortcomings has occurred as economic theory has permeated health law and policy in the form of microeconomic market-based solutions.

As these market-based ideas have been increasingly adopted, health law has shaped to accommodate them, using regulation as scaffolding. Examining several of the most vital areas of modern health care regulation reveals that market ideology has become increasingly institutionalized—and bureaucratized—as the intellectual core of the field.

Each of the Sections of this Part look to a different economic theory and market tool that has been relied on in efforts to reduce health care spending or to improve quality. Section A examines relying on consumers to choose well among insurance plan options with the hopes that their choices will put pressure on insurers to negotiate better prices and offer better plans. Section B examines a trend of looking to consumers to ration medical care at the point of sale to reduce spending, especially lower-value spending, by putting more of their own spending dollars at stake. The final Section C describes looking to the tools of antitrust regulation to improve dynamics in larger market competition to drive value. It focuses in particular on the attempt to get the right power balance between providers and insures by scrutinizing mergers and acquisitions and, in particular, how myths of consumerism impede such attempts in part. By looking at these ideas in parallel, this Part highlights that they share two main themes in common. First, each relies on the theory that markets will achieve the best solution if we can just get the regulation (or deregulation) right. Second, they have all failed to do so, despite tremendous investment of regulatory effort and intellectual capital. Although these studies cited below are certainly

87 Evans, supra note 26, at 450. Even though these examples are cited as successes because prices have decreased over time in real terms, it does not mean that patients navigate these markets especially well. Anyone who has been to LA knows there is a glut of bad cosmetic surgery, even if competitively priced.

not definitive proof that these ideas with never work, they are moving asymptotically closer to that truth.

A. Managed Competition and the Market for Health Insurance

Managed competition has been one of the most influential ideas of the past half century over the development of health insurance design and regulation and yet its theoretical predictions of the benefits consumer choices among health plans can produce have not materialized. This Part documents this irrefutable failure, as well as the herculean efforts and massive regulatory infrastructure built in unsuccessful attempts to produce better results.

1. Alain Enthoven’s Theory and Its Promise

The ACA’s health insurance exchanges were built loosely on a concept that has come to be called managed competition, most often associated with Stanford economist Alain Enthoven. Republicans, even as they called for a dismantling of the ACA, proposed policies that build on this same idea, and private exchanges have begun to develop in parallel to serve the employer-based health insurance market.

The oversimplified idea is that when consumers choose among health plans in a marketplace that is carefully controlled by “sponsors,” they will make choices based on their preferences. Since they will presumably choose plans where they get better care at lower costs, their choices will ultimately drive health plans to compete for their business by offering higher-value plans. Enthoven initially called the idea “Consumer-Choice Health Plan” (CCHP), emphasizing the element of choice involved. Because most people with private health insurance have employer-sponsored health insurance, he imagined transforming that sector, although the idea has been applied more pervasively.

Enthoven proposed implementing this idea with a system of vouchers for buying health insurance, where each employee would receive a credit to buy a health plan in a regulated, competitive market. The value of these vouchers would vary based on an


92 Enthoven First Part, supra note 89, at 650.
individual’s age, and low-income people would receive additional subsidies.93 The ground rules he proposed included mandating that insurers accept any applicant during an open enrollment period (guaranteed issue), requiring “community-rated” premiums that do not vary based on health status, and placing limits on out-of-pocket spending94—all rules that the ACA enacted for exchange plans to make those plans both accessible and more affordable to people regardless of their health status.

In his vision, an individual consumer would assess the different offerings and structure among plans and buy the one most consistent with her preferences. As Enthoven put it: “What distinguishes [this plan] from the others is that it seeks to give the consumer a choice from among alternative systems for organizing and financing care, and to allow him to benefit from his economizing choices.”95 For example, Enthoven described that if someone wanted a plan that prioritized better access to home health care or ambulatory care, over, for example, hospitalization, she could choose it.96

Enthoven’s implicit assumption, introducing this idea at the nascent of managed care, was that managed care plans would prevail. These plans adopted a payment model that aimed to reduce incentives for wasteful care, paying doctors based on the number of patients they cared for and not based on individual patient visits. These plans also relied on primary care providers as gatekeepers to ration more expensive specialty and inpatient care, enabling them to benefit financially if they kept down use of this expensive care among their patients.

This gatekeeping function, in turn, unlocks the rest of Enthoven’s masterplan. The reduction of wasteful care, especially as provided by specialists, would prompt a rationalization of the health care workforce, reducing the number of specialists. Enthoven writes: “Primary care physicians would assume more of the responsibility for the total costs of care of their patients, and specialists whose costs were judged by such primary-care physicians to be excessive would find themselves obliged to negotiate lower fees to retain their referrals.”97 Enthoven thought mobilizing consumer choice could correct the overreliance on expensive, specialty doctors in the United States—a politically thorny problem that was resistant to direct regulation.

Managed competition has so deeply permeated the health policy zeitgeist that it has influenced nearly every major health financing reform effort of the past decades. It graduated to main stage on the policy scene in the early 1990s, when it was incorporated into the blueprint for President Clinton’s attempt at health reform, the Health Security Act,

93 Enthoven, Second Part, supra note 89, at 710.
94 Id. at 713-714.
95 Id. at 718.
96 Enthoven, First Part, supra note 89, at 652.
97 Enthoven, Second Part, supra note 89, at 715.
in 1993.\textsuperscript{98} Although that reform failed, the idea lived on. It influenced the design of the Medicare Part D prescription drug coverage and Medicare Advantage, where Medicare beneficiaries can choose among plans administered by private health insurance companies. Most recently, the idea undergirds the creation of the ACA’s health insurance exchanges, or marketplaces, based on the 2006 Massachusetts reform. And managed competition ideals have informed proposals floated by Republicans to replace the ACA and to privatize Medicare.\textsuperscript{99} Even though none of these efforts followed Enthoven’s blueprint exactly, they all internalized the concept he preached: that consumers with buying power will drive value in a managed, competitive insurance marketplace.

2. The Shortcomings of Managed Competition

Enthoven’s hope was, in part, to solve some of the most politically intractable problems in the health care system: fee-for-service payment, where providers are paid per unit of care, and overuse of overpriced specialty care. However, the theory, as applied, has neither enabled people to choose better what they want, nor has it generated the hoped-for system transformation.

a) Conceptual Shortcomings

The conceptual problem with Enthoven’s vision is that it is built on false assumptions about people’s ability to select among health plans based on preferences. To Enthoven’s credit, the best empirical evidence on this point emerged later, but the outcomes were largely predictable.

Choosing a health insurance plan implicates all of the challenges described in Part I. The choices are complex and typically deal with issues of first impression. He expected people to consider tradeoffs between, for example, possible future use of home health care versus hospital care, possibly having no experience with or exposure to either. For many people, especially those who have experienced neither of these types of care, it is hard to imagine how to order preferences between the two, and how much to be willing to pay for each one.

Furthermore, insurance choices require at least moderate mathematic skills to determine total possible spending, taking into consideration benefits, networks, premiums, and cost-sharing.\textsuperscript{100} Most importantly, the choice of health plan is all about risk and uncertainty, conditions that thwart decision-making for even a perfectly informed and well-educated buyer.

Finally, even if Enthoven’s idealized customer did exist, managed competition would be unlikely to transform health care delivery, as he theorized, in the health care marketplace as it exists in reality in the U.S. He imagined insurers would hear consumers’ signals of

\textsuperscript{98} Health Security Act, H.R. 3600, 103d Cong. (1993-1994).
\textsuperscript{99} Supra note 8.
\textsuperscript{100} See supra note 47.
what they wanted and put pressure on providers to improve health care delivery structures in accordance. Yet, insurers lack the market power vis-à-vis providers to do so. Although less true when Enthoven first wrote, providers have accreted substantial market power through consolidation, undermining insurers’ relative bargaining position. When providers flex their muscles in negotiations, they usually win. Even more, the very structure of Enthoven’s model undermines insurers’ ability to gain leverage over providers. Managed competition relies on having multiple insurers competing for customers, but the more insurers there are, the harder it is for any single insurer to enroll enough people to gain power over providers. The ACA’s piecemeal design exacerbates this problem by rolling out the policy to a small slice of the population. In initial best-case scenario estimates, about twice the current reality, 23M people (a mere 7% of the population) would buy an ACA exchange policy. This number of people spread across fifty states does not give insurers much added leverage against behemoth hospital systems. The theory of managed competition loses its shine when played out in real markets and, especially, with real consumers.

b) Empirical Evidence on Managed Competition

Mountains of empirical evidence confirm that people do not choose wisely, as Enthoven predicted. Studies have tried to pinpoint what exactly impedes decisions—from complexity of choices to insufficient information—presumably to correct the elements that cause people to fail. But increasingly, experts have recognized a fundamental inability among consumers to evaluate and rank options even in the best-case scenario with simple choices and transparent information.

Much of the empirical research studies situations where there is a dominant—or clearly superior—choice among options. This means that there is no scenario in which Plan A is better than Plan B, for any buyer. For example, imagine Plan A has high monthly premiums and low cost sharing and Plan B has low premiums and a high deductible. They cover identical benefits and offer the same provider network, but someone who chooses Plan A will face higher total spending at any level of medical care use. Studies of private

101 Infra note 314 and corresponding text.


104 Saurabh Bhargava & George Loewenstein, Choosing a Health Insurance Plan: Complexity and Consequences, 314 JAMA 2505, 2506 (2015) (“The main barrier to financially efficient choice was not the number of options confronting employees, nor the transparency of their presentation, but rather the … lack of basic understanding on health insurance”); Saurabh Bhargava, George Loewenstein, & Justin Snyder, Choose to Lose: Health Plan Choices from a Menu with Dominated Options, 132 Q. J. Econ. 1319, 1325 (2017) (“Taken collectively, results from the experiments suggest that the demand for dominated plans does not predominantly reflect the informed preferences of consumers or the consequences of menu complexity, but instead involves a failure of consumers to accurately evaluate and compare plans.”).
insurance, the Medicare market, and ACA plans all reveal the pervasiveness of people choosing dominated plans. Since there is no one who would rationally choose a dominated plan, doing so is objectively a poor choice and ripe for study.

Based on a simulated insurance purchase, one study by Eric Johnson and colleagues reported that people have less than even odds of making the right insurance choice when given a small number of options and information about a family’s medical needs. This study excluded respondents who failed to demonstrate that they understood basic insurance terms (premiums, deductibles, or copayments) after a brief lesson. This means that the under 50 percent rate of success was among a pool of people with relatively more knowledge or capacity. Even the Wharton business school participants in this study got it right only 73 percent of the time.

Studies reveal similar results when employees choose among options for their employer-sponsored health insurance. Among enrollees in the University of Michigan employee plan, over one-third of all workers enrolled in a dominated plan, which was identical to another option in every way, except that it had a more restricted provider network. Again, there is no scenario in which a worker would be better off enrolled in this plan that a large number of the University’s employees “chose.” Another study of a large U.S. firm similarly found that a majority of employees chose a dominated option, which was more expensive than a higher-deductible option at every level of possible health care use but otherwise identical (in terms of benefits, provider network, administrator, etc.), and which resulted in 24 percent excess spending on premiums. Lower-income employees were more likely to select dominated plans.

105 Johnson et al., supra note 20, at 3. The study concludes: “Consumers left to their own devices seem to make large errors when choosing health insurance, and they seem to be unaware of that failure.” Id. at 5.

106 Id. at 4.

107 Id. at 4.


109 One may rightfully ask why U of M is even offering such a plan—a point discussed further below.

110 Bhargava, Loewenstein, & Sydnor, supra note 104, at 1321 (studying an employer where employees can “build” their own plans by choosing four cost sharing elements (deductible, copayment, coinsurance, and out-of-pocket maximum) for plans that otherwise are identical in terms of, for example, covered benefits, provider network, and plan administrator). To illustrate a dominated plans, for employees to lower their deductible from $1000 to $750, they had to play $528 more in premiums per year, spending $278 more than they would in any scenario under the $1000 deductible plan. Cf. Benjamin R. Handel, Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts, 103 AM. ECON. REV. 2643 (2018) (showing that in one employer setting, correcting inertia that leaves people in dominated plans exacerbates adverse selection and leads to an overall welfare reduction).

111 Id. at 1322.
In the Medicare market, a study of Part D, where beneficiaries choose among private prescription drug plans, showed that over 73 percent of enrollees could have chosen a less expensive plan without increasing future spending variance, and the average enrollee could have spent nearly one-quarter less. Another revealed that fewer than 10 percent of Part D enrollees choose plans that end up being optimal for them in terms of total cost. Even though people might chose a more expensive plan for rational reasons other than price, including formulary or favorite provider, this study tested and ruled out such possibilities. One-quarter of individuals could have done better by picking at random, and nearly three-quarters would have done better by picking the plan with the lowest premium.

Despite some early evidence suggesting that people might get better at making decisions over time, these poor choices have persisted in the decade since the program began and have in fact grown worse over time, suggesting that people are not learning to be smarter consumers.

The same results emerge in the Medicare supplemental insurance market, where people buy private policies to pay for costs not covered by traditional Medicare, which only pays for 50 percent of costs for the average retiree. There are two main types of plan. Medicare Advantage is a managed care plan that replaces original Medicare with a private plan that has a narrower network of providers. These plans cover all Medicare benefits plus they fill in gaps in cost-sharing and sometimes cover additional services such as dental, vision, and hearing. The second option, “Medigap” plans, layer on top of original

\[112\] Jason Abaluck & Jonathan Gruber, Heterogeneity in Choice Inconsistencies Among the Elderly: Evidence from Prescription Drug Plan Choice, 101 AM. ECON. REV. 377, 379 (2011). They find that individuals consider premiums, instead of total out-of-pocket costs, in making decisions. Id. See also Florian Heiss et al., Mind the gap! Consumer Perceptions and Choices of Medicare Part D Prescription Drug Plans 3 (NBER Working Paper 13627, 2007) (finding that Medicare Part D consumers selected inexpensive plans when more expensive plans with more comprehensive coverage were actuarially better); Chao Zhou & Yuting Zhang, The Vast Majority of Medicare Part D Beneficiaries Still Don’t Choose the Cheapest Plans that Meet their Medication Needs, 31 HEALTH AFF. 2259, 2261 (2012) (finding that only 5.2 percent of beneficiaries choose the cheapest plan and that, by doing so, they spent on average $368 more annually).


\[114\] Id. at 24.

\[115\] Id. at 21.

\[116\] Jonathan D. Ketcham, Sinking, Swimming, or Learning to Swim in Medicare Part D, 102 AM. ECON. REV. 2639, 2653 (2012) (studying enrollment in Caremark Part D plans in the initial and second year (2006-2007) and finding that people switched to plans that notably decreased their overspending). Later studies, such as Abaluck and Gruber, supra note 112, were not able to replicate such results while looking at a longer time period and a broader range of plan options.

Medicare, filling in cost-sharing gaps but not narrowing the network or covering any additional services. Once someone chooses between Medicare Advantage or Medigap, few make an active choice again between them in subsequent years, which leaves some people in a dominated plan. One study documented that when a policy change made Medicare Advantage clearly superior, 75 percent of enrollees remained in the dominated Medigap plans. The authors hypothesized any number of reasons might have influenced them, from inertia to limited cognitive capacity to the complexity of these decisions and the difficulty of comparing the many options. Not surprisingly, insurers in this market take advantage of this stickiness by increasing premiums after the first year.

Other studies document how the overwhelming number of options in the Medicare supplemental market can also impede consumers. For example, if the number of Medicare Advantage options become too many, people opt instead for original Medicare and Medigap. Likewise, for Medigap, consumers can choose among ten different benefits designs, but a majority choose the most comprehensive plan design with the highest premiums. It is possible, but unlikely, that most retirees have the same preference for this plan. More likely, people are opting for what seems simplest and least risky, as a result

118 Anna D. Sinaiko et al., Enrollment in Medicare Advantage Plans in Miami-Dade County: Evidence of Status Quo Bias, 50 INQUIRY 202, 211 (2014). This stickiness may be from a genuine aversion to revisiting options or over-loyalty to a past choice, what psychologists call “status quo bias.” William Samuelson & Richard Zeckhauser, Status Quo Bias in Decision Making, 1 J. RISK & UNCERTAINTY 7, 26-31 (1988) (observing health plan choices among Harvard University employees).

119 Christopher C. Afendulis et al., Dominated Choices and Medicare Advantage Enrollment, 119 J. ECON. BEHAVIOR & ORGANIZATION 72, 73 (2017) (finding that a majority of beneficiaries did not switch out of traditional Medicare plans dominated by private fee-for-service plans, which became available in the mid-2000s).

120 Id. at 75. See also J. Michael McWilliams et al., Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decision Making, 30 HEALTH AFF. 1786, 1791-92 (2011) (describing the cognitive limitations of Medicare beneficiaries, especially as they age, and how it affects plan choice).


122 McWilliams et al., supra note 120, at 1791. See also Yaniv Hanoch et al., How Much Choice Is Too Much? The Case of the Medicare Prescription Drug Benefit, 44 HEALTH SVCS. RES. 1157, 1163 (2009) (increasing the number of drug plan options decreased accuracy of identifying plans with specific attributes, including lowest cost).


124 Mark J. Brown & Helen Doerpinghaus, Asymmetric Information and the Demand for Medigap Insurance, 31 INQUIRY 445, 448 (1994) (“There is no statistically significant difference in the policy provisions chosen or the premiums paid by self-reported high -and low-risk insured individuals).
of what is called “choice overload,” where too many choices cause people to attempt to simplify,\textsuperscript{125} disproving the basic economic assumption that more choices are better.\textsuperscript{126}

Even when there is not a plan that is objectively correct, people may still not choose the plan most aligned with their own stated preferences. The study by Handel and Kolstad described above showed that basic misunderstanding of plan options could influence decisions significantly.\textsuperscript{127} They estimated that someone who believed incorrectly that one option with a lower deductible had a larger network than a second option valued the latter at $2,326 less than someone who understood they both had the same network structure.\textsuperscript{128} This person might choose based on misunderstanding, rather than a genuine preference for more comprehensive coverage.

The bottom line of this body of studies is that regardless of age, plan type and options, and capacity, people fail to choose well among health plans. Early evidence on the ACA exchanges, discuss in the next subpart, only affirms this fact. A common response has been to attempt to nudge people toward better decisions. That strategy has not worked either, as the following discussion illustrates.

c) The ACA, Flawed Decision-making, and Failed Nudges

Emerging studies of the ACA exchanges show that, even with “nudges” toward better decisions, people are not choosing well. Consistent with the evidence above, many people are selecting almost exclusively based on lowest premium sticker price, often resulting in the choice of a dominated plan once subsidies are factored in.\textsuperscript{129}

Others choose health plans that are not aligned with their own stated medical needs and preferences.\textsuperscript{130} In a study simulating the purchase experience on ACA exchanges, only

\textsuperscript{125} Sheena Iyengar & Emir Kamenica, \textit{Choice Proliferation, Simplicity Seeking and Asset Allocation}, 94 J. PUB. ECON. 530, 538 (2010) (“Our results establish that the size of the choice sets also impacts what types of options are selected by the market participants. We find that a larger choice set increases the appeal of simple, easy-to-understand, options.).

\textsuperscript{126} For a comprehensive, easily digestible version of this idea, see BARRY SCHWARTZ, \textit{THE PARADOX OF CHOICE} (2016).

\textsuperscript{127} Handel & Kolstad, \textit{supra} note 56, at 2485.

\textsuperscript{128} Id.

\textsuperscript{129} Reed Abelson, \textit{Cost, Not Choice, is Top Concern of Health Insurance Customers}, N.Y. TIMES (Aug. 12, 2016) \url{https://www.nytimes.com/2016/08/13/business/cost-not-choice-is-top-concern-of-health-insurance-customers.html?r=0}; DEPT. OF HEALTH & HUMAN SERVICES, ASPE RESEARCH BRIEF: HEALTH PLAN CHOICE AND PREMIUMS IN THE 2016 HEALTH INSURANCE MARKETPLACE 7 (Oct. 30, 2015) (In 2014, the majority (64\%) of enrollees selected the lowest (43\%) or second lowest (21\%) priced plan in their metal tier. In 2015, 47\% selected the lowest or second lowest price plans (31\% and 17\% respectively))

\textsuperscript{130} Andrew J. Barnes, Yaniv Hanoch, & Thomas Rice, Determinants of Coverage Decisions in Health Insurance Marketplaces: Consumers’ Decision-Making Abilities and the Amount of Information in their Choice Environment, 50 HEALTH SVCS. REV. 58, 67 (2014) (finding in a simulation based on purchasing
one-third of respondents chose the cost-minimizing plan, based on their own anticipated medical care need.\textsuperscript{131} Forty-three percent over insured, on average overspending by 24\% or $1324 on premiums, and nearly a quarter underinsured.\textsuperscript{132} The authors estimated that if all people buying plans on the ACA exchanges had similar error rates as the study population, “the result would be roughly $7.1 billion of excess spending each year, borne by a population with low to moderate incomes.”\textsuperscript{133}

The study suggested that the labeling of plans in the ACA exchanges, which was an attempt to make choices more straightforward, may have created consumer confusion.\textsuperscript{134} The ACA plans are organized and sold by “metal” level, such as Gold, Silver, and Bronze. Higher metal levels meant that a plan will on average pay for a higher share of spending on essential health benefits—known as higher actuarial value. Plans with higher actuarial values tend to have higher premiums to make up for less cost-sharing.\textsuperscript{135} The authors found more generic labels improved choices, but only a little.\textsuperscript{136}

Consumers are leaving money on the table. For people with especially low incomes (defined as 100-250\% of the federal poverty level, or $25,750 to $64,375 for a family of four in 2019\textsuperscript{137}), the law requires insurers to provide a second subsidy called cost-sharing reductions (CSRs), which decrease out-of-pocket spending when someone uses medical care. To get CSR assistance, someone must buy at least a Silver-level plan. If she buys the plan with the cheapest premiums she can find, likely a Bronze plan, she disqualifies herself from these subsidies, and her total spending on premiums and cost sharing will almost

\begin{itemize}
\item \textsuperscript{131} Saurabh Bhargava, George Loewenstein, & Shlomo Benartzi, \textit{The Costs of Poor Health (Plan Choices) & Prescriptions for Reform}, \textit{3 Behavioral Sci. & Pol’y} \textit{1} (2017). This study varied plans only by cost. It told respondents that benefits were equal among plans and did not mention network differences \textit{Id.}
\item \textsuperscript{132} \textit{Id.} at 7-8.
\item \textsuperscript{133} \textit{Id.} at 10.
\item \textsuperscript{134} \textit{Id.} at 1.
\item \textsuperscript{135} This is not universally true after the 2018 open enrollment, where plans in many states priced up Silver Plans to increase federal premium subsidies to make up for the cost-sharing reductions the Trump Administration won’t pay. \textit{See} Margot Sanger-Katz & Kevin Quealy, \textit{When Silver Costs More than Gold: How Trump’s Actions Have Scrambled Insurance Prices}, \textit{N.Y. Times} (Oct. 27, 2017), https://www.nytimes.com/2017/10/27/upshot/when-silver-costs-more-than-gold-how-trumps-actions-have-scrambled-insurance-prices.html.
\item \textsuperscript{136} Bhargava et al., \textit{supra} note 131, at 10.
\end{itemize}
certainly be higher than if she bought the Silver-level plan. Millions of enrollees have fallen into this trap.138

The overwhelming response by scholars and policymakers to all of this evidence has been to try to correct pervasive decision-making errors, using the insights of behavioral law and economics.139 For example, several exchanges try to nudge consumers eligible for cost-sharing reductions to Silver plans by displaying them first on websites, instead of showing the cheapest Bronze plans first as they do for other buyers.140 More assertively, the federal exchange healthcare.gov issues a warning if someone eligible for cost-sharing reductions tries to buy a Bronze plan.141 Even with such efforts, over 20 percent of those eligible for CSRs were still buying Bronze plans.142 It is possible that some people could stomach no higher spending on premiums at the point of purchase, but this discuss is shortsighted for those who end up spending more in total over the year by defaulting on the CSRs.

Healthcare.gov and eight state exchanges have also instituted total cost calculators to encourage consumers to consider subsidies and cost sharing in making purchases.143 The marketplaces have struggled to design these calculators in a useful way, trying to balance the brevity of input questions with the accuracy of output. One state reported, tellingly, that it avoided asking too many input questions because it “might give consumers a false sense of accuracy.”144 The output is still very complicated, breaking down a total annual estimate into monthly premiums, deductible spending, and basic plan information.145 The study aptly noted: “Delivering on this vision [of a consumer-friendly shopping experience] is


141 XPOSTFACTOID, supra note 139. Some reports are, however, that the warning itself is confusing. Id.

142 Id.

143 Giovannelli & Curran at, supra note 139, at ___.

144 Id. at 5.

145 Id. at 6.
difficult because health insurance is complicated.” More, or different, information does not necessarily help.

The Johnson simulation, discussed above, tested various decision support tools and concluded that most had little positive effect. For example, a cost calculator, which displayed total annual cost among options resulted in only small decision making improvements.\textsuperscript{147} The only approach that substantially reduced errors was a combination of just-in-time education, cost calculator, and, most importantly, a smart default with an opt out.\textsuperscript{148} Yet, consumers with these tools did not show a large increase in their confidence in their decisions, even though their final decisions were considerably better.\textsuperscript{149} The study authors conclude: “Consumers left to their own devices seem to make large errors when choosing health insurance, suggesting that they will select options that are not cost-efficient and they seem to be unaware of their failure.”\textsuperscript{150}

Another favorite approach among researchers is to simplify the choices or to package them differently. One set of health economics researchers homed in on and tested the hypothesis that people would do better if they had fewer, simpler options, only to find out that it made little difference when tested empirically.\textsuperscript{151}

Others propose repackaging options to deal with problems of bounded rationality. For example, law professor Russell Korobkin has proposed a redesign of health insurance policies, which he calls “relative value health insurance.”\textsuperscript{152} Insurance policies would bundle services based on evidence of their comparative cost effectiveness, or technically-calculated value. Putting aside the lack of data to calculate in this way (which is a large concession), the idea is that a Level 1 policy would cover only the most cost-effective treatments and a Level 10 would cover the universe, from high to low value. He explains that: “[t]he simple numerical rating scale would provide boundedly rational consumers with a useful tool for allocating resources between their medical care and other goods and services.”\textsuperscript{153} He imagines that “[a]t the time of insurance enrollment, consumers could consult the current list of relative value ratings for all treatments, organized by condition,

\begin{flushleft}
\begin{enumerate}
\item Id. at 7.
\item Johnson et al., supra note 20, at 4.
\item Id. at 5.
\item Id.
\item Id.
\item Bhargava & Loewenstein, supra note 104.
\item Korobkin, supra note 9.
\item Id. at 528.
\end{enumerate}
\end{flushleft}
which would provide concrete examples of what interventions would need to be covered by policies set at different rating levels.”

The proposal may offer a reasonable way to root out some low-value care, if most people do not buy the top-Level plans and it might eliminate some bias toward overuse that occurs when rationing occurs at the point of care, but other biases will be stronger with ex ante decisionmaking, including over-optimism, anchoring on certain treatments on or not on a list, or risk aversion.

More detrimentally, this fantasy of insurance policy purchasing is hard to square with how people actually make such decisions. Even if policies ranked by value are marginally more logical than the current metal-level health insurance options, people will no more understand what they are getting or not getting with a Level 8 policy than with the Gold-level Blue Shield PPO option. More fundamental problems, such as the lack of well-ordered preferences, the failure to understand risk and probability, and literacy and numeracy deficits remain. What will undoubtedly occur is that people with more disposable income will pick more comprehensive coverage, while people without will buy as much as they can get. Few people will make the kinds of rational tradeoffs Korobkin envisions. So, his proposal merely becomes an even more forceful rationing of medical care by economic means and does little to enhance meaningful choice.

Worse even, it perpetuates the false notion that people are getting what they want. Most people will have a hard time deciphering what the effects of different bundles would be on their lives and livelihood. Furthermore, to the extent people have preferences about deeper or shallower coverage, they might not at all align to bundles of services organized by some measured value. Yet, an insurer, hospital, or policymaker can claim that someone chose her own fate if she selected a Level 5 plan, when later denied Level 6 medical care.

This type of technocratic tinkering is celebrated as innovation within a market structure. It might reduce the use of low-value care overall, if fewer plans cover it than now (although that same end could be achieved without an overhaul of health plan design). Yet, it unquestionably grows market bureaucracy, requiring huge investment in comparative effectiveness research, sorting treatments into levels, and redesigning health insurance policies accordingly.

At the end of the day and in light of the reality of how people choose among health plans, creating choices, even among simplified or differently-organized options, neither produces the ability for people to choose what they want nor does it drive health care value based on those choices. The ACA exchanges have successfully increased the number of people with insurance. Yet, it is a stretch to say that they have enabled people to choose health plans more aligned with their preferences or that competition among plans has resulted in better healthcare.

Enthoven’s vision of managed competition—and the many iterations on it over the years—seems hard to square with reality. The research shows that people do not navigate

\[154\] Id. at 557.
options with the sophistication Enthoven imagined. More so, it is difficult to improve their decisions with anything short of a strong default, a decision-support shove, so to speak.155 At that point, of course, choice is not doing any real work.

3. The Bureaucracy and Costs of Managed Competition

Managed competition has not produced efficient results, nor has it avoided government oversight. Just the ACA version of managed competition has generated a massive regulatory infrastructure that was established and continues to grow apace in a futile attempt to support better consumer choice among barely distinguishable health plans. And all of these efforts serve the only 3-4 percent of the population who are enrolled in the exchanges.156

The cost of setting up and running the ACA exchanges is staggering. The federal government spent nearly 5 billion dollars on state grants to establish exchanges and continues to spend 1-2 billion dollars a year on an ongoing basis for operation of healthcare.gov, the federally-funded exchange.157 It spent $2.5 billion dollars to support temporary health insurance cooperatives, many of which later failed.158 When the initial rollout of the healthcare.gov website, which over half of the states rely on, failed, enrolling only six people on its first day, the effort to overhaul it cost $1.7B, compared in an initial budget of $93.7M.159 It also wrought reputational harm on the ACA and the Obama Administration.

States with their own exchanges must fund a large part of their ongoing operations. California estimated it would spend $534 million, excluding federal grants, by the end of FY 2017 on administration of Covered California with ongoing annual costs of over $350

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155 Cf. Bubb & Pildes, supra note 11, at 1621, 1625 (describing default contributions rates as operating more like a mandate than a nudge in reality).


million dollars, funded out of plan assessments.\textsuperscript{160} Even a smaller state like Vermont will spend about $50 million dollars a year to run its state exchange on an ongoing basis.\textsuperscript{161}

Innumerable hours of labor have been spent launching and refining this market. HHS proposed, revised, and issued hundreds of pages of federal regulations to implement the exchanges—all of which face the same risk of regulatory capture as non-market based regulation.\textsuperscript{162} From the passage of the ACA through the end of the Obama Administration, CMS promulgated 24 new rules and generated 64 guidance documents with respect to the exchanges alone.\textsuperscript{163} An entirely new office, the Center for Consumer Information and Insurance Oversight, was established within CMS in part to implement them.\textsuperscript{164}

In parallel, the state regulators have been doing the same, first to set up the exchanges and then later to adapt to the many regulatory changes that have rolled out over the past ten years of ever-shifting implementation. To say the least, implementing an ACA model based on the ideas of managed competition has required a tremendous investment of money and regulatory effort.

This type of effort is duplicated in various degrees for the Medicare supplemental market, including Medicare Advantage and Medigap, and the Medicare Part D market. Add to these costs the private bureaucracy, including the operating costs and profits of the insurers who sell policies in these various managed marketplaces. Finally, the cost of this bureaucracy arguably includes price inflation that might have been avoided with a more effective policy strategy.

The costs include the opportunity costs in the form of time of policymakers and academic experts, distracted from higher-value efforts. The efforts needed to bolster the exchanges has consumed health insurance regulators—at both the state and the federal level. They have commanded oversized technocratic analysis of exchanges and their

\textsuperscript{160} Covered California, \textit{supra} note 22.

\textsuperscript{161} Department of Vermont Health Access (DVHA) Budget Document, State Fiscal Year 2016, at 88.

\textsuperscript{162} As one example, the 2019 annual ACA exchange market rule received over 400 comments, about one-third of which came from industry participants, including Anthem, PhRMA, and DaVita. HHS Notice of Benefit and Payment Parameters for 2019, 82 FR 51052 (Nov. 2, 2017); Cf. Bubb & Pildes, \textit{supra} note 11, at 1605 (“Soft paternalistic measure run the risk of being less visible than more traditional regulations and mandates, which could make the political dynamics more prone to capture rather than less”).


successes and shortcomings, with some of the most talented researchers and think tanks consumed by this task.\footnote{See Allison K. Hoffman, Cost-Sharing Reductions, Technocratic Tinkering, and Market-Based Health Policy, 46 J. L. Med. & Ethics 873 (2019) (offering one example of such analysis with respect to cost-sharing reductions).}

From 2010-mid 2017, a constant stream of research studies and news articles obsessed over the functioning of the exchanges. The New England Journal of Medicine published 35 articles focused on the exchanges, Health Affairs 280 articles that mention and 140 that focus on the exchanges, and over 800 law review articles have discussed the exchanges, 250 of which focus on them in depth.\footnote{Original research (on file with author).} The New York Times published over 300 articles discussing the exchanges from 2010-2016,\footnote{Id.} many of which focus almost obsessively on the state of competition, as measured by the number of competitors or premiums.\footnote{Id.} Scores of researchers track premium prices, declaring them higher or lower than anticipated and setting off celebration or dismay.\footnote{Id.} Stories of increasing prices or a major insurer, such as United Healthcare, dropping out of the exchanges incite panic.\footnote{See, e.g., Jon R. Gabel et al., In Second Year of Marketplaces, New Entrants, ACA ‘Co-ops,’ and Medicaid Plans Restrained Average Premium Growth Rates, 34 HEALTH AFF. 2020 (2015) (measuring premium growth in federally facilitated and state-based marketplaces from 2014-2015 and finding only modest growth); SABRINA CORLETTE & JOANN VOLK, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE AND NATIONAL ACADEMY OF SOCIAL INSURANCE, ACTIVE PURCHASING FOR HEALTH INSURANCE EXCHANGES: AN ANALYSIS OF OPTIONS (2011) (analyzing requirements for and models of active purchasing in health insurance exchanges); DAVID CUSANO & KEVIN LUCIA, THE COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: PROMOTING COMPETITION IN THE INDIVIDUAL MARKETPLACES (Feb. 4, 2016) (studying the ACA’s effects on competition in the individual market in Kansas, Nevada, Rhode Island, and Washington).} Microscopic attention to increases in premium prices grabs attention, while revealing little about whether this model is working or will eventually work.\footnote{Christopher F. Koller, United’s Withdrawal from Exchanges—Much ado about the Wrong Things, 375 NEW ENG. J. MED PERSPECTIVE 303 (2016).}

Finally, the exchanges have fueled several high-profile, high-stakes legal challenges, including \textit{King v. Burwell} over the availability of premium subsidies in the federal exchange\footnote{Id.} and \textit{House v Hargan} (nee \textit{House v. Burwell} and briefly \textit{House v. Price}) over the legitimacy of the Obama Administration’s payment of cost-sharing reductions without
Congressional appropriation.\textsuperscript{173} Dozens of lawsuits have been filed against the federal government for the nonpayment of money owed to exchange insurers under the ACA.\textsuperscript{174} Such litigation arises largely due to the complexity of the market-based infrastructure and likely consumes a lion’s share of the resources in the Solicitor General’s office.\textsuperscript{175} 

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In sum, managed competition, embodied in the ACA health insurance exchanges has created a massive regulatory scaffolding—bureaucracy—without the payoff that the theory promises. Billions of dollars per year go to the mere administration of various marketplaces. Countless hours of time are spent scrutinizing them and making technocratic adjustments to try to get them to work a little better at the margins, and they have fueled an endless stream of litigation and related costs. This is all in addition to the costs of administration for the private insurers who are the machinery behind the exchanges. In all likelihood, this market-based policy created as much, perhaps more, bureaucracy than a more direct approach to expanding access would have, and consumers are arguably worse off than under a simpler approach.

B. Moral Hazard and the Market for Medical Care

Perhaps the most influential of economic theories on the development of health law and policy over the past decades has been moral hazard.\textsuperscript{176} And perhaps more than any other idea, it has impeded productive health care regulation by perpetuating the flawed idea that health care consumers can, and should, rationalize health care spending at the point of use. Reflecting on the American obsession with moral hazard, Malcolm Gladwell wrote in 2005: “Health economists in other Western nations do not share this obsession. … But [in the U.S.] moral hazard has profoundly shaped the way think tanks formulate policy and the way experts argue and the way health insurers structure their plans and the way legislation and regulations have been written.”\textsuperscript{177} He goes on to credit the U.S. health care “mess” to the particular way moral hazard has shaped how American policymakers think about insurance.\textsuperscript{178}

\begin{itemize}
  \item \textsuperscript{173} House v. Hargan, Case 14-cv-01967-RMC (Dec. 15, 2017).
  \item \textsuperscript{174} \textit{How the ACA ‘Risk Corridor’ Fallout Is Hurting Health Care, KNOWLEDGE@WHARTON} (Mar. 29, 2018), \url{http://knowledge.wharton.upenn.edu/article/significance-risk-corridors-lawsuits/}.
  \item \textsuperscript{176} Arrow, \textit{supra} note 28, at 961-62 (introducing the idea of “the moral hazard” for patients and physicians); Mark V. Pauly, \textit{The Economics of Moral Hazard: Comment, 58 AM. ECON. REV.} 531 (1968) (arguing that moral hazard is more serious of a problem than Arrow hypothesized and that it may make some expenses uninsurable).
  \item \textsuperscript{177} Malcolm Gladwell, \textit{The Moral Hazard Myth, THE NEW YORKER} (August 29, 2005), at 44.
  \item \textsuperscript{178} \textit{Id.}.
\end{itemize}
Among other influences, moral hazard prompted a phenomenon of “consumer-driven health care.” (CDHC). Like managed competition does for health plans, CDHC relies on individual decisions regarding medical care—at the point of care—to spark price competition among providers and to reduce spending on low-value care. As economists Jamie Robinson and Paul Ginsburg put it: “In the consumer-driven world view, patients should manage their own care, with the advice of their physicians and with information on prices and performance derived from Internet sites, patient groups, and personal advisers.” CDHC predicts that, in theory, if patients must pay for more care out-of-pocket, rather than with insurance, they would price compare and spend less on low-value health care, which would enable them to spend more on things they value more, such as housing, food, or leisure. In turn, a regulatory morass has developed to try to realize this vision—with a web of laws promoting the transparency of price information and policing the amount of skin in the game—even as mounting evidence show this concept does not work in application as theory predicts.\(^\text{180}\)

1. The Theory and its Promise

Moral hazard has come to mean, most simply, that insurance increases losses. The greater protection against losses someone has, the less incentive she has to avoid them.\(^\text{181}\) The concept of moral hazard originated in early fire insurance underwriting, where it operated in a different way, to describe individuals as “moral hazards,” or not trustworthy enough to deserve the benefits that insurance confers.\(^\text{182}\)

Economists, including Kenneth Arrow in 1963\(^\text{183}\) and Mark Pauly, writing in response to Arrow in 1968,\(^\text{184}\) brought the idea of moral hazard into broader economic theory, where Pauly made it a phenomenon about rationality, more than morality.\(^\text{185}\) Instead of a character flaw, moral hazard came to represent the idea that any rational person who does not have to internalize the full extent of a cost has less incentive to avoid or limit it.\(^\text{186}\) Pauly argued


\(^{182}\) Id. at 263-264.

\(^{183}\) Arrow, supra note 28.

\(^{184}\) Pauly, supra note 176.

\(^{185}\) Baker, supra note 181, at 271 (describing that temptation became incentives and rational actors took the place of moral ones.)

\(^{186}\) Pauly, supra note 176, at 535. Arrow and others extended the idea beyond insurance, to any situation where one party’s actions create a loss borne by another Kenneth Arrow, The Economics of Moral Hazard:
that “need” for health care does not exist independently, and that demand for health care is elastic and follows the same rules as any other consumer product. In turn, insurance should be limited so people don’t overconsume health care because the price feels artificially low.

Moral hazard can in theory arise two ways. First, insurance reduces incentives to take care to avoid harms, which is sometimes called “ex ante” moral hazard. Second, insurance creates a risk of malingering after a loss, or “ex post” moral hazard. For example, once sick, people will overuse care if it is fully paid for by insurance, in turn driving up health insurance premiums.

From its initial adoption into economics, leading economists challenged the accuracy of Pauly’s conception of the idea, on both technical and normative grounds. Arrow, both in his original writing and in response to Pauly, pushed back on the extent of moral hazard by suggesting that other countervailing factors limit overuse, including that the physician acts as a “controlling agent” by attesting to necessity of a treatment and that insurance company review and social norms counter it. John Nyman challenged the notion that moral hazard was a problem, as Pauly suggested by showing that much of what Pauly’s initial models deemed inefficient was in fact efficient spending because insurance caused a positive income effect once people were ill.


187 Pauly, supra note 176, at 532.
188 Id. at 536.
189 See Baker, supra note 181, at 270 (explaining the distinction between the two); George L. Priest, The Current Insurance Crisis and Modern Tort Law, 96 YALE L. J. 1521, 1527 (1987) (describing the former as the “reduction in precautions taken by the insured to prevent the loss” and the latter as an “increase in claims against the insurance policy beyond the services the claimant would purchase if not insured.”).
190 Priest, supra note 189 at 1547.
191 Id. at 1547.
192 Pauly, supra note 176, at 533.
193 Arrow, supra note 28, at 961.
194 Arrow, Further Comment, supra note 186, at 538. (“Nonmarket controls, whether internalized as moral principles or externally imposed, are to some extent essential for efficiency”).
195 JOHN A. NYMAN, THE THEORY OF DEMAND FOR HEALTH INSURANCE (2003). Nyman also challenged the accuracy of the findings in the RAND study that suggested that cost-sharing did not produce negative health effects, illuminating that a significant number of people in the high cost-sharing experimental population dropped out of the study. John A. Nyman, Moral and Other Hazards of Economic Analysis of Health Insurance in RESEARCH HANDBOOK ON THE ECONOMICS OF INSURANCE LAW (Daniel Schwartz and Peter Siegelman, eds. 2015).
Pauly’s arguments and overly-simplified conception prevailed in the marketplace of ideas, and moral hazard became a central tenet of law and economics scholarship and is applied widely in fields from torts to contracts to bankruptcy, usually to justify limiting liability and compensation regimes. In health care, it motivated a cottage industry of policy design and scholarship attempting to solve the problem that “over-insurance” causes people to use medical services inefficiently. The solution is to scale back insurance coverage so that people experience a greater share of costs, referred to as having more “skin in the game.” In turn, people with more money at stake, in theory, will stop choosing low-value medical care. Once patients reduce their demand for certain lower-value goods and services, economic theory predicts their prices will drop.

The idea of moral hazard has fueled the growth of high-deductible health plans, where insureds have to pay the first share of medical care costs before insurance kicks in, starting in a strong wave in the late 1990s and early 2000s. Proposals usually pair these plans with private savings accounts that patients can use to pay for their increased share. Mark Pauly and Regina Herzlinger, who has written volumes on creating competition among providers and informed consumers who choose among them, were early academic proponents. Tim Jost and others were wary of the idea from its nascence, cautioning that it likely would not work and would disproportionately harm lower-income and sicker patients. These cautions were prescient.

196 See, e.g., STEVEN SHAVELL, ECONOMIC ANALYSIS OF ACCIDENT LAW 21, 26 (1987) (discussing the need to make sure that liability rules induce people to take the right amount of care to reach an equilibrium between risk and utility created by their actions); Richard A. Epstein, Products Liability as an Insurance Market, 14 J. LEGAL STUD. 645, 666 (1985); (arguing against the foreseeable misuse doctrine that holds manufacturers liable in products cases because shifting liability to manufacturers creates moral hazard of misuse); George L. Priest, A Theory of the Consumer Product Warranty, 90 YALE L.J. 1297, 1313-14 (1981) (discussing how to limit moral hazard through ex-ante definition of warranties in products contracts).

197 WILLIAM G. MANNING & SUSAN MARQUIS, RAND CORPORATION, HEALTH INSURANCE: THE TRADEOFF BETWEEN RISK POOLING AND MORAL HAZARD 31 (1989) (contending that 55 percent coinsurance is optimal); JOHN C. GOODMAN AND GERALD L. MUSGRAVE, CATO INSTITUTE, PATIENT POWER (1992) (arguing for 50 percent coinsurance and 10 percent of income limits on out-of-pocket spending).

198 For a comprehensive history of and critique of consumer-driven healthcare, see Jost, supra note 2; JACOB HACKER, HEALTH CARE AT RISK: AMERICA’S AILING HEALTH SYSTEM AND HOW TO HEAL IT (2008).


CDHC is in strong resurgence. Policymakers have recently advocated for an expansion of tax credits for health savings accounts and regulations that allow higher cost-sharing in ACA health plans. A new wave of Medicaid waiver proposals includes, for example, higher cost-sharing and penalties for use of the emergency room for non-emergency care.

2. The Shortcomings of Law and Policy to Combat Moral Hazard

Moral hazard relies on assumptions about how people react to incentives that, even if compelling in theory, have not proven true in practice. The conceptual shortcomings and the mounting body of evidence described in the following Part make clear that the presumed informed and capable consumer will no sooner appear to choose high-value medical care than she will to select wisely among health insurance plans, regardless of how exactly the incentives are structured.

a) Moral Hazard: Conceptual Shortcomings

Like with managed competition, even before applied in the real world, the assumptions that the theory of moral hazard relies on struggle under scrutiny, as Arrow’s and Nyman’s work argued and as Tom Baker has artfully detailed.201 In theory, moral hazard assumes money can compensate for losses, so that someone who is fully insured can be made whole and lacks incentive to avoid losses.202 For example, if a fully-insured house burns down and the fire insurance company pays the owner the full value of the house, the owner is made whole. Theoretically, if insured for more than the full value of the house, the owner would not prevent a fire or, even worse, might encourage one. This example illustrates clear practical limits to moral hazard. Although money can replace some losses, there are many that it cannot, such as the emotional value of home and possessions.

In the context of health insurance, where losses follow in most cases from bodily harm, money is even less of a good substitute, which tempers moral hazard’s effects. An individual has independent reasons to avoid bodily harm, even if the costs of medical care are fully reimbursed. Many people exercise and eat vegetables to stay healthy, regardless of whether they have comprehensive health insurance.203 And much of illness is random.

It is more plausible that well insured people will use more medical care after they are sick or injured. The first empirical support for this idea came when the RAND Health Insurance Experiment (RAND HIE) showed that, indeed, people scale back on care when they have to pay for more of it themselves.204

201 Baker, supra note 181, at 276-283.
202 Id. at 276.
203 Studies, including the RAND Health Insurance Experiment, show no evidence of ex-ante moral hazard in the form of riskier behavior with health insurance.
204 JOSEPH P. NEWHOUSE ET AL., FREE FOR ALL?: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 162 (1993) (showing that people with less insurance coverage used less care). This study
Yet, even this ex-post moral hazard has its limits. People have reasons independent from cost to use, or not use, care. Many people would rather spend their time in places other than a waiting room, and some avoid medical care altogether.\(^{205}\) Using more care, especially diagnostic care, increases the risk of false positives that will require more testing, time, and possibility invasive procedures.\(^{206}\) On the other end of the spectrum, some types of expensive care, including emergency care, are insensitive to price, meaning that people will use roughly the same amount regardless of whether well insured.\(^{207}\) And as Arrow noted, doctors as “controlling agents” will resist overuse of care, at least to some extent.\(^{208}\)

A second assumption of moral hazard is that people control their spending so that they could in theory avoid spending on low-value care if sick or injured. This assumption is overstated even in contexts where insureds seemingly have the most control, as in automobile accidents, where other drivers, road design, and equipment failure all contribute.\(^{209}\) The assumption maps poorly in the health care context. The RAND HIE showed that most of the difference in care utilization by less-insured subjects occurred when they decided to forgo care altogether.\(^{210}\) Once someone went to a doctor or hospital, the amount of care used did not differ by level of insurance coverage.\(^{211}\) This is because people routinely follow their doctors’ advice.\(^{212}\) Doctors are especially influential when care is most expensive, for serious illness or injury.\(^{213}\) While moral hazard has some blunt, predictive value on spending, countervailing forces mute its impact.

examined nearly 3000 families in plans with several levels of cost sharing, ranging from none to 95% and found that people with higher coinsurance used less care, reporting spending 31% lower in the 95% co-insurance plan than in the free plan.

\(^{205}\) Jennifer M. Taber et al., *Why do People Avoid Medical Care? A Qualitative Study Using National Data*, 30 J. GEN. INTERNAL MED. 290 (2015) (“People often avoid seeking medical care even when they suspect it may be necessary; nearly one-third of respondents in a recent national United States (U.S.) survey reported avoiding the doctor.”).

\(^{206}\) See, e.g., Joan G. Elmore et al., *Ten-Year Risk of False Positive Screening Mammograms and Clinical Breast Evaluations*, 333 NEW ENG. J. MED. 1089 (1998) (finding that a 49 percent risk of false positive result in a retrospective cohort study of 2400 women, resulting in 870 outpatient appointments, 539 diagnostic mammograms, 186 ultrasound examinations, 188 biopsies, and one hospitalization.).

\(^{207}\) Newhouse et al, supra note 204, at 47 (showing that demand for some categories of care, including inpatient medical care for children, was inelastic).

\(^{208}\) Arrow, supra note 28, at 961.

\(^{209}\) See Baker, supra note 181, at 279.

\(^{210}\) Newhouse et al., supra note 204, at 42, 45, 82, 98-99.

\(^{211}\) Id.

\(^{212}\) Levinson et al., supra note 65.

A final, critical assumption is that with more skin in the game people will cut out low-value care. Yet, as discussed above and proven by the empirical evidence below, individuals struggle to make decisions dealing in complex information, including medical care choices. So, health care consumers will indeed ration, but not in ways that are especially efficient, as the evidence described below makes clear.

b) Moral Hazard: Problems in Practice
(1) How the Theory of Moral Hazard Informs Policy

Despite resting on shaky conceptual ground, moral hazard has motivated legal rules that scale back insurance indemnity to, in theory, create incentives for judicious consumer decision-making. In health care, moral hazard is used to justify the current trend toward increased cost sharing and other “personal responsibility” policies in state Medicaid programs.214 It informs increasing employer take-up of high deductible plans and justifies plan design changes that reduce their responsibility for their employees’ medical care spending; 51% of workers with an employer plan had a deductible of $1,000 or higher for individual coverage in 2015, compared to 10% in 2006.215

Moral hazard also motived the rise of tax-advantage savings accounts that individuals can use to pay for their medical care, when their insurance no longer does. These accounts were first created as a demonstration project as part of HIPAA in 1996.216 Even though the demonstration results were disappointing with very low uptake, a next generation product of health savings accounts (HSAs) emerged in response to lobbying efforts as part of the 2003 Medicare Modernization Act and the Bush Administration’s “‘ownership society’ agenda.”217 In parallel, the IRS created rules that require a person to have a plan with a high deductible to qualify for a tax-advantaged HSA.218 This combination of high-deductible plans with tax-favored savings accounts made them disproportionately appealing to people with high incomes who benefitted more from tax-sheltered savings. In 2017, in the wake of the elections, countless policies supporting high-deductible plans and HSAs came in quick sequence from Congress and the Trump Administration.219

948 (1992) (finding that 59% of newly diagnosed cancer patients preferred physicians to make treatment decisions on their behalf; only 12% wanted an active role).


216 Jost, supra note 2, at 81-83.


218 Internal Revenue Service, Health Savings Accounts and other Tax-Favored Health Plans (Publication 969, 2016) (requiring at least $1,300 for individual coverage and $2,600 for family coverage)

219 Supra note 8.
Moral hazard, however, has not translated well into practice. A deep body of empirical evidence has grown to show that the theory has strong practical limits. In health care, CDHC-based policies are for the most part not encouraging better tradeoffs between medical care and other goods, nor is this market-based approach quelling bureaucracy or regulatory intervention. In fact, it demands quite the opposite.

(2) Evidence on Reductions of Care and Outcomes

To review, proponents claim that CDHC increases efficiency because people will spend less on lower-value medical care and shift resources to things they value more. One way they might do so is by reducing the use of low-value types of care. Another way is that people might price compare and choose less-expensive providers. The evidence suggests that people are not following this theoretical playbook.

Studies beginning with the classic RAND HIE, which provided the initial empirical validation of the idea of moral hazard, confirmed the basic claim that increased cost sharing will lower healthcare spending. Yet, what RAND HIE also showed, and has been affirmed now by a quarter-century of empirical research, is that reductions do not result from better consumerism, such as shopping for lower-priced services, or from elimination of wasteful care.

With higher cost-sharing, people reduce “good” care as much as wasteful care. Consumers reduce spending across most health services, including cutting out beneficial

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220 Studies of social insurance programs fail to show the increased utilization that moral hazard predicts would occur with the introduction of indemnity programs. Baker, supra note 181, at 284-89 (citing empirical studies that provide no strong evidence that insurance reduces the level of care and little evidence of significant “ex-post” moral hazard). As one example, switching from third-party to no-fault insurance, which under classic theory would increase accidents considerably, shows only small increases. J. David Cummings & Mary. A Weiss, The Stochastic Dominance of No-Fault Automobile Insurance, 60 J. RISK & INS. 230, 233 (1993).

221 Joseph P. Newhouse et al., Free for All? supra note 204; Amelia M. Haviland et al., Do Consumer Directed Health Plans Bend the Cost Curve Over Time?, 46 J. HEALTH ECON 33, 42 (2016) (“We find that health care cost growth among firms offering a CDHP is significantly lower in each of the first three years after offer”); see also M. KATE BUNDORF, ROBERT WOOD JOHNSON FOUNDATION, THE SYNTHESIS PROJECT, CONSUMER-DIRECTED HEALTH PLANS: DO THEY DELIVER?, at 12 (2012) (reporting, based on survey of studies, between 5 percent and 14 percent reductions on health care spending on average from CDHPs.).

222 Joseph P. Newhouse et al., Free for All? supra note 204 at __; Brot-Goldberg et al., supra note 78, at 1266 (“consumers meaningfully reduce both types of care, calling into question whether quantity reductions overall are net welfare increasing or decreasing”); Mitchell D. Wong et al., Effects of Cost Sharing on Care Seeking and Health Status: Results from the Medical Outcomes Study, 91 AM. J. PUB. HEALTH 1889 (2001) (cost-sharing reduced the use of care for both minor and serious symptoms in a chronically ill population who faced high copayments); Judith H. Hibbard et al., Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?, 65 MED. CARE RES. & REV. 437, 444 (2008) (showing reduction in both low-priority, or less cost-effective, and high-priority acute and chronic visits among people who switched into a CDHP).
pharmaceuticals and preventive care,\textsuperscript{223} as well as lower-value care, such as nonemergent use of emergency departments.\textsuperscript{224} Economist Katherine Baicker and colleagues call the underuse of high value care “behavioral hazard,” which can result even from small cost sharing.\textsuperscript{225}

There is more debate over the extent to which such reductions ultimately lead to negative health outcomes, although increasingly studies suggest they can. There have been only two controlled experiments—RAND HIE and the Oregon Experiment—to examine the ultimate link between insurance coverage and health outcomes, and neither found a strong connection for the overall study population.\textsuperscript{226} If these studies were definitive and people with higher cost sharing randomly reduce both high- and low-value care and end up no worse off, that might be an acceptable result, even if different than anticipated.

However, other studies have shown evidence of harm when people face high cost sharing and reduce care. Even RAND HIE found negative health outcomes for low-income populations.\textsuperscript{227} Numerous observational and quasi-experimental studies since found negative outcomes both among low-income populations and more broadly, especially among older adults, a population that was excluded from RAND HIE.\textsuperscript{228}

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223 See id. See also, e.g., Brot-Goldberg, supra note 78 (“Despite the fact that preventive services are free both before and after the switch to high-deductible care, we find that consumers meaningfully reduce consumption of these services.”). Consumers also reduce services like mental health care and prescription drugs for diabetes management, cholesterol management, depression, and hypertension. Id. at 1296; Michael T. Eaddy et al., How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review, 37 PHARMACY & THERAPEUTICS 45, 47, 49 (2012) (reporting that 85% of relevant studies reviewed showed that increasing patient share of medication costs led to lower adherence and, among studies on adherence and outcomes, 86% showed statistically significantly improved outcomes with increased adherence); Leonard Fromer, Prevention of Anaphylaxis: The Role of the Epinephrine Auto-Injector, 129 AM. J. MED. 1244, 1247 (2016) (showing increased abandonment of prescriptions for life-saving EpiPens as cost increases, with more than 50 percent of prescriptions abandoned when patient cost exceeds $300) (figure 1).

224 J. Frank Wharam et al., Emergency Department Use and Subsequent Hospitalizations Among Members of a High-Deductible Health Plan, 297 JAMA 1093 (2007).


226 Id. Amy Finkelstein et al., The Oregon Health Insurance Experiment: Evidence from the First Year, 127 Q.J. ECON 1057 (2012).

227 Joseph P. Newhouse et al., Free for All? supra note 204, at ___.

228 Amitabh Chandra, Jonathan Gruber, & Robin McKnight, Patient Cost-Sharing and Hospitalization Offsets in the Elderly, 100 AM. ECON. REV. 193, 194 (2010); John Hsu et al., Unintended Consequences of Caps on Medicare Drug Benefits, 354 NEW ENG. J. MED. 2349, 2354-55 (2006); Robyn Tamblyn et al., Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons, 285 JAMA 421, 426-27 (2001); Other studies show that higher cost-sharing reduces behaviors that are known to improve health outcomes, such as medication adherence. Michael Chernew et al., Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care, 23 J. GEN. INTERN. MED. 1131, 1134-35 (2008) (studying data from 6 million employees in large firms and finding that increased cost-sharing resulted in relatively lower medication adherence among individuals in low-income areas); Amelia Haviland et al., How
For example, Medicare beneficiaries whose drug benefits were capped showed lower rates of drug adherence than those without caps, even for chronic diseases like high blood pressure and diabetes.\textsuperscript{229} Those with capped benefits were, in turn, more likely to have higher blood pressure and LDL cholesterol and higher rates of visits to the emergency department, non-elective hospitalizations, and death.\textsuperscript{230} In a study of elderly persons and welfare recipients who under a new Canadian law became subject to a 25% coinsurance rate and a deductible on prescription drugs, rates of serious adverse events, including hospitalization, nursing home admission or death, roughly doubled.\textsuperscript{231} A study of significant increases in cost-sharing in the California Public Employees Retirement System (CalPERS) supplemental coverage for retirees showed decreased use of prescription drugs and physician office visits.\textsuperscript{232} Savings from this decrease were offset by increased hospitalization, which contradicts the results of the RAND study.\textsuperscript{233}

Studies also show that people with less insurance act in ways that might cause more significant future medical problems, and short-term spending reductions may not mean less spending in the long run—a finding that neither the RAND nor Oregon studies were able to measure.\textsuperscript{234} Inversely, studies show a link between increased insurance and participation

\begin{itemize}
\item Hsu et al, \textit{supra} note 228, at 2354-55.
\item Id. at 2355-2356.
\item Tamblyn et al., \textit{supra} note 228, at 426-27 (reporting incidence of adverse events associated with reductions increasing from 5.8 to 12.6 per 10,000 person-months in the elderly population and from 14.7 to 27.6 among welfare recipients in the study). People reduced use of both non-essential and essential drugs—the latter including, for example, antibiotics and gastroprotective medications. \textit{Id}.
\item Chandra, Gruber, \& McKnight, \textit{supra} note 228, at 194.
\item Id. at 209 (conflicting with the RAND HIE bottom line and suggesting that it may have missed implications by focusing on a non-elderly population).
\item Research shows that uninsured people who forgo beneficial care in their pre-Medicare years catch up and spend relatively more when they age into Medicare. J. Michael McWilliams et al., \textit{Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults}, 290 \textsc{JAMA} 757 (2003); J. Michael McWilliams et al., \textit{Use of Health Services by Previously Uninsured Beneficiaries}, 357 \textsc{New Eng. J. Med.} 143 (2007).
\end{itemize}
in activities that are proven to make people healthier, such as better medication adherence and using certain preventive services.\textsuperscript{235}

(3) Why Incentives are Not Working

Empirical studies reveal a range of reasons why skin-in-the-game incentives are not working as predicted and suggest that even with endless regulatory tinkering, they are unlikely to do much better. Most simply, people do not seem to understand the incentives created by these policies and, if they do, fail to respond as a “rational” person would to them. For example, when high-value care is fully covered by insurance, with no cost-sharing in a plan that has a high deductible for other care, it is supposed to create incentives for people to maintain use of this care. Yet, patients do not understand when care, including preventive care, is excluded from their deductibles.\textsuperscript{236} As another example, people reduce care throughout a plan year, even if it is fairly certain they will exceed the deductible and other cost-sharing obligations over the course of the year.\textsuperscript{237} That means that they eliminate care that is free to them.

More detrimentally, people do not seem willing to price compare to get a better deal, even with their own dollars on the line, for relatively fungible services, and when price data is right at their fingertips.\textsuperscript{238} A recent study, based on a natural experiment that occurred when a large employer changed its employee plan from coverage that paid for all medical care to a high-deductible health plan with high cost-sharing, showed decreased

\textsuperscript{235} Benjamin D. Sommers et al., Health Insurance Coverage and Health—What the Recent Evidence Tells Us, 377 NEW ENG. J. MED. 586 (2017) (surveying research on the impact of health insurance on financial security and health). Amy Finkelstein et al., The Oregon Health Insurance Experiment: Evidence from the First Year, 127 Q. J. ECON. 1057 (2012) (reporting higher use of preventive care, access to care, and perceived quality of care, as well as self-reported health improvements, following Medicaid expansion to previously uninsured).

\textsuperscript{236} Mary E. Reed et al., In Consumer-Directed Health Plans, A Majority of Patients were Unaware of Free or Low-Cost Preventive Care, 31 HEALTH AFF. 2641 (2012) (finding that a majority of enrollees were unaware that the deductible did not apply to certain high-value care).

\textsuperscript{237} See e.g., Brot-Goldberg, supra note 78, at 1306-1307 (describing that 25% of total spending reductions over the year in population studied occurred from consumer while under the deductible who are predictably sick and will almost certainly outspend the deductible). This pattern holds in future years, suggesting people do not learn to estimate their true shadow prices in future years. \textit{Id.} at 1308.

\textsuperscript{238} Brot-Goldberg et al., supra note 78, at 1286-88 (showing that consumers with a sophisticated price shopping tool are not price comparing providers); Judith H. Hibbard & Edward C. Weeks, Does the Dissemination of Comparative Data on Physician Fees Affect Consumer Use of Services, 27 MED. CARE 1167, 1172-73 (1989) (finding that providing hundreds of government employees and Medicare Part B enrollees a directory listing and the fees charged by local physicians for common procedures had little effect on their behavior and use of services); Sunita Desai et al., Association Between Availability of a Price Transparency Tool and Outpatient Spending, 315 JAMA 1874, 1879 (2016) (testing a price transparency tool among employees at two large companies and finding it was not associated with lower spending or choosing lower-priced ambulatory settings and, in fact, resulted in modestly higher spending). This study found that only 10% of employees even logged into the tool in the first year of use. \textit{Id.} at 1897.
overall utilization, as in earlier studies. Yet, there was no evidence that employees price compared among services, even though the price comparisons were made easy and employees paid a significant share of the costs out-of-pocket. A co-author of this study, leading economist Amitabh Chandra, told the New York Times: “I was all for high-deductible plans before I wrote my paper,” which he said disabused him of the belief that deductibles and data would prompt good consumerism.

Other studies testing price transparency laws or decision aids show similar results. Despite a tool offered in the California Public Employees’ Retirement System (CalPERS) that displayed prices for lab tests, office visits, and imaging services, only 12 percent of people used the tool in the first fifteen months after it was introduced and, for the most part, they did not choose a lower-priced service after using the tool. The study authors concluded that “simply increasing deductibles and introducing price transparency tools will not induce consumers to price-shop.” Even the study with the strongest positive results showed very limited consumerism.

239 Brot-Goldberg, supra note 78, at 3.
240 Id. at 5.
242 Sunita Desai et al., Offering a Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees, 36 HEALTH AFF. 1401, 1405 (2017) (finding that only a small percent of purchases followed a price search and access to a price transparency tool did not lower spending). This study did find that people used lower-priced imaging services, but only 1% of people using imaging services conducted a price search. Id. Ateev Mehrotra et al., American Support Price Shopping for Health Care, But Few Actually Seek Out Price Information, 36 HEALTH AFF. 1392, 1398-99 (2017) (finding that an unwillingness to switch providers or insurance networks constraints contribute to extremely low levels of price shopping). Two studies do show modest reduction in prices for imaging services among people who used a price-transparency tool, but also show that only a small number of people used it. Christopher Whaley et al., Association Between Availability of Health Service Prices and Payments for These Services, 312 JAMA 1670; Anna D. Sinaiko et al., Association Between Viewing Health Care Price Information and Choice of Health Care Facility, 176 JAMA INTERNAL MED. 1868, 1869 (2016) (reporting that 3.5% of users used Aetna’s web-based price transparency tool and, of those, users chose lower-price services for sleep studies, but the difference was not significant for the other six services studied).
243 Desai et al., supra note 242 at 1405.
244 Id. at 1406.
245 Whaley et al., supra note 242, at 1672-73 (finding that about 6-7 percent of employees searched prior within 14 days of using a service and among those who did, spending was 13.93% lower for laboratory tests, 13.15% lower for advanced imaging, 1.02% lower for office visits, and 2.4% lower for new patient office visits). There is some limited evidence that people may respond more to a well-designed system of reference pricing—where price is set at the level of a designated provider and patients must pay extra if they choose non-designated providers with higher prices. For example, the California Personnel Retirement System (CalPERS) has had success in reducing spending with reference pricing combined with preauthorization to explain pricing to patients. David Frankford & Sara Rosenbaum, Go Slow on Reference
A sweeping study of lower-leg MRIs, which are shoppable, expensive, and “among the least differentiated health care services” found that “on average, patients travel past six lower-priced providers in route to where they received care.”246 People passed up lower-priced services at every level of cost sharing. This study found that only 14% of people went to the lowest-cost MRI provider within 30 minutes of her home and that patients could have reduced out-of-pocket costs by over $80 and insurer spending by over $220.247 The referring physician was the strongest determinant of where people went for an MRI and the median referring orthopedic doctor sent no patients to the lowest-cost provider.248 While many of the above studies document the failures of consumerism without pinpointing the exact situs of the failure, this one suggests that the agency problem—that patients rely on their doctors to make decisions—is one root cause.

In sharp contrast to these scenarios where prices were made transparent, the price of health care is usually indecipherable.249 Often, neither insurers nor providers can or will tell a price of a service beforehand. This is in part due to a belief that prices are proprietary—a problem regulation could address. Yet, it is also due to the unpredictable way medicine is reimbursed, by units of care, so that prices may genuinely be unknowable in advance. If a surgery proves more complicated than anticipated, surgical or hospital bills will be higher. Prices may differ by insured, by insurer, and by provider, so that even the doctor providing the services is unlikely to know how much her services will cost for the patient.250

It is also noteworthy that typically even if users have good information on price, they do not on quality, which is as important for making wise decisions. Although ratings systems have attempted to judge high and low hospital performers, they are underdeveloped and inconclusive; four existing national rating systems have resulted in inconsistent assessments.251 Even if consumers had good data on both price and quality and

Pricing: Not Ready for Prime Time, Health Affairs Blog (March 9, 2015). Although this experiment showed the ability to steer people toward lower-cost services, it saved .26 percent of total expenditure and increased plan administrative costs. Id.

246 Michael Chernew, Zach Cooper, Eugene Larsen-Hallock, & Fiona Scott Morton, supra note 19, at 19.

247 Id. at 5, 19.

248 Id. at 4.


251 J. Matthew Austin et al., National Hospital Ratings Systems Share Few Common Scores and May Generate Confusion Instead of Clarity, 34 Health Aff. 423 (2015).
wanted to use it, they would be faced with impossibly complex decisions about cost/quality tradeoffs.

CDHC advocates argued consumers would overcome such shortcomings because they successfully navigate markets for other complex goods, such as computers or cars. Yet, the complexity of health care has proven greater than choosing between a Mac and PC. More importantly, it is becoming evident that patients do not view their medical care as just another consumer good and resist invitation to price compare. They will follow a doctor’s specific advice, even if the doctor points them to avoidably higher-priced options.

Some scholars herald international examples as consumerism success stories, such as Switzerland, Singapore, Germany, and even China. Even though these countries have systems that build in some degree of choice of services or health plan, none relies on consumerism to save money; rather, they (and other developed peer nations) all use supply-side incentives and regulatory price controls and rationing to get results. Choice allows people to opt for higher level service or amenities, such as a private room, for the most past. The theory is simply becoming increasingly hard to defend, as CDHC is tested in practice.

(4) More Technocratic Tinkering to Improve CDHC’s

Rather than see these deep failures as a sign that consumers may not be the right ones to drive down prices or root out low-value services, these shortcomings have impelled attempts to design more nuanced systems to nudge consumers toward better decisions. Scholars propose rebates and incentives to steer decisions, by making low-value goods relatively more expensive. The classic model in this mold is value-based insurance design (V-BID), proposed by A. Mark Fendrick and Michael Chernew and others, which proposes charging a patient higher copayments for lower-value therapies and less for


253 This idea began with value-based insurance design (VVID) research by A. Mark Fendrick, Michael Chernew and others and was initially called “benefit-based copay.” A. Mark Fendrick et al., Value-Based Insurance Design, 26 HEALTH AFF. WEB EXCLUSIVE w 195 (Mar./Apr. 2007), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.26.2.w195. Iterations on the idea by legal scholars include Korobkin, supra note 9; Christopher Robertson, The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game, 98 CORNELL L. REV. 921 (2013).
therapies more likely to be effective for her. Unlike later iterations, Fendrick and Chernew wisely suggest not paying for wasteful care at all, which would reduce or eliminate care with zero value without any need for consumerism. A related idea is reference pricing, usually applied to pharmaceuticals, where the insurers cover the price for a low-cost benchmark drug and if the patient chooses another higher-priced drug that is deemed a close substitute, she must pay more. These efforts show some, albeit limited, success in carefully designed pilots and populations.

Other proposals, like Korobkin’s discussed above, create a weaker nudge, and a more complex system for people to navigate. People pre-commit to plans that cover only higher value care, and have to pay out of pocket altogether for uncovered services they want, creating a blunt and strong deterrent against using such services and, as a side effect, a maze of coverage and decisions for consumers to navigate.

Another proposal in this vein uses cash payments to discourage people from lower-value care through a complex system. Christopher Robertson proposes that when a doctor recommends expensive treatments that are arguably not cost effective, the insurer offer patients the choice between a portion of the cost of the treatment in cash or the full treatment in kind. He gives the example of a drug that costs $70,000, where the insurer will either provide the drug or pay the patient $10,000 in cash. Although he sells this approach as the “painless” way to have skin in the game, it’s not clear it will produce less pain—maybe different pain.

The proposal enhances incentives to forgo care, but much more strongly for poor people. They feel the potential for a cash payoff as a shove, rather than a nudge. Such choices are not only morally uncomfortable, they are also unproductive in the long run. By suggesting people have a “choice” to use care, such a policy reduces social obligations to ensure care for one another, while forcing poor people to tradeoff among what they may perceive as basic needs.

More importantly, this proposal only adds complexity to decisions that people already struggle to make. Imagine that a patient is deciding between an expensive drug with a low probability of saving her life, versus paying the rent, or helping her child afford higher education. Dangling in front of her the potential for this treatment that her doctor has recommended or offered and that she will struggle to evaluate independently and then

254 Fendrick et al. supra note 253.
256 Frankford & Rosenbaum, supra note 245.
257 Korobkin, supra note 9.
258 Robertson, supra note 260.
259 Id. at 945.
making her choose between it and desperately-needed cash is far from a painless way to put skin in the game.

Both the Korobkin and Robertson proposals offer clever, technocratic solutions that reinforce scaffolding around market-based CDHC approaches. Yet, to the extent certain drugs or treatment have no value or “are not worth their cost,” the goal should be for insurers simply not to pay for them and for doctors not to prescribe them. Scholars and policymakers should redouble efforts on resisting FDA approval for such drugs, rather than contorting the shape of insurance policies in hopes that patients will refuse them, to preserve some illusive and unattractive version of choice.

Nudge solutions result in an unsatisfactory middle ground. The stronger the push, the less the approach honors individual decision-making. Choice and autonomy become illusory. The weaker the incentive, the less an individual will decide based on it, as the evidence above shows. When it comes to health insurance or health care decisions, the level of default needed to prompt successful consumerism for most people must be a determinative default, not a suggestive nudge, such as through framing effects.

Finally, to the extent higher cost sharing plus informed nudges did prompt better consumerism, system effects would be marginal. A relatively small number of very sick people are responsible for the majority of health care spending annually, and most high spenders are not using discretionary services, or those that a consumer would perceive as discretionary. One study estimates that at most only seven percent of consumer out-of-pocket spending is on “shoppable” services, defined as scheduled in advance and with a choice of providers and price data. Conversely, many clearly discretionary services, including elective procedures such as cosmetic surgery, laser eye surgery, or bariatric surgery, are generally not covered by insurance. So even if these skin-in-the-game policies incentivized consumers to decline low-value, discretionary spending or to shop for lower-priced services, the potential dollars saved would be small in comparison to the investment needed to get these policies to work.

260 Id. at 927.
262 Johnson et al., supra note 20.
263 Steven B. Cohen, The Concentration of Health Care Expenditures and Related Expenses for Costly Medical Conditions: 2012, at 1 (Statistical Brief #455, 2014) (reporting that the top 5% of the population accounted for 50% of total health care spending).
One more extreme response one might have to the failures described above is to eliminate insurance altogether—or make it cover only catastrophic spending—to maximize skin in the game and drive down prices to what people are willing to pay.266 Optimistic proponents claim that such a system would eventually grow good information and savvy consumers. A no-insurance approach would undoubtedly have a downward effect on overall spending, but that would be the only good result. The early 20th century taught that even though medical markets can work without insurance, results were unsatisfying.267 People failed to get critical care. Others faced insolvency due to medical spending. And eventually, this cash pay system receded and insurance grew up because medical professionals who had a hard time getting bills paid had to select patients with an eye to who could pay the bills.268 It is no surprise that no developed country takes this path.

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This growing body of evidence undermines the very foundation of CDHC and skin-in-the-game thinking. People with financial incentives and good data do not reduce low-value care or make decisions based on price comparisons. It seems the best possible result of these policies is a reduction in use of care overall—good and bad—which evidence suggests will be harmful in some cases even if not in others.

What these policies have accomplished is to shift responsibility for paying for health care from insurance pools and employers to individuals. The policies will slow growth in insurance premiums, even if they don’t reduce medical spending. In truth, this result might be the bottom line that CDHC advocates seek—less on-budget healthcare spending, rather than a genuine rationalization of medical care use or prices. But it is fallacious to claim that such a result improves welfare by enabling people to better use their resources to get what they want.

3. Scaffolding a Failing Idea and Distraction from Better Alternatives

As with managed competition, legal and health policy attention to these efforts to limit moral hazard through market-based policies has produced tremendous regulatory and intellectual scaffolding. This infrastructure has high direct and opportunity costs, which are hard to justify especially in light of the ethical concerns with and technical failings of such policies in practice.

The CDHC bureaucracy is perhaps best illustrated by the proliferation of transparency laws and private investment into transparency tools that have become building blocks of this particular market-based bureaucracy. To some extent transparency can work even without consumerism if what it does is shame entities to lower prices, but many of the policies are focused on transparency to support consumer decisionmaking.

266 Silver & Hyman, supra note 10.
267 Jost, supra note 2, at 43-46.
268 Id. at 46.
Transparency has generated business for private companies like Castlight or Truven Health Analytics, who build cost-estimator and other tools that major health plans are now offering. Venture capital firms, according to one source, “have poured money into healthcare transparency tool companies,” including $184 million into Castlight before its 2014 initial public offering, $86.3 million into a provider-search website competitor, Vitals, $26.5 million for MDsave, which lists prices for competitors, and $45 million for Amino, part of a “new wave of transparency companies with its consumer-friendly interface and real-time data.”

Proposals—academic and legislative—to increase price transparency have become nothing short of a health policy obsession. Half of the states have passed laws to make prices more transparent to consumers. Many states are working to create, either through regulation or through voluntary efforts, databases that aggregate commercial claims data in part to publish price comparisons for consumers. Organizations encourage proliferation of these laws by rating each state based on them, including the scope of information, type of information, and quality of website for consumers.

The federal government has also joined in. As current CMS Administrator, Seema Verma, touts in a press release on the various transparency rules the current Administration has issued: “You Have the Right to Know the Price.” To help vindicate this right, CMS finalized a new rule for 2019 requiring that all hospitals publish a list of their standard


272 Id. at ___. These states must navigate carefully, after Vermont’s law requiring all employers and insurers to disclose claims and utilization data was found preempted by the federal Employee Retirement Income Security Act of 1974 (ERISA). Gobeille v. Liberty Mutual Ins. Co., No. 14-181 (March 1, 2016).


274 Seema Verma, cms.gov, You Have the Right to Know the Price (Nov. 17, 2018), https://www.cms.gov/blog/you-have-right-know-price (last accessed March 4, 2019).
charges online in a machine-readable format. CMS requested input on what it would take for hospitals to better inform patients of out-of-pocket obligations, including those for out-of-network physicians working at an in-network hospital, resulting in high surprise bills. CMS has also required drug manufactures to include list prices in television ads and has launched new dashboards for Medicare and Medicaid drug spending—presumably to shame the companies, as much as to inform consumers. And CMS is releasing a web-based Medicare price lookup to compare the prices and copayments for procedures that are offered both in hospital and outpatient settings.

This regulatory fixation imagines that if prices were transparent and comprehensible, it would pave the way for better consumerism, despite the rich body of evidence to the contrary, discussed above. CMS’s intended regulated disclosure of surprise bills from out-of-network anesthesiologists or radiologists is especially ironic because most patients have little or no ability to navigate around these bills.

The governmental infrastructure in support of CDHC takes other forms as well, including consumer protection regulations and constant revision of tax laws. Before the passage of the ACA, states had enacted consumer protection laws to limit the amount of financial exposure people, especially vulnerable populations, could have to health care spending. The rise of high deductible plans and HSAs demanded that states reconsider these laws. For example, many states prohibited cost sharing for certain services or populations, such as for home health visits or for victims of violent crimes. Yet, because health plans had to be considered “high-deductible” (defined in 2018 as having deductibles of $1350 per individual and $2700 per family) to be eligible to be paired with HSAs under federal law, states revisited and often repealed these protections. In addition, states had to decide whether to reconcile state tax law exemption of HSAs with federal exemption. In 2005-2006, fifteen states amended their tax laws to enable favorable treatment for HSAs under state tax law. In total from 2004-early 2011, states passed over eighty laws to accommodate and promote HSAs, losing tax revenue in the process.


276 Verma, supra note 274.

277 Id.

278 Jost, supra note 2, at 160-165.

279 Id.

280 Id.


282 Id. at Tables 1-3 (summarizing HSA bills signed into law from 2004 through March 2011).
Federal law regarding HSAs and high-deductible plans is also in constant flux. The ACA mandated that preventative health care is covered without copayments even in high-deductible plans.\footnote{ACA § 1001 (2010), amending Public Health Service Act § 2713 (including routine examination and well-child care, immunizations, tobacco cessation programs, and certain preventive health screenings).} It also reduced the breadth of services that could be funded out of HSAs, eliminating, for example, the use of HSA funds on over-the-counter drugs without prescription.\footnote{ACA § 9003 (2010).} This type of regulatory tinkering is a constant revisiting of how much skin in the game is appropriate and for what services, with much greater precision that consumers could possibly understand.

Even before actively encouraged to do so in early 2018 by the Trump Administration,\footnote{Letter from Centers for Medicare & Medicaid Services to State Medicaid Directors (SMD: 18-002, Jan. 11, 2018), \url{https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf}.} state Medicaid programs experimented with policy designs that incorporated cost sharing, despite the unambiguous evidence that even small amounts of cost-sharing can cause poor health outcomes in low-income populations.\footnote{Jost, \textit{supra} note 2, at 21.} These demonstration experiments consume regulatory resources and deflect attention away from testing other ways to achieve more efficient Medicaid spending without risking negative health outcomes.\footnote{Kaiser Commission on Medicaid and the Uninsured, Premiums and Cost-Sharing in Medicaid (2013), \url{https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf}.} To try to create some boundary for experimentation with such strategies in Medicaid, DHHS developed a set of detailed federal rules outlining how much cost-sharing is allowable and in what forms. These rules are rehashed and rewritten by each administration, playing in the weeds of health policy.\footnote{Id.}

More detrimentally, building up this kind of regulatory scaffolding around CDHC perpetuates the idea that we should look to individuals to solve what are complex, systemic problems, like high prices. CDHC feeds a culture of individual responsibility for high healthcare spending on low-value care, yet is not making progress to solve this problem.\footnote{Allison K. Hoffman, \textit{The Unhealthy Return to Individual Responsibility in Health Policy}, The Regulatory Review (Jan. 16, 2017), \url{https://www.theregrevue.org/2017/01/16/hoffman-unhealthy-return-individual-responsibility-health-policy/}.} The focus on moral hazard also perpetuates a false idea that consumer overconsumption of health care drives high health care spending in the U.S., even though empirical work regularly affirms that price and mix of services, not quantity, is where the U.S. is an outlier.\footnote{Id.} Americans rely more on specialists and high-end technology that may not lead to better

\footnote{Gerald F. Anderson et al., \textit{It’s the Prices, Stupid: Why the United States Is So Different from Other Countries}, 22 \textit{Health Aff.} 89 (2003); McKinsey, \textit{supra} note 265; Gerald F. Anderson et al., \textit{It’s Still the Electronic copy available at: https://ssrn.com/abstract=3394970}
outcomes. This American story of overuse will not be solved by the blunt instruments of deductibles and copayments, or transparency laws, especially if the providers who guide patient decision-making recommend such care. Consumers lack the power, knowledge, and will to rewrite this story.

C. Health Care Marketplace Competition and Antitrust Law

The focus of the above two sections is on how economic theory influenced the rise of policies that rely on individual-level consumerism. This section considers antitrust law, focusing on merger analysis, which is one step removed from consumer decision-making yet still deeply reliant on consumerist behavior, to show how reflexive and pervasive reference to consumer preferences has become in the backbone of health law, even when less explicit.

What antitrust law shares with the two ideas above is the desire to use market dynamics to drive higher-value health care. It also shares that, although falling short in practice, great regulatory effort and intellect is spent on technocratic tinkering in hopes to get antitrust regulation right, foregoing more promising alternatives to address health care’s outsized prices.

The hope of what competitive markets will deliver is bold. As one set of experts wrote, “[e]nsuring that markets function efficiently is central to an effective health system that provides high quality, accessible, and affordable care.” The primary goal is to maintain competition to moderate price increases.

Yet, as with the earlier examples, efforts to create competitive health care markets have fallen short, despite years of deep regulatory investment. Experts have offered up various explanations, all undeniably true. Some critique poor implementation and misguided judicial decisions. Others point to regulatory failure due to other competition-impeding state health regulations. Yet, policy is necessarily implemented in an imperfect judicial and regulatory environment, and inconsistent courts and stifling state regulations predated the take-up of antitrust enforcement in health law in the 1970s. The problem may be as much the results we expect antitrust enforcement to produce in an imperfect environment as the imperfect environment itself.

Looking at antitrust law is important both as a discreet example of a struggling market-based regulatory approach, and also because the application of antitrust law to health care has lubricated the accelerated roll out of market-based policies more generally by offering principled boundaries for government intervention and regulation. Instead of arguing for total deregulation, proponents of market-based solutions made the more moderate case that

Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt, 38 Health Aff. 87 (2019).


if the government enforces antitrust law well, competitive markets can create efficient results and, in turn, government regulation of prices or production will be unnecessary. 293 Further, they argued that markets can find sweet spots in pricing and production in a way that government regulators cannot. As antitrust expert Tim Greaney described: “Properly applied, antitrust law should promote decentralized decision-making by market participants while encouraging efficient combinations that serve consumer welfare.” 294 What these promises did was turn attention to getting antitrust law right, in hopes that doing so would create a market that produced better quality and lower cost care so that regulators would not have to be the arbiters of such things.

Finally, proponents argued that even if antitrust law produced imperfect results, it would be better than direct regulation of market participants or prices, tainted by capture and risking harm to innovation. 295 Yet, time has shown that antitrust law and enforcement is no more resistant to industry influence than other regulatory approaches. And evidence shows that much recent U.S. health care “innovation” is on the flat of the curve, doing more work to drive up prices than to improve health, suggesting that the industry is not self-regulating well through competition. 296

Although the end patient is often obscured in antitrust analysis, the value of a competitive marketplace for health care services can only be fully realized if patient consumers can navigate options well, or their proxies do so on their behalf. Merger law, for example, often scrutinizes interactions between providers (hospitals, doctors, medical device or pharmaceutical companies), on the one hand, and the buyers (usually insurers and employers), on the others. Yet, an imaginary patient consumer is ever-present in several ways. First, courts and regulators sometimes consider the insurer a proxy for the


294 Thomas (Tim) Greaney, Competition Policy and Organizational Fragmentation in Health Care, 71 U. PITT. LAW REV. 217, 225 (2009).

295 Havighurst, supra note 293, at __.

296 See, e.g., Skinner, supra note 5 (questioning innovation in cardiac research); Ian F. Tannock & John A. Hickman, Limits to Personalized Cancer Medicine, 375(13) NEW ENG. J. MED. 1289 (2016) (questioning whether spending on precision medicine will justify outcomes); Vinay Prasad, Tito Fojo, & Michael Brada, Precision oncology: origins, optimism, and potential, 17 LANCET ONCOLOGY e81 (2016) (noting high prices of proton beam accelerators and scarcity of evidence regarding their superiority to other therapies. For critiques that focus on suggestions for driving higher-value innovation, see STEVEN GARBER ET AL., REDIRECTING INNOVATION IN U.S. HEALTH OPTIONS TO DECREASE SPENDING AND INCREASE VALUE, RAND CORPORATION (2014); NICHOLAS BAGLEY ET AL., CORRECTING SIGNALS FOR INNOVATION IN HEALTH CARE, at 5 (2015).
hypothetical end consumer, an idea that is problematic for reasons discussed below.\textsuperscript{297} Second, courts often factor in how patients navigate insurance plan options or medical care options, or how they might in a changed landscape, which is problematic for all of the reasons discussed in the sections above.\textsuperscript{298} In the end, the consumer’s behavior—for example, whether she will buy a plan that fails to include a particular hospital in network or how far she might travel for good care or to save money—deeply influences legal analysis.\textsuperscript{299} Reliance on the idea of how a patient will respond to choices and incentives has embedded into antitrust analysis some of the same logical flaws that impede managed competition and CDHC.

This Part describes places the theory of antitrust law falls short in health care and the host of technocratic solutions experts propose in response. It also describes the costs of this approach, in terms of regulatory accretion and, more importantly, forgone opportunities to deal with the price problem in health care. Even though improved antitrust enforcement could be beneficial, it will not solve existing pricing problems, and continued excessive focus on it will impede better solutions.

1. \textit{The Theory of Antitrust Law and Competitive Markets}

The U.S. Department of Justice’s website states that the goal of antitrust law is to promote competition to protect the people from harms that could result from an anticompetitive environment.\textsuperscript{300} Since the Progressive Era, antitrust law has shifted its analytical center from trust busting and preventing concentrations of private power to consumer welfare.\textsuperscript{301} As the DOJ website promises: “Competition in a free market benefits

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\textsuperscript{299} See, e.g., FTC v. Butterworth, 946 F. Supp 1285, 1291 (W.D. Mich. 1996) (“… the FTC must present evidence of practical alternative sources to which consumers of general acute care and primary care inpatient hospital services would turn if the merger were consummated and the merged entity raised prices beyond competitive levels. Determination of the relevant geographic market is a pragmatic, highly fact-driven undertaking.”); Saint Alphonsus Medical Center v. St. Luke’s Health System, 778 F. 3d. 775, 784-85 (9\textsuperscript{th} Cir. 2015) (recognizing that insurers are considered the “consumer” for market analysis, but then asserting that because residents in Nampa would resist going outside the local areas for primary care, the insurers would include local primary care services in the plan even in light of a price increase.); FTC v. Penn State Hershey Medical Center, 838 F.3d 327, 343 (3rd Cir. 2016) (“Patients, of course, are relevant. For instance, an antitrust defendant may be able to demonstrate that enough patients would buy a health plan marketed to them with no in-network hospital in the proposed geographic market. It would necessarily follow that those patients who purchased the health plan would have to turn to hospitals outside the relevant market (lest they pay significant out-of-pocket costs for an out-of-network hospital.”)
\textsuperscript{301} Rahman, \textit{supra} note 9, at 72, 81.
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American consumers through lower prices, better quality and greater choice.\textsuperscript{302} This shift has brought with it an analytical lens that also focused on the end consumer, which creates problems when applied to health care.

Antitrust law became relevant in health care starting only in the mid-1970s. Before then, the health care marketplace was largely sheltered from antitrust liability by the “learned profession exemption,” which was first described by Justice Holmes in 1922,\textsuperscript{303} and which placed professionals outside the scope of normal commerce.\textsuperscript{304} The basic idea was that since doctors, and other professionals, acted to serve patients, they should be exempt from antitrust scrutiny, which could have the adverse effect of introducing considerations of profitmaking into their consciousness.\textsuperscript{305}

In the mid-1970s, as medicine looked and acted more and more like a business, the Supreme Court rejected the learned profession exemption,\textsuperscript{306} and, in parallel, the Federal Trade Commission (FTC) and Department of Justice (DOJ) bolstered their health care antitrust enforcement programs and efforts.\textsuperscript{307} The FTC and DOJ may review\textsuperscript{308} and block a transaction when the “effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.”\textsuperscript{309} Legal inquiry weighs harm to consumers against potential benefits of a merger to competition, and usually focuses on price effects.

Especially as regulatory attempts to stem growing health care costs failed or were rejected, such as health planning in the 1970s and managed care in the 1980s, attention turned to fostering competition in the industry to use the market to mediate price inflation and value. In recent years, the potential anticompetitive effect of health care mergers has gained particular attention once again. The basic theory is that if antitrust law can preserve a competitive market, healthy competition will keep prices in check and quality high. In practice, antitrust regulation has fallen short of this ideal.

\textsuperscript{302} Supra note 300.


\textsuperscript{304} Joseph P. Bauer, Professional Activities and the Antitrust Laws, 50 NOTRE DAME L. REV. 570, 572 (1975). Other rationales were that professional activity was local (not interstate commerce) and that physicians were already supervised and regulated by state laws. Id.

\textsuperscript{305} Id.

\textsuperscript{306} Goldfarb v. Virginia State Bar, 421 U.S. 773, 778 (1975). Goldfarb included a placeholder in footnote 17 that suggested the exception might not be totally extinguished. Id. In a second case, the Supreme Court held that local hospital activity affects interstate commerce sufficient for it to exercise subject-matter jurisdiction under the Sherman Act. Hospital Blgd. Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976).


2. Shortcomings of Antitrust Theory as Applied to Health Care Mergers

a) Conceptual Problems

Conceptually, the unusual structure of health care purchasing through insurance complicates antitrust analysis in health care from the start. Even defining the consumer is challenging. Insurers or employers usually act as an intermediary between the patient and health care providers (doctors, hospitals, and other suppliers), by designing plans and networks and negotiating for prices for services. 310

Antitrust analysis sometimes assumes that these intermediary buyers will negotiate on their behalf for the best plans, networks, and prices possible. 311 Yet, neither employer nor insurer interests are necessarily aligned with the end users. 312 For example, insurers can and do pass higher prices off to individuals or employers. Employers who face higher health care spending, in turn, pass costs off to their employees in the form of stagnant wages. 313 These dynamics reduce the motivation for insurers to find the hard edge of negotiation. When they do, they often retain excess profits for themselves, rather than passing them down the chain.

Additionally, employer and employee interests might diverge when employers design health plans. Employers operate on short time frames because of the transient nature of employment and underinvest in certain types of care that produces benefits in the long run. Likewise, employees might most care about being able to go to any hospital or doctor they want, but employers might choose narrow network options to keep plan costs down and wages competitive. So, conceptually, even in the best-case scenario, if competition among providers were more robust and insurers and employers had more leverage, competition may not benefit end consumers.

310 Most people have insurance through employers, and most of those plans are “self-funded,” which means the employers have nearly total control over defining health plan options for employees, including what services are covered and what providers are included. KAISER FAMILY FOUNDATION AND HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2016 ANNUAL SURVEY, at 1 (2017).

311 Sage & Hammer, supra note 297; Kartell v. Blue Shield, 749 F. 2d 922, 925-26 (1st Cir. 1984); FTC v. Penn State Hershey Medical Center, 838 F.3d 327, 342 (3rd Cir. 2016) (looking to how insurers would respond to a SSNIP when considering result of a merger); FTC v. Advocate Health Care Network, 841 F.3d 460, 475 (7th Cir. 2016) (“But as we have explained, insurers are the most relevant buyers. Insurers must consider both whether employers would offer their plans and whether employees would sign up for them.”).


b) The Strained Application of Antitrust Law to Health Care

Application of the law, in practice, only draws further from the theoretical ideal. After four decades of enforcement of antitrust law in the health care industry, the provider market is more consolidated than ever, sending prices on a steep upward trajectory without notable increases in quality.314

Scholars have advanced a host of reasons for these failures.315 One common explanation is that courts and regulators misapplied antitrust law.316 Tim Greaney describes that with respect to litigation, the “principal shortcoming was the courts’ tendency to oversimplify antitrust analysis by adopting simplistic, Chicago-school assumptions about markets while failing to incorporate the effects of market imperfections in their analyses of health markets.”317

Courts, like consumers, have found health care products harder to define than cars or computers, despite the fact that legal scholars sometimes flippantly claim otherwise.318 Reasonable substitutes are often not obvious. For example, any one condition might be treated in a range of ways, from taking a pill to surgery to waiting and seeing. Which are reasonable treatments might depend on the age of the patient, health history, or genetics, among other factors. Furthermore, health care is sold in disaggregated process parts and inputs (e.g., appointment with surgeon, hospital bed, anesthesia), rather than as “assembled products” (e.g., knee surgery), which makes it more difficult for courts and customers, alike, to scrutinize the product being sold.319 In response, courts have defined markets coarsely, in “clusters,” such as by level of inpatient care (primary, secondary, or tertiary care), rather than service-by-service (cardiac care vs. orthopedic care), which can mask

314 William B. Vogt & Robert Town, The Synthesis Project, How has Hospital Consolidation Affected the Price and Quality of Hospital Care?, at 1, 6 (2006) (documenting changes in concentration during the 1990s); Martin Gaynor & Robert Town, The Synthesis Project, The Impact of Hospital Consolidation—Update (June 2012) (reporting that hospital consolidation increased the price of hospital care and sometimes decreases quality); Leemore S. Dafny, Hospital Industry Consolidation—Still More to Come?, 370 NEW ENG. J. MED. 198 (2014) (“[T]he last hospital-merger wave (in the 1990s) led to substantial price increases with little or no countervailing benefit”).

315 Coverage of these failures and explanations for them are voluminous. See, e.g., Barak D. Richman, Antitrust and Nonprofit Hospital Mergers: A Return to Basics, 156 U. PENN. L. REV. 121, 122-124 (2007) (cataloging reasons from court nullification of regulatory actions to complexity of analysis to hostility among courts to competition in health care).

316 See, e.g., Thomas L. Greaney, Efficiencies in Merger Analysis: Alchemy in the Age of Empiricism?, in ECONOMIC THEORY AND COMPETITION LAW 191 (Josef Drexl et al. eds., 2009) (arguing that regulators and judges should be more realistic about the uncertainty in the application of the “efficiencies defense”).

317 Greaney, Competition Policy, supra note 294, at 227.

318 Havighurst, supra note 10, at 743. (suggesting auto mechanics is equally complex of a field for the unfamiliar as selecting medical care or health plans).

anticompetitive effects at the service level.\textsuperscript{320} Courts also struggle with how and whether to consider quality in their analysis. They typically do not consider it explicitly but rather assume that competition will drive up quality, while it also mediates price.\textsuperscript{321}

Others blame the problems on a pro-professionals bias that survived the formal rejection of the learned professions exemption, causing regulators and judges to balk at strict application of antitrust doctrine to hospitals, especially nonprofit hospitals, and doctors.\textsuperscript{322} Regulators devised various exceptions to per se illegality and are more willing to consider surrounding facts and circumstances when it comes to the health care industry,\textsuperscript{323} especially if in the service of protecting hospitals or doctors from the forces of managed care.\textsuperscript{324} Courts overrode regulators’ well-justified challenges to hospital mergers in dozens of decisions in the managed care era, starting in the 1990s, which led to a period of chilled enforcement, ending only recently.\textsuperscript{325} Judges’ inclination to protect hospitals threatened by managed care companies seems to have led courts to permit providers to consolidate to bolster their relative bargaining power.\textsuperscript{326} This judicial gerrymandering proved to be playing with fire. The courts were not well situated to gauge and mediate the relative market power of providers and insurers, as evinced by the current level of market concentration among providers.

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\textsuperscript{320} Havighurst & Richman, \textit{supra} note 293, at 869.
\textsuperscript{321} Sage & Hammer, \textit{supra} note 297, at 258.
\textsuperscript{322} Spencer Webber Waller, \textit{How Much of Health Care Antitrust is Really Antitrust?}, 48 L\textsc{o}YOLA U. L. J. 643 (2017).
\textsuperscript{323} Id. at 657-659. \textit{See also}, e.g., U.S. Dept. of Justice and Fed. Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, at 4 (1996) (discussing ways that “efficiencies,” in the forms of financial and clinical integration will be considered with respect to physician joint venture arrangements).
\textsuperscript{324} Greaney, \textit{Competition Policy, supra} note 316, at 228.
\textsuperscript{326} Thomas L. Greaney, \textit{Whither Antitrust? The Uncertain Future of Competition Law in Health Care}, 21 HEALTH AFF. 185 (2002).
\end{flushleft}
Another common explanation is regulatory failure. Various health care laws prevent potentially useful cooperation, integration, and entry.\textsuperscript{327} Scholars argue that these existing state-level healthcare regulations prevent efficient firm arrangements.\textsuperscript{328}

For all of these reasons and more, it is clear that antitrust regulation has failed to achieve the above-quoted DOJ ideal for consumers and faces a steep climb to ever do so, even if there is room for improvement. To the contrary, it has not stopped harmful consolidation among hospitals and providers, and health care costs continue to grow faster than the rest of the economy.\textsuperscript{329} Faith that competition will magically generate high-value options for consumers is getting hard to defend. Yet, it has produced considerable market-based bureaucracy.

3. The Implications: Legal Smoke and Mirrors

Strong faith in the potential of antitrust law to create competitive markets has spurred deep governmental regulatory investment in getting competition to work better. It is difficult to know exactly the size of the apparatus created to evaluate and litigate anticompetitive activity in the health care sector, but it is sizeable. Between 2009 and 2014, over one-third of all Federal Trade Commission investigations involved hospitals.\textsuperscript{330} From 1996 to 2016, the FTC initiated 211 cases or proceedings to enforce health care antitrust matters – 92 of those after 2010.\textsuperscript{331} Between 1976 and 1996, the FTC and DOJ settled by consent decree an estimated 65 enforcement actions against price-fixing.\textsuperscript{332} The federal healthcare division of the FTC alone employs several dozen attorneys. In 2015, the FTC Chairwoman Edith Ramirez reiterated that healthcare was a major area of focus: “the FTC devotes significant resources to preventing mergers that threaten to raise prices or undermine cost-containment efforts in a variety of health care markets.”\textsuperscript{333} And most states have their own regulatory agencies, working in parallel. The calls by experts for better and stronger enforcement would require a doubling down.

\textsuperscript{327} Greaney, \textit{Competition Policy}, supra note 294, at 228.


\textsuperscript{329} Supra note 323.


\textsuperscript{332} Greaney, \textit{Competition Policy}, supra note 294, at 232.

Antitrust cases are expensive to investigate and litigate, relying deeply on the opinions of high-priced experts in economics and law. Leemore Dafny describes what level of investment is required even in the best-case scenario of a hospital merger that has not yet occurred:

"enforcers must devote substantial time and resources to evaluating these individual transactions and—if appropriate—to satisfying the legal standards for challenging them. Economics experts must comb through reams of claims data, using complex statistical methods to assess the extent to which the merging hospitals compete and, where possible, to predict the magnitude of likely price increase. On the other side of the scale, enforcers must weigh the potential benefits that would accrue from the merger (and that cannot otherwise be realized), which may arise from cost reductions, improvements in quality or access to care, or all of the above." 334

These direct costs may be relatively small compared to overall health spending, but they represent a significant investment for lukewarm results to date.

The larger cost in this realm is distraction from better alternatives. A byproduct of being overly focused on markets to regulate prices is that prices have skyrocketed out of control on everything from medical devices to pharmaceuticals to outpatient care with few checks.

Antitrust law and the potential of competitive markets has captured the attention of academics and the imagination of news sources. From 2001-2015, over 1600 law review articles included in depth discussion of health care antitrust enforcement. 335 Over that period, the Wall Street Journal has published 1500 articles that mention the topic and the New York Times and Washington Post, over 500 each. 336 The New England Journal of Medicine had over 50 articles on the topic. 337 This level of attention to a technocratic endeavor is striking.

This focus on what it would take to generate more competition has muted discussion of whether certain types of consolidation (likely plus price regulation) may better produce high-value health care. Even though evidence so far suggests consolidation has harmed quality, 338 some of the best health care in the United States comes from large, integrated systems like Kaiser or the Mayo Clinic. And some of the sharpest experts advocate that larger health systems could enable everything from easier sharing of patient insights and data among providers to systemic oversight of medical error to better coordination of care.

334 Dafny, Supra note 314, at 199.
335 Search criteria and results on file with author. Search conducted through December 2016.
336 Id.
337 Id.
338 Synthesis Project, supra note 314, at 8 (reporting that on balance consolidation lowers quality). See sources supra note 82.
among specialists in complicated cases, and, in theory, lower overhead costs. Yet, allowing consolidation would demand a whole different approach to think about price regulation.

The infatuation with perfecting market competition has grown a sizeable bureaucratic structure of enforcement and a deep scholarly conversation on how to tinker with antitrust or other laws to improve competition. All of this regulatory effort goes toward the hope of getting markets to do what is critically needed—slow down healthcare price inflation, while sustaining or improving quality. The problem is that, at the end of the day, these efforts are coming up short, while perpetuating the myth of what well-regulated markets can produce for patients at the end of the day.

Some experts, including Leemore Dafny and Tim Greaney remain circumspect about getting the legal analysis “right” and acknowledge the intensive investment that would be needed to do so. Furthermore, even if better enforcement were to reduce future consolidation, it can do little to address current levels of provider concentration. Thus, increasingly, experts are beginning to ask whether price regulation may be the singular response to current levels of consolidation. This more direct approach is complicated in its own right, but the focus on antitrust and competition-enhancing reforms has built a market-supporting bureaucracy that draws attention away from such direct solutions that might be a better, or only real, option.

4. **Redux: Proposals to Bolster Competition and the Consumer Turn**

Ironically, as some experts recognize antitrust’s shortcomings and begin to discuss alternatives, others continue to pour efforts into trying to spur competition or to disrupt consolidation in ways that that do little more than add regulatory scaffolding. Some advocate for better antitrust enforcement, including increased oversight and improved legal

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Such suggestions are often paired with better Medicare payment policies to support competition. Others propose deregulation or federal preemption or repeal of state laws that lessen competition. For example, some states have “scope of practice” laws that overly define the bounds of what each medical professional can do, based on licensure category, which dampens access to lower-cost providers for services (e.g., nurses for certain primary care they are qualified to provide instead of doctors). These legal reforms are all beneficial for reasons both related to and apart from competition, but even if all were taken up, the result would be more options and price points that consumers would still struggle to navigate for all of the reasons outlined above. They would, for example, have to weight when to use a nurse practitioner versus when they might need doctor, if the latter cost more out-of-pocket.

Further, these types of legal reforms are not enough on their own to fix already-present consolidation. Ironically, in response, experts turn back to different modes of consumerism to disrupt the status quo and reignite competition by adding new options, with ideas ranging from new products—medical tourism, mobile health, or telemedicine—to new incentive structures to get people to expand geographic markets and to travel elsewhere for care. These solutions, like those discussed above, look to ways to spur more consumer choice.

343 E.g., Havighurst & Richman, supra note 293, at 874-75 (arguing for pre-approval of every proposed ACO); Sage & Hammer, supra note 297, at 267-289 (arguing for a “Copernican” view of antitrust, focused more on social welfare to gauge efficiency); Thomas L. Greaney, Regulating for Efficiency in Health Care through the Antitrust Laws, 2 UTAH L. REV. 465, 475-482 (1995) (discussing the problems with DOJ and FTC policy statements and the inconsistent use of efficiency defenses in ways that could increase productive efficiency through, for example, economies of scale and simultaneously lead to monopoly power and price increases for end consumers); Robert F. Leibenluft, Antitrust and Provider Collaborations—Where We’ve Been and What Should be Done Now,” 40 J. HEALTH POL., POL’Y & L. 847 (2015).

344 Gaynor et al., supra note 292, at 10 (arguing, for example, to eliminate “facility fees” for services that can provided out of hospitals, and simplifying administrative and payment requirements to encourage small-group physician practices).

345 Id. at 22-27 (summarizing these types of laws and proposed solutions); Clark C. Havighurst, Deregulating the Health Care Industry: Planning for Competition (1981); Barak D. Richman, American Enterprise Institute, Concentration in Health Care Markets: Chronic Problems and Better Solutions (2012).


347 Of course, insurance could choose to pay for certain services only from nurse practitioners, when appropriate, but limiting access to doctors is inconsistent with the choice proliferation they promote.

348 See, e.g., Sage, supra note 319 (seeking to define products in “assembled” way that make sense to end consumers), Leemore Dafny & Thomas H. Lee, Healthcare Needs Real Competition, 94 HARV. BUS. REV. 76, 87 (2016) (“Consumers can energize the marketplace by creating real consequences for the winners and losers. If patients choose to receive care from high-value providers, which may mean traveling farther, then providers will focus their energy on improving care delivery.”); David M. Cutler & Fiona Scott Morton, Hospitals, Market Share, and Consolidation, 310 JAMA 1964, 1969 (2013) (suggesting higher cost sharing for health care at a “dominant health system” than at a less expensive one in the market).
among providers and new, or better, defined products as the pathway to reignite competition.

Bill Sage has critiqued, for example, how the product is defined in hospital merger enforcement. He suggests that a major flaw is that we treat health care products as process steps, rather than as assembled end products, as with all other consumer goods.\footnote{Sage, supra note 319} In other words, when someone goes in for surgery, she gets one bill from her surgeon, another from her anesthesiologist, and another (or several) from the hospital. Sage argues that the end good must be something that a patient values and understands, rather than disaggregated lines on a bill. He loosely gestures at what an assembled end product a patient could decipher might be, including a hip surgery with a warranty, medical tourism, or end-of-life care,\footnote{Id. at 634.} and outlines the many ways antitrust law and other regulations would need to change to accommodate assembled products.\footnote{Id. at 637.} Although he does not promote this idea as a consumer cure all, the implication is that if the regulation were better and the products were clearer, consumers and their proxies would resist options with high prices or low quality.\footnote{Id. at 694-695 (discussing how assembled products would enable people to comparison shop).}

In a similar consumerist turn, Clark Havighurst and Barak Richman advocate for requiring hospitals to negotiate prices individually for each service, rather than as they usually do in a bundle of all services they offer, a practice known as tying.\footnote{Havighurst & Richman, supra note 293, at 877.} Havighurst and Richman imagine that once insurers know the price of an individual service at one hospital versus another, they could institute more favorable coverage terms, such as lower copayments, to encourage patients to travel to providers farther from home or in a new facility.\footnote{Id. See also Cutler and Morton, supra note 348}

These solutions simply come back to the idea that the right decisionmaking architecture can solve structural problems—here anticompetitive prices wrought by provider consolidation.\footnote{Sage, supra note 319, at 694, (“As in other commercial sections, however, consumers become motivated when they understand what they are buying and can compare their options.”)} The evidence above on the reality of how people really make medical care choices strongly suggests otherwise.\footnote{See Part II.B.} Even if products were assembled into comprehensible bundles, legal barriers were lifted to allow new entrants, and consumers could save money under the terms of their insurance policies by traveling further for care,
this new market would still face an imperfect consumer, who has shown an inability and unwillingness to navigate such options.

Imagine that a patient has a choice between two assembled products. The first is hip replacement surgery with Dr. A at a large, well-known academic medical center. Dr. A has a 90% success rate, offers a 30-year warranty, and charges $30,000. The second is the same hip replacement surgery with Dr. B at a small local hospital. Dr. B has an 80% rate of success and offers a 15-year warranty, but charges only $20,000. Patients would struggle to determine whether the slightly higher rate of success and additional fifteen years on the warranty are worth $10,000 more. There may be some easy choices. Some people will not be able to afford the more expensive surgery, and will go with Dr. B. If the surgeries were the same price, it might be easier to choose the one with a higher success rate but, even in that case, the patient would have to gauge if some aspect of quality were not captured in the numbers. Maybe one doctor’s success rate is lower because he is especially skilled and is referred the most challenging cases. Such choices are considerably more complicated than the simple price comparisons that patients in the studies above did not embrace and would likely boggle most purchasers.

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This Part has illustrated how in the past several decades scholars and policymakers have embraced economic theory and market-based solutions to attempt to solve some of health care’s most intractable challenges by looking to forces of market competition and to consumers to solve them. Yet, this embrace has been too full. Market-based policies have not resulted in a utopia where smart consumers approach a plethora of options, reject wasteful care, and send signals so that competition among industry players drives down prices. Even more, attempts to create some semblance of this ideal by chipping away at market failures and boundedly-rational consumers have required intense regulatory scaffolding and constant refinement. As illustrated above, this market bureaucracy comes with high costs, direct and indirect, and is not making people better off. Quite the opposite.

Some object by saying that the problem is not the markets themselves but the overregulation of markets that have caused the problem by impeding health competition. In fact, legal scholars, like Charlie Silver and David Hyman in a recent book, argue for a doubling down. These market loyalists argue that the problem is not the markets, themselves, but that we haven’t let them operate freely enough or demanded enough of health care consumers. Hyman shared this view in testimony before the Senate Committee on Health, Education Labor, and Pension on reducing health care costs in June 2018, suggesting it still holds purchase in policymaking.

357 Silver & Hyman, supra note 10; Havighurst, supra note 10.

358 Silver & Hyman, supra note 10.

There are several problems with this reasoning. The first is that we have already seen the effects of unregulated markets. They serve the wealthy and healthy and leave the rest uninsured. In turn, providers have to scramble for payment and cherry-pick patients. Second, the evidence cited above makes clear that health care consumerism does not work.

Even more, a world of increasing choices is actively making people worse off. Although there are exceptions to the rule (likely disproportionately among academic readers of this Article), most people do not prefer to make decisions about their own health insurance or, in many cases, their medical care. People dread shopping for health insurance; thirty percent of respondents to one survey report they would rather prepare their taxes than shop for health insurance. In a book on choice by one legal expert, the very example he uses to illustrate people not wanting to have to make choices is when a doctor asked him if he wanted to get an MRI or not. He wrote: “Sometime we want to be told what’s best.” Health law experts Carl Schneider and Mark Hall quipped: “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.” The very existence of a market-based system is contrary to many people’s preferences. Increasing retail health care or medical tourism will do nothing to address this fact.

In a poignant memoir written as he was dying from lung cancer and published posthumously, Dr. Paul Kalanithi, a Stanford neurosurgeon, cedes decision-making to his doctor, a peer and colleague, as his body weakens during the course of cancer treatment. He still had the capacity to weigh prognoses and side effects and costs, but he did not want to do so any longer. He wanted a trusted expert to guide him, once he had made the initial decision to begin aggressive treatment to slow the advancement of his terminal lung cancer.

The point of these arguments is not that private industry and competition has no place in health law or policy. Rather, it is that we have over-relied on policies that look to consumer choices and market forces to solve system-level failures, in light of mounting

https://www.help.senate.gov/imo/media/doc/Hyman1.pdf. Thank you to Matt Lawrence for pointing this testimony out to me.

360 Schwartz, supra note 126.
361 See sources and corresponding text supra note 65.
364 Id. at 133.
365 Schneider & Hall, supra note 2, at 51.
366 PAUL KALANITHI, WHEN BREATH BECOMES AIR (2016).
evidence of the limitations of these approaches in practice. Many scholars and policymakers have gone so far in the direction of market-based health policy that they cannot find the brakes, even when evident that the road is a dead end.

This Part’s comprehensive review of empirical evidence hopes to shine a light on this fact to make the following case: if market-based approaches are no more efficient and as bureaucratic as any other approach, it is time to end our reflexive reliance on them. The law has normalized market-based approaches and deflects attention from alternatives. If instead, we assessed different policy approaches based on what they produce, rather than on a myth of what they could produce, the dominance of market-based ideas in health care, and likely in other fields too, will recede and create space for alternatives. Then, the hard work begins.

III. COMPARING BUREAUCRACIES AND CONSIDERING CHOICE

This final Part considers briefly why market-based approaches proliferate in the face of mounting empirical proof of their failings. It looks first briefly at the deep problems of politics and political economy, which have been examined in more detail elsewhere.\(^\text{367}\) It then turns to a second, underexamined driver, contending that their durability lies also in the way these approaches have elevated the value of choice—a particular version of choice defined in individual, microeconomic terms. Finally, it concludes by suggesting that this sanctification of choice has gone too far and that for health policy and regulation to move forward in a more productive way demands, first, pushing back on the privileging of choice where it is not meaningful and, second, seeking a more capacious understanding of when, and what expressions of choice, are meaningful.

A. Understanding the Loyalty to Faltering Market-Based Policies

1. Politics and Political Economy

Economists sometimes say something like the following: “Everyone knows healthcare markets don’t work.” Simultaneously, they—and others to whom that fact might not be so obvious—continue to pour their efforts into testing and attempting to mend health care markets, at best making incremental improvements. This Section considers why, looking at both the political economy of these policies and their rhetorical resonance.

Consider the ACA exchanges as an example. Before they were even written into law and before a wealth of time and money was devoted to building and bolstering a new marketplace, there was enough evidence on literacy, numeracy, and earlier experiments with managed competition to foreshadow that consumerism in a managed marketplace would fall short. If the end goal was simply to get more people insured, which is what the exchanges have in fact done adequately well, there were certainly simpler and less expensive options on the table on how to do so.

\(^{367}\) See, e.g., sources supra note 26.
One explanation is that the average policymaker may genuinely have thought that competition among private plans in a new marketplace would work, unaware of the empirical evidence otherwise. Others were laser focused on getting more people insured, and the exchanges may have seemed the only path forward politically, whether they were or not.

Since the 1970s, markets are a language that both Democrats and Republicans have increasingly become willing to speak. Market-based approaches, the product of a political movement beginning in the Reagan era, have come to be perceived as more neutral, scientific, or measurable than other approaches. They focus on metrics. We measure numbers of health plans competing and insured lives with managed competition. With moral hazard, economic experts measure the effects of different levels and types of cost-sharing on consumption. With antitrust, economic experts scrutinize the market share a combined entity will have, using complex indices. All of this measuring and managing numbers casts the project as an objective science.368

Yet, this “objective science” is far from neutral. It obscures the morality of an end result defined by aggregation of individual decisions. People with more buying power have more influence and people with more education, time, and resources navigate the system more successfully. It surreptitiously lubricates a distribution of care that favors the wealthiest and educated.

These models also allow policymakers to avoid making unpopular rationing decisions, but they can still claim that they have acted to solve spending problems. If competition and consumerism cuts spending and reduces industry revenue, it happens a step removed from legislators. If the exchanges had worked as Enthoven envisioned, providers would have eventually received lower reimbursements, and reliance on specialists would slowly have decreased. But it would have been consumers and insurers, not elected officials, to blame.

More likely, these solutions will not reduce spending and will produce affirmative benefit to influential constituents.369 The winners from market-based policies are the health care industries and member who have accreted political power over the past decades and now exert it on the political process. With the ACA exchanges, for example, insurers gain business and hospitals and providers benefit from having a larger share of patients who have insurance, some with relatively well-paying private insurance. The aggregation of years of reliance on market-based approaches to control prices, to no avail, has helped to spur a massive health care industrial complex with layers of highly-salaried executives and consistently high profits. Although there has undoubtedly been benefit from this investment in health care, including significant employment of health care workers, it is

368 Frankford, supra note 27; Jost, supra note 2, at 89 (describing Robert Evans claim that economists see mathematics as conferring special authority, allowing them to “get away with a good deal of nonsense”).

difficult to justify health care spending that does not result in demonstrable improvement to Americans’ health.\textsuperscript{370}

These policies, in turn, also have become a way to hold public spending harmless from high health care cost growth, but they have done so by shifting spending from the public budget to individual household budgets. As Enthoven initially envisioned, if competition does not drive down prices and insurance voucher values increase more slowly than cost growth, individuals will finance the increasing gap.\textsuperscript{371} Most versions of policy based on Enthoven’s ideas are in part a strategy to control on-budget spending, by covertly moving shortfalls onto individuals, simultaneously transforming the project of insurance from one of social solidarity to individual responsibility.\textsuperscript{372}

Enthoven explicitly envisioned that managed competition would produce—or preserve—a two-tiered system, where wealthier people topped off their vouchers to buy better plans. Defending this aspect of his proposal, Enthoven wrote, “I believe it would be foolish to reject it on the grounds that it does not reach a hypothetical egalitarian ideal that has never been attained in any society and is surely not supported by the American people today.”\textsuperscript{373} While he might be right that many people think egalitarianism is un-American, managed competition obfuscates the choice of budgetary frugality (dressed up as “choice”) over equality as a value.

Likewise, when employers adopt high deductible health plans, they leave the rationing and bargain hunting to their employees, even if the employees might not trim or shop wisely, or at all. At the end of the day, the employer can control health benefit spending, and the employee either reduces her care or spends more out of pocket on it.

2. \textit{The Role of Choice}

This story of winners and losers is critical to the perpetuation of ill-fated market-based solutions. Yet, I suggest it is not the whole story. An underexamined, but perhaps as important, reason for their durability is that these policies align with a relatively recent American obsession with choice since at least the 1970s, when a generation defined itself in protest to the draft and Vietnam War. Early kernels in health care might be traced to tomes like \textit{Our Bodies Ourselves}, published first as a course booklet in 1970 by a group of women called the Boston Women’s Health Collaborative, who were seeking to help

\begin{footnotes}
\item[370] \textit{Supra} footnote 296. See also Silver & Hyman, \textit{supra} note 10, at 21-22 (providing an overview of their chapters that document excessive industry profit and a lack of concomitant health outcomes).
\item[371] Enthoven, Second Part, \textit{supra} note 89, at 716.
\item[373] Id. The structure of the proposal, however, conceals egalitarian shortcomings of the idea because everyone gets an equal voucher, adjusted only to account for age.
\end{footnotes}
women find self-empowerment over their bodies.\textsuperscript{374} Choice takes legal root in cases like \textit{Griswold v. Connecticut} in 1965 and \textit{Roe v. Wade} in 1973, which recognized control through a language prohibiting government intrusion over individual reproductive choices. Although this choice revolution does not spark from neoliberalism, it may have fueled it, by centering on a particularized and individual version of choice.

In health care, the sanctification of choice was an understandable response to a century where what individual patients wanted often came second. For most of the 20\textsuperscript{th} century, doctors largely controlled medical care decisions. After the passage of Medicare and Medicaid in 1965 and the concurrent growth of private insurance, spending grew, prompting the rise of managed care in the 1970s-1980s, when insurers held the reins to control patients’ access to doctors and medical care. Since then, however, consumer choice has come to be something of a “sacred value,” or one that “a community treats as possessing transcendental significance that precludes comparisons, trade-offs, or indeed any mingling with secular values.”\textsuperscript{375}

Informed consent gained steam, seeking to put medical decisions back in the hands of patients, for better or for worse. Market-based policies grew up in parallel, elevating the value of choice and defining choice narrowly—in microeconomic terms of preferences and purchases. An individual’s agency came to be measured by her buying power and self-interest.

Choice, even if laudable in concept, can obfuscate what people, or a polity, genuinely value when defined so narrowly. For example, measuring what people value by how they act individually in a market can undermine tools that by their very purpose serve collective goals. Health insurance aims to make health care spending a collective endeavor, spreading the costs of medical care among an insured population, regardless of any one person’s individual medical needs in a particular year.\textsuperscript{376} Although it might have been otherwise,\textsuperscript{377} the downfall of the ACA’s individual mandate that required most Americans to carry health insurance came in part because it sought to achieve a collective goal through individual choices and purchases. It prompted Americans to think not about the goal of guaranteed and universal coverage but instead about their own bottom line—exactly how much their insurance policy cost and what they got in return. Choice centered the policy discussion in the wrong ideological place.

The political economy of health care is notoriously sticky, but the obsession with choice—and, in particular, the narrow market conception of choice—may be less so.

\begin{itemize}
\item \textsuperscript{374} Our Story, Our Bodies Our Selves, \url{https://www.ourbodiesourselves.org/our-story/} (last visited March 4, 2019). Thank you to Tom Baker for highlighting this aspect of the choice movement.
\item \textsuperscript{375} Tetlock, \textit{supra} note 11, at 320.
\item \textsuperscript{376} Deborah Stone, \textit{Health Equity in a Trump Administration}, 42 J. HEALTH POL., POL’Y, & L. 995, 997 (2017).
\end{itemize}
Americans in recent decades may have become enamored of the idea of choice and critical of big government, but views on such issues change. There is evidence that they are, in fact, shifting now. Studies show many conservative voters disliked Obamacare and exchanges not because they didn’t want government involvement in health care but rather because they wanted Medicaid expansion instead.\textsuperscript{378} The recent surge in popularity of the idea of single payer systems, even if rooted in an incomplete understanding of what such a policy would mean, signals an increasing openness to new regulatory approaches that are less focused on individualism.

\section*{B. Considering Choice Beyond Markets}

If health policy and law is to progress, it is imperative to examine the overemphasis on individual choice. In many cases, individual choice is altogether the wrong organizing principle to animate health regulation. In other cases—way fewer than imagined—it may be meaningful. And in many cases, even if the principle of choice is meaningful in concept, looking to individual market activity to measure what people value is flawed in practice. Dismantling the ineffective market bureaucracy lies in untangling these spaces.

\subsection*{1. Pushing Back Against the Privileging of Choice}

In many cases, better regulatory responses, including to inefficiencies in the system, reveal themselves only through push back on the modern sanctification of choice.\textsuperscript{379} When choice is illusory or unnavigable or makes people miserable, it is not worth privileging. Sometimes there is only one best option. When one treatment option is far superior to another, enabling choice between the two is illogical, and arguably cruel. If a particular treatment does not work, or when it is very expensive and does little good, having it as an option is a ruse.\textsuperscript{380}

Insurers, with public insurers in the lead, must begin to exclude such treatments from coverage, even if doing so faces resistance. Further, the FDA and other regulatory bodies should take a hard line and reject treatments and therapies with little or no marginal value.\textsuperscript{381}

\begin{footnotesize}
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\item \textsuperscript{378} Sarah Kliff, \textit{Why Obamacare Enrollees Voted For Trump}, VOX.COM (Dec. 13, 2016) (reporting that interviews with Trump supporters, enrolled through the exchanges, reveal a pattern of frustration that those on Medicaid are “getting even better, even cheaper benefits”).
\item \textsuperscript{379} Some scholars wholly reject the idea of choice in favor of justice, such as rejecting “reproductive choice” for “reproductive justice.” Dorothy Roberts, \textit{Reproductive Justice, Not Just Rights}, Dissent Magazine (2015), at https://www.dissentmagazine.org/article/reproductive-justice-not-just-rights (last accessed December 17, 2018).
\item \textsuperscript{380} As one example, studies have exposed excessive overuse of Cardiac stents that is expensive, and possibly harmful. Aaron E. Carroll, \textit{Health Stents are Useless for Most Stable Patients. They’re Still Widely Used}, THE UPSHOT, NY TIMES (Feb. 12, 2018). For other common wasteful spending see OECD, \textit{Tackling Wasteful Spending on Health} (2017) (describing practices ranging from overdiagnosis and overtreatment to underuse of generic drugs).
\item \textsuperscript{381} Silver & Hyman, \textit{supra} note 10, at 120-21 (citing examples of wasteful care that Medicare reimburses, including colonoscopies for patients over age 75, prostate cancer screening for men over 75,
\end{itemize}
\end{footnotesize}
Where to draw the line can be difficult but drawing it even very conservatively would be progress. Although this kind of regulatory hardline will undoubtedly garner backlash from some vocal interest groups, it is nonetheless the sounder regulatory option in the end.382

Likewise, if one insurance plan dominates another in all or most cases, it would be better simply to issue the better plan, rather than create a false semblance of choice. Employers should stop offering dominated plans or be penalized for doing so. Medicare should cull out dominated Part D and Medicare Advantage plans and regulators should significantly narrow the proliferation of options in these spaces, which would make the project of periodically reviewing and culling out dominated plans much easier.

Paternalism, even if unpopular, is preferable in these cases to creating complex regulatory structures that set people up to make poor choices and are not avoiding paternalist intervention. The reality is that, in health care, market-based approaches are themselves moving in a paternalistic direction with the layering of increasingly directive decision aids and default rules. “Libertarian paternalism” is sold as a means to preserve choice.383 Yet, it struggles to maintain its libertarian dimension in health care, where challenges with decision-making run deep, and simple nudges fall short, as discussed above.

A second benefit of decentering the discussion from choice is that it would force discussion of better, non-choice promoting alternatives that have been pushed aside to avoid political struggles or hard, normative debates. If consumer choice among health plans will never rationalize overreliance on highly-paid specialists, then we must reckon with this problem directly. If consumers cannot or will not root through choices of providers to choose the lowest price one, then we need to deal directly with the outsized prices in the U.S. healthcare system. If antitrust law cannot effectively spur higher-value healthcare or keep prices in check, health care regulation must find other ways to do so.

Fortunately, there is a roadmap with a variety of alternatives from all other developed countries, whose superior approaches do not depend on market choices to solve system problems. The U.S. is an outlier, and not in a good way. Every other OECD country has a procedures for vertebral fractures that were shown to be both ineffective and risky and cost Medicare about $1 billion annually).

382 Such resistance surfaced in ACA debates when Congress created a new organization called the Patient-Centered Outcomes Research Institute (PCORI) to consider comparative effectiveness of different treatments. In response to initial backlash, PCORI’s power was limited and Medicare cannot rely on comparative-cost effectiveness assessments for payment decisions, but it is still collecting potentially valuable data. Zeke Emanuel et al., Center for American Progress, Re-Evaluating the Patient-Centered Outcomes Research Institute (May 31, 2016), at https://www.americanprogress.org/issues/healthcare/reports/2016/05/31/138242/re-evaluating-the-patient-centered-outcomes-research-institute/. Some of the backlash arises from groups who argue that research is not conducted evenhandedly and could disproportionately harm certain people, but instead of using such input to reject data-based policymaking, it should motivate efforts to improve research quality.

383 Thaler & Sunstein, supra note 67.
centralized regulatory solution to controlling prices and to rationing. Some seem to work better than others, but they all work better than the consumerist approaches in the U.S.

For example, most peer nations regulate prices centrally to keep spending down, even those that are often cited as market success stories, such as Singapore, Switzerland, or China. These systems all have elements of choice but do not depend on them for important ends like cost control. Even some individual states have shown successful experimentation with price controls in the U.S., suggesting its feasibility within the U.S. healthcare system. Maryland, has been centrally setting payment rates for hospitals in the state for over forty years and updated its payment structure in 2018, estimating savings of as much as $1 billion over the next five years. These types of effective, but politically contentious, regulatory solutions are proven, which is perhaps why conflict-avoidant or captured policymakers turn to consumerism instead.

Likewise, peer countries offer various more thoughtful ways to conduct rationing. The British system is perhaps the best known, where the National Institute for Health and Clinical Excellence (NICE) explicitly makes decisions about what treatment will be reimbursed by the National Health Service based on cost-effectiveness and other social values, including factors like clinical need and innovation potential. Other countries like France and Germany have a less formal system, yes have developed centralized processes for identifying and not paying for unnecessary or low-value services.

Finally, pushing back on the sanctity of choice would not only unlock consideration of better solutions that are not choice centric, it would also prevent further construction of ineffective market-based bureaucracy. For example, if prices were regulated centrally, there would be no need for CMS and states to invest in a web of transparency laws to try to track and understand the variance in prices across the states. Likewise, imagine if the ACA had created—or a future policy creates—a baseline health plan for all uninsured lower-income Americans that is issued to anyone who qualifies. It would eliminate the need for the entire market bureaucracy produced by the exchanges.

384 See discussion supra note 252

385 Id.

386 Frankford & Rosenbaum, supra note 312, at 11. Aaron Baum et al., Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers, 38 HEALTH AFFAIRS 237 (2019); Carmela Coyle, Maryland’s Progress on the Path to the Triple Aim, HEALTH AFFAIRS BLOG (Nov. 12, 2015), https://www.healthaffairs.org/do/10.1377/hblog20151112.051749/full/.

387 Coyne, supra note 386.


389 Katharina Kieslich, Social Values and Health Priority Setting in Germany, 26 J. HEALTH ORG. & MGT. 374 (2012); Monika Steffen, Universalism, Responsiveness, Sustainability—Regulating the French Health Care System, 374 NEW ENG. J. MED. 401, 404 (2016).
Admittedly, any regulatory approach has its own complexities and its own bureaucratic needs. Design of a baseline health plan would demand navigating the state-by-state nature of insurance and provider networks and contests over what benefits to include and how much to reimburse for care. Yet regulatory efforts could and should focus on these kinds of critical questions that might produce valuable results, rather than on technocratic tinkering to scaffold competitive structures that are not producing the desired results.

2. **Reinvigorating Meaningful Choice**

Setting choice aside reveals better solutions to more efficient spending through direct regulation, but that does not mean that all health regulation should become paternalistic.

In limited circumstances, individual, market-level choice may be valuable and thus should be honored and supported by regulation, but, as the discussion above illustrated, market choice is less often a good proxy for what people value than imagined. In such cases, it is imperative to lift up out of the weeds to develop better proxies. There is a wealth of collective engagement and public consensus bubbling up on issues of health care that could help to shape regulations policies more in line with shared priorities and popular will.

a) Individual Choice

Choice in an individualized sense may be valuable in some, more limited, ways. Market-based health policy has generated myriad layers of choice. An individual must choose whether to have insurance and, if yes, then among health plan options. She then must choose her providers, including her doctor, hospital, imaging center, pharmacy, lab, physical therapist, and so on. Then, she must choose what care to use from each of these providers. Yet, most people do not value, or want to make, most of these choices and do not navigate them well, as shown above.

That said, people deeply care about being able to choose a doctor they know and trust. This message has come through in recent years. Resistance to managed care in the 1990s and deliberations and town hall meetings debating the ACA in 2010 made perfectly clear that people do not want to lose access to their doctors.390

Choosing a doctor “well” is a different endeavor than most of the quantitatively-driven choices the market bureaucracy has asked people to make. It can be deeply personal. For many, it is not about value or prices. For some, it is indeed about finding “the best.” For others, it about shared values or morals. Others care about finding someone who will take the time to communicate in a way that makes sense. For some, it is about convenience of

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location, scheduling or office hours. This is the type of decision that is in fact heterogenous and that many people could in theory make in way aligned with a genuine set of preference.

Ironically, this is an aspect of choice that health regulation has not done especially well to preserve.\(^{391}\) Even though President Obama promised that people could keep their doctors, his promises proved empty for some people (and earned him PolitiFact’s lie of the year).\(^{392}\) Insurers cancelled existing individual plans to accommodate the development of new ACA exchange plans, cutting people off from their existing providers, and new plans had notoriously narrow provider networks.\(^{393}\) Medicaid and Medicare are both increasingly moving toward managed care, where provider networks are often more limited.\(^{394}\) If health care regulation honored when individual choice actually does matter to people, it would instead maximize the ability to find and keep doctors we like and trust.

As another more contentious example, polling suggests that a majority of people—and a large majority of women—support reproductive choice.\(^{395}\) Yet, state legislatures continue to pass extremely restrictive legislation that limits reproductive choice in nearly all circumstances, in a likely counter-majoritarian way.\(^{396}\)

b) Collective Choice

In the market-based era, we have conflated choice with purchases. Going forward, these two must be disaggregated. This part offers one last reflection, turning back to the reason that markets elevate choice in the first place. At its core, a regulatory system to support market choices was supposed to enable people to use their resources on the things they most value, which is an admirable goal in concept. Yet, when what people care about cannot be expressed in market purchases, it is necessary to work to understand “preferences” or value or priorities in a more capacious, and sometimes collective, way.

It is common refrain that a lack of consensus is what led us to market-based policies in the first place, but such pronouncements are overblown. There are clear threads of

\(^{391}\) I thank Zach Liscow for helping highlight this irony.

\(^{392}\) Louis Jacobson, Barack Obama says that what he said was you could keep you plan ‘if it hasn’t changed since the law passed’, politifact.com (November 6, 2013), [https://www.politifact.com/truth-o-meter/statements/2013/nov/06/barack-obama/barack-obama-says-what-hed-said-was-you-could-keep/](https://www.politifact.com/truth-o-meter/statements/2013/nov/06/barack-obama/barack-obama-says-what-hed-said-was-you-could-keep/) (last accessed March 4, 2019).

\(^{393}\) Id. Jason Millman, This is Obama’s Explanation for Why You Might Not Get to Keep Your Doctor, WASH. POST (March 14, 2015).


agreement that weave broadly among the populace. Some of what people value is self-evident. Most people value access to lifesaving or life-enhancing medical care for themselves and for others. And they want—and want others to have—this access without incurring financial insecurity.

Contentious moments reveal consensus, and, in this area of health care turmoil, people are actively deliberating over values and priorities in public fora. For example, when Congress tried to repeal the ACA, including its Medicaid expansion, in the summer of 2017, public outcry arose against the roll back of the expansion. Similarly, public outrage percolates on exorbitant drug pricing and the bind in which it has put many American families, causing Americans to identify lowering drug prices as a top 2017 Congressional priority.

Health care is a ripe forum to reexamine how we understand meaningful choice. We have turned to markets in part because of skepticism of democracy’s ability to fix entrenched problems at a moment of deep political dysfunction. In health care, problems of vested interests and political capture are especially acute.

Yet, even at this moment when democracy limps along, examples have emerged where democratic deliberation over health care priorities is vibrant. This final part offers a few examples—themselves admittedly imperfect—of ways that people have collectively discovered or expressed what they most value in a health care system. It does not imply

397 Poll: Most Back Public Health Care Option, CBS NEWS (June 19, 2009, 4:50 PM), https://www.cbsnews.com/news/poll-most-back-public-health-care-option/ (finding that 64% of surveyed think the government should guarantee universal coverage and 57% would be willing to pay more taxes to ensure it).

398 Id. (50% were satisfied with their own costs but only 19% satisfied with costs for the country as a whole).


400 More generally, political scientists have documented how policymaking has become less democratic, for reasons ranging from a bias in the voices that policymakers hear from and care about to more complex policy feedback effects that discourage certain groups of people from active civic engagement. For an overview of both of these lines of study, see Suzanne Mettler & Joe Soss, The Consequences of Public Policy for Democratic Citizenship: Bridging Policy Studies and Mass Politics, 2 PERSPECTIVES ON POLITICS 55 (2004) (outlining systems theory in political science and the rise of research on policy feedback and its effects on mass political behavior); Joe Soss & Lawrence R. Jacobs, The Place of Inequality: Non-participation in the American Polity, 124 POL. SCI. Q. 95 (2009) (documenting the effects of rising economic inequality on political participation).

401 Pharmaceutical companies consistently top industry spending on lobbying activity over the past twenty years, followed by insurance (#2), hospitals and nursing homes (#9), health professionals (#13), and health services/HMOs (#16). Opensecrets.org, Top Industries, at https://www.opensecrets.org/lobby/top.php?indexType=i. Adding all of these categories, combined health care industry spending dwarfs that of all other industries.
these are the best or only examples but rather offers a few to illustrate the possibility that deliberative or democratic processes can produce health regulation that is responsive to shared commitments.

(1) Rationing Care with Community Input

Assume consensus indeed exists that it is a social priority to identify and reduce spending on low-value care, there are then many possible ways to do so.402 With regard to rationing, some doubt the value of collective deliberation,403 which may be right when thinking of rationing treatment-by-treatment. Yet, deliberation over principles that can guide priorities and tradeoffs may be more productive. A first step might be to define how voters, citizens, and patients define value.404

Oregon attempted such deliberation in order to effect an expansion of its Medicaid program in the early 1990s. Through a public, iterative process, it developed the Oregon List, a prioritized list of medical care for its Medicaid program in order to expand coverage to more people by covering fewer services for some.405 The state Health Services Commission held eleven public hearings, conducted 1000 random-digit-dialed telephone surveys, and authorized a citizens’ advocacy group, Oregon Health Decisions, to hold forty-seven community forums, soliciting input on a questionnaire about the relative importance of certain health conditions or services and engaging in public discussion.406

Based on public input, clinical data, and outcomes research, the state developed an algorithm to array medical conditions in rank order of priority.407 Medicaid dollars would be allocated based on rankings, starting by paying for items at the top of the list and moving down the list as far as funds for a particular year would allow.

One of the insights that arose in Oregon was that the public gave relative priority to preventive services and dental care, and services such as dental checkups were, in turn,

402 See e.g., MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS (1997)(discussing the ethics and economics of different systems of rationing).

403 Jonathan Oberlander et al., Rationing Medical Care: Rhetoric and Reality in the Oregon Health Plan, 164 CANADIAN MED. ASSOC. J. 1583 (2001).

404 Frank Pasquale, The Hidden Costs of Health Care Cost-Cutting: Toward a Postneoliberal Health- Reform Agenda, 77 L. & CONTEMP. PROBLEMS. 171, 173 (2014); Cf. Richard H. Pildes & Cass R. Sunstein, Reinventing the Regulatory State, 62 U. CHI. L. REV. 1, 9 (1995) (“A special goal is to incorporate public judgments about risk so long as they are appropriately informed and reasonable, even when those judgments diverge from expert understandings. We spend considerable space on this complex subject, contending that public judgments often reflect a distinctive kind of rationality, one that rejects some conventional forms of cost-benefit balancing.”)


406 Fox & Leichter, supra at 20.

407 Id. at 21-22
ranked higher than the physician members would have placed them.\textsuperscript{408} Further, the public and experts both rejected some of the ways that the algorithms prioritized low-cost yet non-essential services over high cost but potentially lifesaving ones, even if the former scored higher on a dollar per outcome measure. For example, on the initial list, addressing thumb sucking ranked above hospitalization for a starving child.\textsuperscript{409} Such priorities were changed in a second list.

Even though the list was first rejected by the Bush Administration in a waiver application and later was revised haphazardly to accommodate federal administrators’ demands and concerns of disability discrimination, and even though the list has not been used as anticipated as a rationing tool, the process to create it nevertheless illustrates the potential for understanding collective preferences, even on sensitive questions. People assembled in community meetings and hashed out concerns and priorities, which directly informed state policymaking.\textsuperscript{410}

Even critics of the Oregon List recognize that the process of developing it built public support for raising taxes to fund expanded insurance for the poor, a valuable end in itself.\textsuperscript{411} The discussion thus created spending priorities that at least marginally better reflected community values and had community support.

(2) Surfacing and Clarifying Shared Values on Complex Topics

Deliberation over health care values has occurred in other fora—both experimental and organic. Over the past two decades, federal agencies have asked how to get better public deliberation on important health care matters. On the question of how evidence should inform healthcare decisionmaking, the Agency for Healthcare Research and Quality created a community forum under the American Recovery and Reinvestment Act to increase public deliberation.\textsuperscript{412} They project relied on a range of tools, including James

\begin{footnotes}
\item[408] Id. at 22.
\item[409] Id.
\item[410] Some criticize that the meetings were over representative of interest groups, especially physicians. Id. at 25.
\item[411] Oberlander et al., supra note 403, at 1586.
\end{footnotes}
Fishkin’s Deliberative Polling, which are designed to gauge and build consensus on complex issues in small-group settings.  

For one part of the demonstration, investigators convened seventy-six deliberative groups for various durations of time with 907 sociodemographically diverse participants in four locations across the U.S. They posed the following question to try to gauge values about the respective roles of patients and physicians in making medical decisions: “Should individual patients, their doctors, or both be able to make any health decisions no matter what the evidence of medical effectiveness shows, or should society ever specify some boundaries for these decisions?”

Research surfaced several important values, including that evidence of harm to communities or individuals was more important than evidence of effectiveness and that people wanted and expected their doctors to be the arbiters of evidence. It also found that even though people resisted “cookie-cutter” medical decisions, a large majority thought that doctors should not be able to provide a medical treatment that will not work for a patient and that participants were comfortable with restrictions on ineffective treatments, including that insurance should not pay for them. Over the course of the discussion, the proportion of participation taking these positions increased. Finally, deliberation increased knowledge of medical evidence and comparative effectiveness research. This type of deliberative process can provide input for shaping policies and may also help participants solidify their support for such policies.

Another, less discrete and more organic example where public deliberation is both shaping and revealing a more dynamic understanding of larger values is on end-of-life and palliative care, which aims to make people more comfortable during illness. Again, here productive engagement has resulted from discussion one level removed from decisions on specific treatments and focused more conceptually on values like pain versus comfort or longer versus more able life.

Conventional wisdom says that Americans have a taste for expensive life-saving interventions. Yet, efforts to engage with people on this question in more conceptual ways—and outside of life and death moments—have revealed otherwise. Hospice care is

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413 James S. Fishkin, Consulting the Public through Deliberative Polling, 22 J. POL’Y ANALYSIS AND MGT. 128 (2003).


415 Id.

416 Id. at 571.

417 Id. at 569-571.

418 Id.

419 Id. at 569.
a half century old, but active efforts to engage people in discussion on what is desirable and possible in the case of terminal illness or at the end of life have been slower to develop.\textsuperscript{420}

One community that has been ahead of the curve is the city of La Crosse Wisconsin, where 96 percent of people who die have an advance directive in place. The movement in La Crosse began in the late 1980s and early 1990s when Bud Hammes, an ethicist who worked in the Gunderson Health System, developed a template for providers to talk to their patients about end-of-life preferences as part of routine medical care.\textsuperscript{421} The program, which began with a successful small pilot run by nurses trained to have end-of-life conversations, later scaled, first in the Gunderson System, and into other communities as an independent organization.\textsuperscript{422} This effort, even though it begin in a very individualized way, spurred collective community deliberation over the value of invasive and expensive life-prolonging interventions.

In parallel, other organizations have aimed to start and shape conversations about dying. One of the earliest such programs, Five Wishes, was started in 1996 by a non-profit called Aging with Dignity in Florida, with support from the Robert Woods Johnson Foundation.\textsuperscript{423} These types of programs attempted to normalize talking and thinking about death and to resist overmedicalization, by using more generalized and plain language, that asks people to consider, for example, who they want help with their care and how comfortable they want to be.

What is interesting about these examples is that they are helping people and communities to discuss what values could shape the way someone thinks about serious illness or death. Does someone care most about survival or about being comfortable? How does someone like to make important decisions, and with whom? Concurrently, clinical trials have shown the potential of palliative care and counseling to avoid unnecessary medical care and to improve outcomes and sometimes even prolong life.\textsuperscript{424} These efforts

\textsuperscript{420} Nicole Fisher, \textit{The History Of Hospice: A Different Kind Of Health 'Care'}, FORBES (June 22, 2018, 8:45AM), \url{https://www.forbes.com/sites/nicolefisher/2018/06/22/the-history-of-hospice-a-different-kind-of-health-care/#6aa3495f660c}.

\textsuperscript{421} Sarah Kliff, \textit{Wisconsin is learning how to die}, VOX (May 28, 2015, 7:00AM) \url{https://www.vox.com/2015/5/28/8672527/death-la-crosse-wisconsin}.


\textsuperscript{424} Preeti N. Malani & Eric Widera, \textit{The Promise of Palliative Care: Translating Clinical Trials to Clinical Care}, 316 JAMA 2090 (2016) (reviewing research on palliative care); See, e.g., Jennifer S. Temel et al., \textit{Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer}, 363 NEW ENG. J.
have both raised and revealed different ways a health care system—and the people in it—might approach death.

Undoubtedly, people remember vividly when payment for end-of-life counseling was proposed as part of the ACA in 2009, and opponents of health care reform famously decried it as a move toward “death panels” and the payments were withdrawn from the healthcare reform package. Yet, only six years after the death panels outcry, CMS faced little opposition to the passage of the rule authorizing Medicare reimbursements for advanced care planning discussions. Indeed, comments on the proposed rule submitted by both individuals and health care organizations overwhelmingly supported the change in policy, once considered on its terms and not as a pawn in a larger battle. The percentage of larger hospitals with palliative care programs is now 90 percent, as compared to only 15 percent in 1998.

This example suggests that, even on one of the most sensitive topics—targeted for attack by overly vocal interest groups—people and communities can engage productively on discussion of tradeoffs between, for example, extending life and quality of life, if engaged in the right settings and at the right level of conceptual abstraction. And these conversations can then begin to support policymaking that increases investments in palliative care, further weaving it into the fabric of medical practice. Although not the primary goal, in the end, this kind of responsive consideration of how people want to deal with serious illness, pain, and death could simultaneously spur policymaking that roots out wasteful, invasive end-of-life expenditures.

(3) Access and Medicaid Expansion

Finally, separating the discussion about what people most value from market mechanisms can reveal that what people might most care about is others, and the distribution of resources to others. The fight over Medicaid expansion is revealing the depths of insight into a shared commitment to access that is being express through a more traditional democratic tool, ballot measures.

The ACA intended to expand Medicaid access in all states to people earning up to 138% of the federal poverty level but was thwarted in the courts. The first major legal challenge to the ACA, NFIB v. Sebelius, in effect made this expansion optional, so states

MED. 733 (finding better quality of life, fewer depressive symptoms, and longer median survival among patients receiving early palliative care.)

426 Id.
427 https://www.regulations.gov/docketBrowser?rpp=25&so=DESC&sb=commentDueDate&po=0&s=%22advance%2Bcare%2Bplanning%22&dct=PS&D=CMS-2016-0116.
could keep their pre-ACA eligibility categories or expand and, in turn, receive federal matching funds for upwards of 90% of the spending on newly qualified enrollees. As of September 2018, 34 states and the District of Columbia had chosen to expand.\(^{429}\) In all of the other states, Republican governors and/or legislators opted against expansion.

What is remarkable is that in these opt-out states, voters have begun to directly override their representatives’ decision with ballot initiatives. As one might imagine, the opt-outs tend to be more conservative states. Maine was the first to pass a ballot initiative in November 2017 to expand Medicaid. Voters in Idaho, Nebraska, and Utah followed in November 2018. Ironically, and illustrating that producing people value may be more challenging than understanding it, politicians including former Republican Governor LePage in Maine and current legislators in Utah are resting implementation of the referenda.\(^{430}\)

A takeaway from these initiatives is that people deeply value access to medical care in their communities, especially for lower-income community members, and might be willing to sacrifice or make tradeoffs to achieve these goals. For these initiatives to pass required people who would not directly benefit personally from the expansion to vote in favor. Health regulation should focus on realizing such expressions of shared commitments. Bureaucracy is inevitable, but it should bolster a health care system that can fulfill, rather than frustrate, what people and communities genuinely care about.

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These examples will not—in and of themselves—transform the US healthcare system, but they illustrate different ways to gauge what the public most values in it. None of health care’s problems is easy. But the hope that the market will simultaneously fix escalating, wasteful spending and also produce what people want has pushed aside deliberation on alternatives that could more effectively achieve these two important and sometimes distinct goals. Relinquishing the false hope in markets can clear space for solutions that could genuinely improve the value of health care spending and make people healthier and more secure.

CONCLUSION

Market-based solutions preserve an aura of choice and autonomy and have widespread appeal. They may be appropriate when there is no right answer, where heterogeneity of wants can genuinely be accommodated by the market, where people are reasonably good


\(^{430}\) Before being replaced in November by a Democratic woman as governor, term-limited LePage sent a Medicaid state plan amendment to CMS for approval of the expansion, as ordered by the State Supreme Court, and concurrently sent a letter requesting that CMS deny approval. Michael Shepherd, Maine’s Top Court Backs Ruling that LePage Must Send Medicaid Expansion Plan to Feds, Bangor Daily News August 23, 2018; S.B. 96, Medicaid Expansion Adjustments, 2019 General Session State of Utah, at https://le.utah.gov/~2019/bills/sbillenr/SB0096.pdf.
decisionmakers, and where the subject in question is not life or death. Then, consumers may be the best arbiters. But such moments are fewer than imagined especially in the realm of health care.

The growing body of evidence discussed herein shows that market-based approaches have largely failed health law and suggests we could do better. It is time to let go of the false hope that market-based solutions will solve U.S. health care woes.

Eschewing market-based policymaking is a refusal to continue to create structures that do not work and that set people up to fail, knowing they will likely do so, and then labeling failure as choice. As Deborah Stone wisely cautioned, “It is cynical to think that people will feel better about deprivation or bad outcomes as long as they believe they have had a hand in choosing their fate. … [C]onsumer choice offers citizens procedural comfort but less substantive help.”431 We must relinquish fleeting and shallow procedural comfort for sounder answers. In some cases, that might mean deprioritizing choice. In other cases, once we divorce choice from markets, we can ask what the polity genuinely values and can work to overcome the barriers to realize such ends, whether those barriers are technical, political, or sociological.

In the end, it is possible that the social and political price of taking on these harder conversations is too high. Collective engagement on hard problems may seem naïve at a moment of time with extraordinary high political divisiveness, a breakdown in representative government, and concentrated wealth and interests controlling policy. Trying to gauge shared priorities in a deeper way will of course be contentious at times and divisive if what people express they want is discriminatory or rights threatening. One possibility is that ineffective, bureaucratic market-based policies may be the price we pay to keep the peace.

Yet, this Article has shown that the price we are paying is extremely high. And, at the end of the day, these market-based policies, as battles over the ACA have most recently illustrated, have not been mollifying. They have merely buried contentious issues to bubble up later.

The unavoidable fact seems to be that we must take on political challenges and uncomfortable conversations to make real progress on the most intractable health policy problems. But so long as we continue painstakingly to build health care’s market bureaucracy, we are too distracted and too tired to have these conversations. This Article has argued that we must put down the technocratic tools and to turn our collective efforts to building more productive intellectual foundations for the next era of health policy, law, and regulation.

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431 Stone, supra note 7, at 486.