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THE PATIENT LIFE: CAN CONSUMERS DIRECT HEALTH CARE?

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THE PATIENT LIFE CAN CONSUMERS DIRECT HEALTH CARE?

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Mark A. Hall**

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

John Bunyan
The Pilgrim's Progress

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

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Abstract

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

This article evaluates consumerism and the regulatory mechanism of which it is essentially an example – legally mandated disclosure of information. We do so by assessing the crucial assumptions about human nature on which consumerism and mandated disclosure depend. Consumerism operates in a variety of contexts in a variety of ways with a variety of aims. To assess so protean a thing, we ask what a patient's life would really be like in a consumerist world. The literature abounds in theories about how medical consumers *should* behave. We look for empirical evidence about how real people actually buy health plans, choose providers, and select treatments.

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

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

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I. INTRODUCTION: THE CLATTERING TRAIN

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

Anonymous

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

Everyone wants to control the train. Governments worry because they pay for so many people’s care. Employers worry because the more they pay for insurance the less they can pay in wages. Employees worry because they defray ever larger shares of medical costs. We all worry (or should) because while insurance appears to insulate us, ultimately we pay – as taxpayers, as employees, as consumers – for what we receive. And even while we worry about costs, we worry also about quality. Controlling the train means reducing costs while improving quality.

A. CONTROLLING COSTS AND QUALITY

Lawmakers, employers, health plans, and hospitals have long tried to subdue the clattering train. But costs rise irrepressibly because irrepressible forces push them. Technology, for example, can be marvelous, but it can also be expensive to develop, implement, and use.⁴ And specialization combines with technology to demand

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

². *Id* at 13.

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

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

expensively bureaucratized medicine.

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

The clattering train was once constrained by want of fuel. When shallow pocketed individuals paid, costs could only go so high. Then came the deep pockets. Employers (stimulated by tax incentives) offered health insurance. Government (stimulated by social duty) insured the elderly and the indigent. Public and private insurers paid the “usual and customary” rate – essentially, what doctors and hospitals charged. Thus fueled, the train sped up. Robinson puts it neatly:

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

So the train chugged along briskly. But perhaps costs were justified by the quality of care? Alas, doctors were presumptively the only qualified judges, and the “profession systematically refused to discuss or divulge quality concerns to

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

⁶. *Id.* at 23.

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

⁸. Robinson at 23.

nonphysicians.”⁹ However, unsettling hints abound. For example, hospitalization and surgery rates have “varied widely across geographic regions, with the best predictor being the number of hospital beds and practicing physicians; the prevalence of disease was not consistently associated with the frequency and intensity of care.”¹⁰ And “[r]esearch studies, authoritative entities such as the Institute of Medicine (IOM), and the insurers’ own claims data reveal widespread overuse, underuse, and misuse of services, compared with evidence-based norms and clinical guidelines.”¹¹

Employers and governments particularly have struggled to slow the train, to reroute it, to improve it. Their best success has been managed care. It seeks to give patients what consumers shop for – low prices *and* high quality. It assumes that providers drive the clattering train and that they can be persuaded to slow, steer, and stop it. Managed care stems costs primarily by limiting patients’ choices of providers and treatments and by giving providers incentives to economize. These incentives have included “oversight and report-card keeping on physicians’ prescribing practices, rules about the use of primary care physicians as gatekeepers or their elimination altogether, too heavy a use of evidence-based medicine as a rationale (whether reasonable or not) for the denial of various therapies, and requirements that doctors gain permission for expensive procedures.”¹²

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

Managed care seeks good care at good prices by influencing providers. Many of its practices survive in some form, but the top-down, supply-side principle has been ravaged. That left a bottom-up, demand-side principle: Why not treat patients like consumers? Won’t they select the care they need at the price they want? Won’t the market then spur competition that expands consumers’ choices while constraining costs? This “consumerism” is today’s watchword.¹⁴ As two writers said fifteen years

⁹. Id at 28.

¹⁰. Id at 24.

¹¹. James C. Robinson & Jill M. Yegian, *Medical Management After Managed Care*, Health Affairs W4-269, W4-269-W4270 (Web Exclusive, 2004).

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

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

¹⁴. “It is clear that a consumer-driven revolution has begun, and there is reason to believe that it will shape the future direction of the health care system.” Jill

ago, “[I]f we want to solve the nation’s health care crisis, we must apply the same commonsense principles to medical care that we apply to other goods and services.”¹⁵ As the HHS Secretary said a few days ago, “We have a better option, to provide beneficiaries with reliable information about the cost and quality of their care. When given that kind of information, we know that consumers will make decisions that drive costs down and the quality up.”¹⁶

B. CRESCENDOING CONSUMERISM

The consumer’s life is a search for goods and services of high quality at low prices. Crucial among services is medical care, but few people shop for it like consumers, if only because insurance has made price little worrisome.¹⁷ This is pleasant, but the gloomy science warns us that when consumers want the best and ignore price, costs soar like the lark ascending. And when providers can bill for each service, prices soar yet faster and further.

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

Quadagno, *Who Wins? Who Loses? Who Pays?*, 27 *Health Affairs* 294, 295 (2008). For especially intelligent treatments of consumerism, see Clark Havighurst’s *oeuvre*. For his own (witty) introduction to his work, see Clark C. Havighurst, *I’ve Seen Enough! My Life and Times in Health Care Law and Policy*, 14 *Health Matrix* 107 (2004). An excellent and up-to-date survey is Timothy Stoltzfus Jost, *Health Care At Risk: A Critique of the Consumer-Driven Movement* (Duke U Press, 2007). Several book reviews provide an efficient (and sufficient?) introduction to consumerist writing. Clark C. Havighurst, review of Michael F. Cannon & Michael D. Tanner, *Healthy Competition: What’s Holding Back Health Care and How To Free It*, 25 *Health Affairs* 1740 (2006); Uwe E. Reinhardt, review of George Halvorson, *Health Care Reform Now!: A Prescription for Change*, 27 *Health Affairs* 291 (2008); Alan Maynard, review of Regina Herzlinger, *Who Killed Health Care? America’s \$2 Trillion Medical Problem – and the Consumer-Driven Cure*, 26 *Health Affairs* 1783 (2007).

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

¹⁶. Robert Pear, *Bush Proposes Linking the Medicare Drug Premium to Beneficiaries’ Income*, *NY Times*, Feb 16, 2008 (quoting Michael Levitt).

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

decisionmaking, consumer deference, and price-insensitive insurance payment.”¹⁸

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

Second, consumerism asks patients to choose doctors, hospitals, and other “providers” considering both quality and cost. This is critical, since patients’ spending turns on what providers offer and advise. Consumerist patients will ask: Which providers offer inexpensive services? Which providers work with patients to control expenditures? Which providers treat patients decently? Which providers are competent – or truly excellent? Here, again, consumers already make some such choices – they sometimes choose doctors, for instance. But patients rarely choose providers with an eye to their prices.²⁰

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

Most people can’t afford high deductibles either; they teeter too close to the

¹⁸. William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 Columbia L Rev 1701 (1999). “The fundamental idea underlying the theory of managed care was to achieve social equity through the distribution of vouchers . . . that could be used only for the purchase of health insurance offered by a variety of private, competing health insurance plans.” Uwe E. Reinhardt, *Can Efficiency in Health Care Be Left to the Market?*, 26 J Health Politics, Policy & L 967, 985 (2001).

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

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

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

economic brink to pay thousands of dollars from their pockets.²² So employers may create tax-sheltered “health-savings accounts” in which unspent funds accumulate from year to year. To qualify for the tax shelter, deductibles must range (currently) from \$1100 for individuals to \$11,000 for families.²³ Typically, employers put a large fraction of the deductible into the employees’ account. Nevertheless, consumers spend their own money in several senses. First, they contribute to the account. Second, the employers’ contribution is effectively part of the employee’s salary. Third, consumers can use unspent money that accumulates (tax-free) for most health-care expenses and can distribute it in their estates.

Here too parts of the consumerist agenda are already operating. Many insurers have already adopted consumerist devices. “Deductibles are increasing, copayments for physician office visits and prescription drugs are increasing, and health plans are increasingly more likely to provide incentives for beneficiaries to use generic drugs and/or mail order pharmacy services, and other forms of tiered benefits”²⁴

Surely consumerism’s time is come. Not only are its three parts old hat; both sides of the ideological spectrum can like it. The right can like using markets to regulate prices and ensure quality. Consumerism simultaneously fits neatly with the standard principles (principle?) of the leftish “bioethics” side of health law. Offering patients control over their medical care is the *fons et origo*, the alpha and omega of bioethical law.²⁵ That law works mainly through mandated disclosure – by requiring patients be given good enough information to make their own decisions.²⁶ The paramount example is informed consent, but it is only one of many programs that – like consumerism – aspire to “empower” patients by giving them information and thus the power to choose what they want.²⁷

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

²³. [Http://www.treas.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml](http://www.treas.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml). Two-thirds of the people with family coverage in a consumerist plan had “a family deductible of \$3,000 or higher; 24 percent reported a deductible of at least \$5,000.” Paul Fronstin & Sara R. Collins, *Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, 228 EBRI Issue Brief 1, 6 (2005).

²⁴. Id at 4.

²⁵. See chapters 1 - 3, Marsha Garrison & Carl E. Schneider, *The Law of Bioethics: Individual Autonomy and Social Regulation* (West, 2003).

²⁶. William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 Columbia L Rev 1701 (1999).

²⁷. For example, the Patient Self-Determination Act seeks to encourage patients to use advance directives to make “pre-need” decisions lest incompetence should prevent them from exercising their authority. 42 USC § 1395 cc(a). The PSDA requires

C. CONSIDERING CONSUMERISM

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

To see the consumerist agenda is to feel *déjà vu* all over again. *Many* plans have been laid to tame costs, improve quality, and expand control. Taming costs fails with doleful regularity. Improving quality is impressively hard. And the principal legal attempts to give patients more control have routinely disappointed.²⁸ When plausible policies repeatedly fail to achieve excellent goals despite exceptional efforts, there are usually high, and sometimes insuperable, barriers, to reaching the goals. Is it thus with consumerism?

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

To assess so protean a thing,²⁹ we scrutinize consumerism’s distinctive and crucial feature: purchasers choosing well. We use a fresh technique – we systematically ask what prerequisites must be met for consumerism to succeed and

that patients be given information about advance directives. HIPAA regulations seek to permit patients to protect the confidentiality of medical information about them. 45 CFR Parts. The regulations require doctors and hospitals to give patients the information they need to manage the handling of confidential information.

²⁸. Carl E. Schneider, *After Autonomy*, 41 Wake Forest L Rev 411 (2006).

²⁹. A complete evaluation would be broad. Not least, it would ask economic questions like: Isn’t much of our health-care dollar spent on a small group of people whose care is so expensive that deductibles are irrelevant? Are health-care costs driven by forces – like technology and the institutions of health care – that consumers can little affect? For an excellent survey of the issues, see Jost, *Health Care At Risk* (cited in note).

whether they will be met. Our answers rest on empirical evidence about how people buy health plans, choose providers, and select treatments. When there is no such evidence, we consult empirical research on similar decisions, especially mandated disclosure.

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

This brings us to our article's second enterprise. One of the law's favorite techniques is to require a more knowledgeable (and thus presumptively stronger) party to provide information to a less knowledgeable (and thus weaker) party.³⁰ Securities laws are an ambitious example. Courts and commentators debate what disclosures should be required in boilerplate contracts. Product-liability law invites manufacturers to disclose dangers their goods pose. Credit-card companies must reveal their terms to card users. Various truth-in-lending acts are supposed to make borrowers good judges of lending terms. *Miranda* warnings give suspects information to use in dealing with police.

Mandated disclosure and consumerism operate in similar ways. Their success depends on how well information can be assembled, disclosed, received, understood, analyzed, and used. This is why research on mandated disclosure helps us understand consumerism and why our technique for studying consumerism helps us evaluate mandated disclosure as a regulatory method.

So to our third enterprise. We conclude that consumerism, and thus mandated disclosure generally, are unlikely to accomplish the goals imagined for them. Consumerism's prerequisites are too many and too demanding. Consumers do make many purchases with aplomb. Most things consumers acquire they buy regularly and judge easily. Those products are sold in national markets in which competition works its Smithian magic. But health plans, providers, and treatments are chosen sporadically, are hard to assess even after the purchase, and are often sold in small markets. So health-care choices are harshly more demanding than most other purchases, as Kenneth Arrow famously said decades ago.³¹

³⁰. As we write, CNN tells us to "take heart, there may be more legislation . . . on the way. Last month New Jersey became the first state to enact a law that requires [match-making websites] to disclose whether they do background checks on members." Jen Haley, *Be a Savvy Consumer When Looking for Love Online*,
<http://www.cnn.com/2008/LIVING/personal/02/14/roym.online.dating/index.html>
(accessed February 14, 2008).

³¹. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*,

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

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

II. THE AVAILABILITY OF GOOD CHOICES

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

T. S. Eliot
The Hollow Men

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

A. THRIFTY HEALTH PLANS

Some prominent consumerists – Havighurst is a distinguished example – propose that costs may be moderated and patients may better match their expenditures to preferences if they can purchase health insurance the way they purchase other services. The consumerist agenda will thus wither if consumers lack adequate choices.

53 American Economic Rev 941 (1963).

Yet many consumers have no such options and faint prospect of getting them.

“[L]arge segments of the population . . . have no real or perceived choice in their employment, health insurance, or health plan.”³² Even larger employers in larger cities may offer employees only a few choices, and few employers offer many. For example, “in 1999 approximately half of individuals covered by employer-sponsored plans had no choice or limited choice of health plans.”³³ And “Robert Berenson . . . contends that ‘only a few large and prominent employers are redesigning employer contribution formulas to encourage value purchasing, contracting directly with provider-based delivery systems, or using quality data . . . in any meaningful way to select plans.’” Medium-sized employers “do not even seem to understand the difference between the price of particular provider services and their aggregate cost . . . , much less to be able to separate fact from fiction on quality measures.”³⁴

Even consumers offered several plans may have scanty choices. This insurance comes in packages; you can’t pick and choose coverage. But you will rarely be offered the combination you’d design for yourself. Buying insurance is not like buying a car, where you can take a showroom package or order your own farrago of options. Insurers cannot afford to let people insure themselves only for care they know they will need. Nor must competition inspire variety; on the contrary, competitors may converge around packages likeliest to attract buyers.

Employers might even dislike long *à la carte* menus. Employers don’t want under-insured and hence under-treated, bankrupt, and bitter employees. The more options consumers have, the likelier they are to choose improvidently, and pressure to economize drives employees toward under-insurance. Under-insurance matters, especially since the distance between lavish and stingy is wide. Under-insurance can wreck financial and physical health. Costs of illness (particularly medical bills and loss of income) contribute to more than half of personal bankruptcies.³⁵ And even shaving back coverage can hurt. One longitudinal study, for example, “demonstrate[d] significantly worse health outcomes among individuals who reported restricting their use

³². Amy B. Bernstein & Anne K. Gauthier, *Choices in Health Care: What Are They and What Are They Worth?*, 56 *Med Care Res & Rev* 5, 11 (1999).

³³. Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 *St Louis U L J* 365, 375 (2003).

³⁴. Lawrence D. Brown, *Management by Objection?: Public Policies to Protect Choice in Health Plans*, 56 *Med Care Res & Rev* 145, 157 (1999).

³⁵. See generally Melissa B. Jacoby, *The Debtor-Patient Revisited*, 51 *St Louis U L J* 307 (2007); Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 *Northwestern U L Rev* 535, 538-539 (2006); R.W. Seifert & M. Rukavina, *Bankruptcy is the Tip of a Medical-Debt Iceberg*, 25 *Health Affairs* w89 (2006).

of prescription medications because of cost. . . . [C]ost-related medication restriction was associated with almost twice the odds of experiencing a significant decline in overall health over 2 years of follow up.³⁶

In short, consumerism's first prerequisite—adequate choice—is not met now for health plans. Nor can it be without restructuring health-care financing in large and possibly unwise ways.

B. THRIFTY TREATMENT CHOICES

Consumerism promises to fix an intransigent problem – the clattering train – by pressuring patients to “take a more active interest than they hitherto have had in the cost-effectiveness of their care.”³⁷ Patients spending their own money should buy treatments cheaply and eschew wasteful care. But will patients have scope to economize on treatments? Not much where no savings are practically possible or where reforms have already eliminated excess expenditures. Nor need patients economize if they will exceed the year's deductible. So, how much opportunity and incentive to save will patients have?

This question has two aspects. First, are there substantial opportunities for economies that have not already been exploited? After all, “health care plans today already contain both substantial cost sharing and managed care measures that are likely to reduce spending.”³⁸ Second, will consumerism induce patients to exploit any such opportunities?

Consumerism's easiest case is where equally effective treatments differ in cost. The classic example is generic drugs. Since by hypothesis the expensive treatment has no advantages, the cheap treatment is so plainly preferable that doctors hardly need offer patients a choice. In these areas it's not clear how much room for improvement is left and whether referring decisions to patients motivates improvement. After all, managed-care has campaigned for years to – for example – get doctors to substitute generics for brand-name drugs, and health plans increasingly use formularies to inveigle doctors to prefer cheap to expensive drugs.³⁹ These efforts and a changing medical culture have helped. For example, as early as ten years ago “[o]nly 8% of

³⁶. Michele Heisler et al, *The Health Effects of Restricting Prescription Medication Use Because of Cost*, 42 *Med Care* 626, 630 (2004).

³⁷. Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 *Health Affairs* 57, 65 (2006).

³⁸. Dahlia K. Remler & Sherry A. Glied, *How Much More Cost Sharing Will Health Savings Accounts Bring?*, 25 *Health Affairs* 1070, 1073 (2006).

³⁹. On formularies, their promise and problems is Peter J. Neumann et al, *Do Drug Formulary Policies Reflect Evidence of Value?*, 12 *Am J Managed Care* 30 (2006).

physicians preferred brand-name medications over generic drugs regardless of cost.”⁴⁰ Similarly, patients who use emergency rooms or specialists for routine problems notoriously waste resources, but health plans have already diminished this problem by increasing copayments for ERs and by requiring referrals to specialists.

Another easy case for consumerism is where patients decide whether a genuinely elective treatment is worth paying for. This category’s borders are hazy, but some decisions fit it neatly enough, like cosmetic surgery. But how much can consumerism save here, since patients already pay for most such treatments?

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

The following cases exemplify this category: The patient has an upper respiratory tract infection and acute sinusitis. A cheaper antibiotic works 70% of the time, a costlier one 80% and about a day faster. The consumerist patient weighs “the increased cost and potential side effects against the possibly quicker return to health.” A “day of lost work may be more costly to her, in money or in other ways, than the additional cost of the more expensive antibiotic.”⁴¹ Another example: In *Pegram*,⁴² the plan delayed a test that could have revealed the patient’s appendicitis. Delay was probably cost-effective for the patient population, but an individual patient might want to pay extra for peace of mind or to avoid coping with a burst appendix.⁴³

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

⁴⁰. Steven Reichert et al, *Physicians’ Attitudes About Prescribing and Knowledge of the Costs of Common Medications*, 160 Arch Intern Med 2799, 2800 (2000). For the contrasting view three decades ago, see Peter Temin, *Taking Your Medicine: Drug Regulation in the United States* 103, 105 (1980).

⁴¹. Paul Clay Sorum, *Ethical Decision Making in Managed Care*, 156 Arch Intern Med 2041 (1996).

⁴². *Pegram v. Herdrich*, 530 US 211 (2000).

⁴³. A plan without burst appendices is performing unnecessary appendectomies, which have their own risks.

a patient anxious to accelerate diagnosis and treatment could decide the test was worth the cost.

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

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

III. THE AVAILABILITY OF INFORMATION

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

Arthur Conan Doyle
The Adventure of the Copper Beeches

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

A. DOES THE INFORMATION EXIST?

Nobody can be told what nobody knows. Much information consumers need for choosing plans or providers cannot practically be compiled, would not willingly be compiled, or has not been worth compiling. Consumers get *much* less information than they need. Reinhardt is blunt: "Only rarely, in a few locations, do American patients have access to even a rudimentary version of the information infrastructure on which the theory of competitive market and the theory of managed care rest."⁴⁴ Nor is

⁴⁴. Reinhardt, 26 JHPPL at 967 (cited in note).

managed care's experience inspiring. Organizations had every incentive to explain themselves, particularly as criticism festered. Yet they offered "patients a bewildering array of acronyms and concepts that even specialists sometimes have trouble characterizing" while doing "little to explain the concept" of managed care.⁴⁵

Might patients' demands induce providers to assemble information? Some, surely. But much information is hard to compile in a practical form. Take one standard and indispensable datum – what doctors and hospitals charge. Prices are often unavailable in any form consumers could use to compare plans, providers, and treatments. They are often unavailable in any form *anyone* can readily use.⁴⁶

Hospital's fees, for instance, are stated in a "charge master" – "a confidential list of charges made by the hospital for all its goods and services." It "is compiled and maintained by the hospital's chief financial officer on the hospital's computer system." Fifteen years ago, one hospital's charge master "contained approximately 295 pages and listed prices for approximately 7,650 items." It was "confidential proprietary information" and "not shown to anyone other than the officers and employees of the hospital and authorized consultants." It was adjusted weekly "to reflect current cost data; the hospital's costs are marked up by a mathematical formula designed to produce a targeted amount of profit for the hospital."⁴⁷ And today, charge masters may contain as many as 45,000 items.⁴⁸

*If you could get a charge master and if you could understand it, you would still have to decide which charges to use comparing plans or providers (recalling that prices change frequently). Even if you knew what illnesses your family would have, you would have to predict the treatments (something even doctors might not know) as the charge master coded their components. Then you would need similar success with other plans and providers.⁴⁹ Even if you *could* do all this, would you want to?*

⁴⁵. Jacobson, 47 St Louis U L J at 374 (cited in note).

⁴⁶. We describe and explain this failure at length in Hall and Schneider, 106 Mich L Rev at 643 (cited in note).

⁴⁷. *Doe v. HCA Health Services of Tennessee*, 46 SW3d 191, 194 (Tenn 2001).

⁴⁸. Hospital charge masters are described in: Gerard Anderson, *From "Soak the Rich" to "Soak the Poor": Recent Trends in Hospital Pricing*, 26 Health Affairs 780, 786 (2007); Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 Health Affairs 57, 58-59 (2006); Allen Dobson et al, *A Study of Hospital Charge Setting Practices* (Medicare Payment Advisory Commission, 2005), http://www.medpac.gov/publications/contractor_reports/Dec05_Charge_setting.pdf
For examples, see <http://www.oshpd.ca.gov/HQAD/Hospital/Chargemaster/2005/chrgmstrA.htm>.

⁴⁹. On the impossibility of all this, see Hall and Schneider, 106 Mich L Rev at 643 (cited in note).

Consumers run a pilot test of consumerism when they buy *in vitro* fertilization, cosmetic surgery, and dental crowns. Experts in those markets say “[c]onsumers engage in little price shopping.” Most consumers accept other patients’ recommendations or physician referrals in choosing providers of IVF and rhinoplasty. “For dental crowns, virtually all patients choose to stay with their regular dentist rather than shop around.” Significantly, an “important reason why shopping takes place so infrequently for these procedures is that accurate price quotes can only be obtained after undergoing in-person screening exams, since costs vary according to patient characteristics and medical needs as assessed by each provider.”⁵⁰

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

examined a hospital bill for a person who was charged more than \$30,000 for an outpatient procedure. Many of the services on the bill were written in a language that only a coding expert could understand. One of the items was a "Bairhugger upper body cov," with a charge of \$77.55. The same hospital bill contained the following additional items and associated charges: Versed 1 MG/ML 2CC VIA-\$11.37; Lactated Ringers 2B2324-\$189.00; Valve IV-\$7.15; Pack Custom Cysto-\$58.00; Set Tur-\$35.35.⁵¹

As one of the Aged Parents commented mournfully, “every emergency room we’ve ever been in, every hospital stay we’ve had, particularly since our retirement, has reduced us to helplessness as far as costs were concerned, choice of hospitals, and choice of the physicians who treated us once we were immured.”

In short, prices are so complex and dynamic that information about them hardly exists. It has not been compiled, cannot easily be compiled, and cannot be reliably analyzed. No wonder it is little provided.⁵² No wonder attempts have far to go before usable information is readily provided.⁵³

⁵⁰. Ha T. Tu & Jessica H. May, *Self-Pay Markets In Health Care: Consumer Nirvana Or Caveat Emptor?*, Health Affairs - Web Exclusive w217, w223 (2007).

⁵¹. Anderson, 26 Health Affairs at 786 (cited in note).

⁵². “[F]ew of these initiatives provide health plan enrollees the data they might need to make informed choices among available providers or treatments.” Mark Merlis, *Health Care Price Transparency and Price Competition (National Health Policy Forum, http://www.nhpf.org/pdfs_bp/BP_PriceTransparency_03-28-07.pdf* (2007).

⁵³. Perhaps consumers shouldn’t even want this information published, since

Quality information is as elusive as price information. Reinhardt gloomily concludes that “[i]nformation on the quality of care is generally unavailable or not trustworthy. Not even the infection or complication rates experienced in hospitals are publicly known.” One study found that “[j]ust 1 in 7 people (12-16 percent) in all plan types said that their plans provided either type of information on doctors and hospitals . . .”⁵⁴ The scant information on quality in the media or on internet sites “typically consists of mysteriously weighted aggregate indexes that obscure the detailed information patients would need in competitive market.”⁵⁵ There are only “very limited opportunities to learn about the health outcomes achieved by particular physicians and hospitals.”⁵⁶ For example, the Association of State Medical Board Executive Directors offers “information on physicians’ education, malpractice judgments, and disciplinary histories.” One employers’ group in the Northwest “publishes a study of patient satisfaction with medical groups and physician networks” which “ranks groups and networks on patient satisfaction, ease of getting referrals, and their records of keeping blood pressure and cholesterol under control and counseling patients on preventive care.”⁵⁷ This is better than nothing, but how much would you wager on such spotty and delphic data?

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

Even experts quarrel about what facts about quality are useful and how to use them. For example, “the National Committee for Quality Assurance found that the ‘average’ health plan provided 61.9 percent of appropriate beta-blocker drugs to patients who suffered a heart attack. Plans ranged between 15 percent and 100

publication of prices may inhibit discounts. See Margaret K. Kyle & David B. Ridley, *Would Greater Transparency and Uniformity of Health Care Prices Benefit Poor Patients?* 26 *Health Affairs* 1384 (2007); Paul B. Ginsburg, *Shopping for Price in Medical Care*, 26 *Health Aff* w208 (2007); Symposium, 23 *Frontiers of Health Service Management* 3 (2007).

⁵⁴. Fronstin and Collins, 228 EBRI Issue Brief at 18-20 (cited in note).

⁵⁵. Reinhardt, 26 *J Health Politics, Policy & L* at 986–987 (cited in note).

⁵⁶. Deborah Haas-Wilson, *Arrow and the Information Market Failure in Health Care: The Changing Content and Sources of Health Care Information*, 26 *J Health Politics, Policy & L* 1031, 1040 (2001).

⁵⁷. *Id.* at 1041.

percent on this indicator.” So far so good. But is “a high favorable score on this count . . . evidence of overall high quality or of a shift of resources to this medical priority at the expense of others, perhaps those left unmeasured in formal surveys”?⁵⁸

There is more. To seek out and interpret quality data, consumers must realize that quality varies. Many consumers do not. For example, “[m]any industry observers express concern that LASIK is regarded as a commodity by some consumers – leading them to shop only on price – when provider quality, in their opinion, varies considerably.” LASIK may be “relatively simple surgery with low complication rates, but for patients whose eyes have certain ‘problem’ characteristics (for example, abnormal topography, large pupils, thin corneas), quality differences can be critical.”⁵⁹

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

Things get no better when we move from choosing plans and providers to choosing treatments. Even experts *often* lack good information about treatments. “Evidence-based medicine” is today’s watchword, but there is decent evidence for only a fraction (albeit a large fraction) of medicine. Indeed, the great fact about the “information” doctors reason from and present to patients is its insistent uncertainty. Uncertainty “is clinically commonplace.”⁶⁰ Medicine “is engulfed and infiltrated by uncertainty.”⁶¹ Physicians practice “in a sea of doubt and uncertainty,”⁶² so that “judgements must inevitably be made on the doctor’s personal experience of past cases; the comparison of the present size, sound or feel of something with what is remembered; and on what a clinician believes to be the problem, based sometimes on very scanty evidence.”⁶³

⁵⁸. Brown, 56 *Med Care Res & Rev* at 160 (cited in note).

⁵⁹. Ha T. Tu & Jessica H. May, *Self-Pay Markets In Health Care: Consumer Nirvana Or Caveat Emptor?*, *Health Affairs - Web Exclusive* w217, w222 (February, 2007).

⁶⁰. Charles L. Bosk, *Occupational Rituals in Patient Management*, 303 *NEJM* 71, 72 (1980).

⁶¹. Jay Katz, *The Silent World of Doctor and Patient* 166 (Free Press, 1984).

⁶². Eric J. Cassell, *The Changing Concept of the Ideal Physician*, *Daedalus* 185, 186 (Spring 1986).

⁶³. *Id.* at 191. On clinical uncertainty, see Schneider, *The Practice of Autonomy* at 48 - 75 (cited in note).

This is uncertainty about how to treat patients. But consumerist patients need still another datum – treatments’ cost-effectiveness. This is even less available than information about efficacy. Managed-care organizations have been trying to generate and acquire such data for years, with incomplete success. Can patients inspire something better?

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

B. WHENCE COMETH INFORMATION?

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

Most vendors yearn to advertise their wares. Unfortunately the incentives that inspire advertising also inspire hype. Furthermore, the beauties of our labor always outshine its flaws. Consumers expect and law tolerates some puffery in sales. So when even scrupulous health plans and providers proclaim their virtues or relate their results, they accentuate the positive. “[N]o one denies that marketing agents [of medical plans], eager to boost a plan’s enrollment, their own commissions, or both, sometimes put consumers’ minds at ease by shading facts.”⁶⁴

Similar problems are inevitable when patients purchase treatments. One canary in this mine is LASIK surgery, which consumers buy directly from providers who advertise. “Misleading advertisements have been a recurring problem with some LASIK providers, most notably discounters; federal and state regulators have taken action against some providers – and investigated many more – for making unfounded claims about price and quality.”⁶⁵

Another canary is direct-to-consumer drug advertising. One study concludes that these ads “have limited educational value and may oversell the benefits of drugs in

⁶⁴. Brown, 56 Med Care Res & Rev at 149 (cited in note).

⁶⁵. Tu and May, Health Affairs at 221 (cited in note). LASIK “is widely regarded as the self-pay market with the most favorable conditions for consumer shopping: It is an elective, nonurgent, simple procedure,” so consumers should have time and capacity to shop for it, “screening exams are not required to obtain initial price quotes, which keeps the dollar and time costs of shopping reasonable; and easy entry of providers (ophthalmologists) into the market has stimulated competition and kept prices down.”

ways that might conflict with promoting population health.”⁶⁶ Similarly, Lyles believes that the “blend of promotion and information has produced more prescription drug awareness than knowledge – it has been largely ineffective in educating patients with medical conditions about the medications for those conditions.”⁶⁷ Not just ineffective in educating, but mis-educating. Advertisements for drugs are regulated, but their information “has frequently been found to be biased or misleading in regulatory and academic evaluations.”⁶⁸ Consumers tested after seeing ads “correctly answered an average of 59 percent of the true/false questions,” fewer when the questions were about risk, and fewer “if the information had been given in text, with or without accompanying audio, rather than in audio only”⁶⁹

Hospital ads may be yet more vacuous (if blessedly less common). An analysis of over 300 hospital web sites said that their information was “rudimentary” and that “few of the designated measures were valid and reliable measures of quality.”⁷⁰

Even when providers are compelled to disclose information, they can usually beautify it. When health plans had to disclose the way their doctors were paid, “almost none” of their statements mentioned “the potential negative impact that incentive arrangements might have on physician behavior.” They more often painted “incentives in a positive light,” by saying, for example, that the incentives rewarded better care (as perhaps they did).⁷¹

All this makes vendors’ unreliable, as consumers know. But *how* unreliable? Vendors paint pretty portraits, but they also paint some warts, not least because they want repeat business and good word-of-mouth, neither of which comes from deceived

⁶⁶. Dominick L. Frosch et al, *Creating Demand for Prescription Drugs: A Content Analysis of Television Direct-to-Consumer Advertising*, 5 Ann Family Med 6 (2007).

⁶⁷. Alan Lyles, *Direct Marketing of Pharmaceuticals to Consumers*, 23 Annual Rev Public Health 73 (2002).

⁶⁸. Steven Morgan et al, *The Economics of Direct-to-Consumer Advertising of Prescription Advertising of Prescription-Only Drugs: Prescribed to Improve Consumer Welfare?*, 8 J Health Services Res & Policy 237 (2003).

⁶⁹. Kimberly A. Kaphingst & William DeJong, *The Educational Potential of Direct-To-consumer Prescription Drug Advertising*, 23 Health Affairs 143, 145 (2004).

⁷⁰. David S. Zingmond et al, *Information Superhighway or Billboards by the Roadside? An Analysis of Hospital Web Sites*, 175 Western J Med 385 (2001).

⁷¹. Mark A. Hall, *The Theory and Practice of Disclosing HMO Physician Incentives*, 65 L & Contemp Prob 207, 227 (2002). Similarly, lending disclosure requirements may “create incentives for lenders to draft contract terms that . . . continue to obscure the actual contract terms.” Susan Block-Lieb & Edward J. Janger, *The Myth of the Rational Borrower: Rationality, Behavioralism, and the Misguided “Reform” of Bankruptcy Law*, 84 Texas L Rev 1481, 1560 (2005-2006).

customers. So how does the consumer distinguish reliable from dubious vendors? Discount favorable information from any vendor? Discount it they do. For example, “[s]everal focus groups have found that consumers particularly distrust information that comes from the plans themselves, or from their employers because they believe they are being ‘marketed’”⁷² Yet too much discounting is as bad as too little.

Consumers of all kinds are especially moved by recommendations from friends and family. And so “when it comes to plan choice, consumers say they most trust the advice of their doctors, friends, and family”⁷³ However, those recommendations are unsystematic, and lay evaluations of technical services are unreliable.⁷⁴ So consumers may trust most those who evaluate quality worst.

Ideally, then, consumers need sounder sources. When you buy flooring, you check *Fine Homebuilding*. When you buy a bandsaw, you check *Fine Woodworking*. Will a *Fine Health Care* appear? *Consumer Reports* does rate health plans, *US News & World Report* does rate hospitals, and internet sites are arising.⁷⁵ But when markets are so fragmented, could *Fine Health Care* evaluate each market thoroughly enough? *FHC* would also struggle with the complexities and mysteries we’ve been describing. Furthermore, the institutions *FHC* evaluated would game the system, just as law schools do with *U.S. News and World Report*. Anderson, for example, says California has tried to proffer useful information by comparing “the prices of only twenty-five items on the chargemaster.” However, “hospitals can lower prices for just those twenty-five items.”⁷⁶ So is a really useful *FHC* possible? And if there were one, would consumers really use it?

Information about everything does bubble up everywhere on the internet. But it must be (1) consulted, (2) reliable, and (3) workable. Onerous requirements. For

⁷². Amy B. Bernstein & Anne K. Gauthier, *Choices in Health Care: What Are They and What Are They Worth?*, 56 *Med Care Res & Rev* 5, 13 (1999).

⁷³. James S. Lubalin & Lauren D. Harris-Kojetin *What Do Consumers Want and Need to Know in Making Health Care Choices?*, 56 *Med Care Res & Rev* 67, 72 (1999).

⁷⁴. For example, B. McKinstry et al, *Do Patients and Expert Doctors Agree on the Assessment of Consultation Skills?* 21 *Family Practice* 75 (2004), found “no meaningful association” between patients’ and experts’ assessments of doctors’ skills. John T. Chang et al, *Patients’ Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care*, 144 *Ann Intern Med* 665, 671 (2006), “found that patient reports about interpersonal quality were distinct from technical quality of care as measured by medical records and patient interviews.”

⁷⁵. For a brief description, see J.D. Kleinke, *Vaporware.com: The Failed Promise of the Health Care Internet: Why the Internet Will Be the Next Big Thing Not To Fix the U.S. Health Care System*, 19 *Health Affairs* 57, 66-67 (2000).

⁷⁶. Anderson, 26 *Health Affairs* at 786 (cited in note).

example, people over 75 “were much less likely to report use of the Internet for health” than their juniors.⁷⁷ And, for example, the best guide to new Medicare drug cards in 2005 was the government’s website. But three quarters of the prospective beneficiaries had never used the internet, and “of the 23 percent who had used it, only 6 percent had visited the website.”⁷⁸

Well, the Luddite old will eventually be replaced by the cyber young. But they still must locate sites and separate wheat-sites from chaff-sites. Inevitably, chaff proliferates; studies repeatedly find internet information dicey.⁷⁹ “[O]nly a few of the web pages” one study reviewed “gave complete and accurate information for such a common and widely discussed condition as fever in children.” The advice those sites gave parents about children’s fevers was “often incomplete and partly misleading” and inadequate to overcome parents’ “beliefs and established practices.”⁸⁰

In addition, making internet information usable seems challenging. One Medicare expert tried to help “a parent, who was taking four prescription drugs, use the [government] website to find the best card.” It took “forty-two ‘clicks’ or word entries to get an answer.” The expert had to supply data “about such things as each medication used and its dosage, current drug spending, and pharmacy preferences.”⁸¹ Not only is this laborious (and irksome, since errors are almost unavoidable) but who has such stuff easy to hand? This hardly inspires you to hunt information on the internet.⁸²

Even were the internet widely used, how consumerist would the results be? “Many have argued that patients using the Web to find providers will finally bring price-sensitivity to health care consumption The exact opposite is more likely to occur. . . . Not only will people never seek the lowest bidder when it comes to their own physical

⁷⁷. Laurence Baker et al, *Use of the Internet and E-Mail For Health Care Information: Results From a National Survey*, 289 JAMA 2400, 2402 (2003)

⁷⁸. Yaniv Hanoch & Thomas Rice, *Can Limiting Choice Increase Social Welfare? The Elderly and Health Insurance*, 84 Milbank Q 37, 54 (2006).

⁷⁹. Baker et al, 289 JAMA at 2405 (cited in note).

⁸⁰. Piero Impicciatore et al, *Reliability of Health Information for the Public on the World Wide Web: Systematic Survey of Advice on Managing Fever in Children at Home*, 314 British Med J 1875, 1878 (1997). Similarly downbeat is Angela Fagerlin et al, *Patient Education Materials About the Treatment of Early-Stage Prostate Cancer: A Critical Review*, 140 Ann Intern Med 721, 724 (2004).

⁸¹. Hanoch and Rice, 84 Milbank Q at 54 (cited in note).

⁸². “Accessing health information using search engines and simple search terms is not efficient. Coverage of key information . . . is poor and inconsistent High reading levels are required to comprehend Web-based health information.” Gretchen K. Berland et al, *Health Information on the Internet: Accessibility, Quality, and Readability in English and Spanish*, 285 JAMA 2612 (2001).

and emotional well-being; they will actively seek out and select the highest bidder, presuming (usually correctly) that higher cost connotes higher quality”⁸³ Furthermore, health-care companies advertise because it moves their products, partly by increasing demand. Increased demand hardly lowers costs.

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

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

IV. WILL DOCTORS DISCUSS AND USE COST INFORMATION?

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

Hippocrates
Precepts

Once again, assume away all the problems of creating and conveying information. Suppose the information consumers need is assembled and is proffered by trustworthy messengers consumers actually trust. Will doctors and patients discuss costs, and will doctors help patients economize?

A. STIMULATING DISCUSSIONS OF COSTS

Consumerism may seem especially plausible for treatment decisions, since

⁸³. Kleinke, 19 Health Affairs at 67 (cited in note).

doctors can help patients make decisions. Such guidance already is given some patients, especially poor patients. But for consumerism to work, doctors must routinely discuss costs, since without that guidance patients cannot identify economies.

So will doctors and patients talk about treatment choices? They might. First, patients might take the initiative and ask about cheaper treatments or foregoing treatment. This surely happens. It surely should be encouraged. But patients often do not realize such a question makes sense. Furthermore, patients report a “wide variety of barriers” to discussing costs.⁸⁴ Who wants to bring up money? Even in an art gallery, embarrassment might inhibit you from asking about price. Partly this is because you probably can't afford the Stieglitz you want, just as you may not be able to afford the treatment the doctor proposes.

Furthermore, you come to the doctor “sick, anxious, and intimidated. So you let the doctor set the boundaries and tone of your relationship.”⁸⁵ You want your doctor's approval, confidence, and concern. Questioning a recommendation and demanding something cheaper rarely strike patients as canny tactics, especially when physicians are selling their services. Thus in one study only 12% of the subjects had ever negotiated with a provider for a lower price.⁸⁶ One sophisticated patient we know thought it “a little difficult” to ask a doctor she had just met about price. She feared raising questions about “respect” for the doctor and getting “off on the wrong foot.” When we said that “you don't want your doctor thinking badly about you,” she replied, “Yeah, getting revenge somehow, perhaps.”⁸⁷ Yet further, patients are notoriously bad at raising the subjects they really want to discuss. Finally, many patients are sick. Sickness can be painful, exhausting, debilitating, disorienting, terrifying, isolating. People so afflicted lack the energy and acuity to ask smart questions and pursue sound answers.

So if patients won't reliably bring up cost, will doctors? This is crucial, because physicians notoriously dominate conversations with patients,⁸⁸ and physicians might

⁸⁴. G. Caleb Alexander et al, *Barriers to Patient-Physician Communication About Out-of-Pocket Costs*, 856 J Gen Intern Med 19 (2004).

⁸⁵. Hall and Schneider, 106 Mich L Rev at 655 (cited in note).

⁸⁶. Sara R. Collins, *Gaps in Health Insurance: An All-American Problem*, Commonwealth Fund, April 2006, at 20, available at http://www.commonwealthfund.org/usr_doc/Collins_gapshltins_920.pdf.

⁸⁷. Hall and Schneider, 106 Mich L Rev at 655-56 (cite in note).

⁸⁸. Even when doctors spoke with sophisticated patients (San Francisco AIDS patients) about an important topic (CPR), conversations were brief, doctors did most of the talking, and they “dominated the discussions.” James A. Tulsky, et al, *How Do Medical Residents Discuss Resuscitation with Patients?*, 10 J Gen Intern Med 436 (1995).

neither raise the topic nor invite patients to do so. Physicians little relish conversations about prices.⁸⁹ Price discussions have been so little interesting that “the literature has only recently begun to address patient-provider communication about health care costs.” On “first pass, it appears that little communication of this type is going on.”⁹⁰ Physicians advertise rarely, advertise fees less, and post no prices.⁹¹ Dr. Hippocrates, quoted two pages above, set the example of reluctance to talk about money.⁹² Stein describes a “taboo in official American health culture: namely, a prohibition upon allowing the physician to appear concerned with financial matters.” Stein believes that people “‘selling’ their services are loathe to affix a price tag to services at the time of the transaction or as an official precondition to ‘delivering’ them. Somehow it would be immoral to do so.”⁹³ And perhaps physicians – whose incomes generally outstrip their patients’ – are embarrassed to reveal fees patients may find incomprehensibly high and intolerably burdensome.

Research confirms that doctors and patients do not regularly discuss costs. “Four hundred eight patients (85%) reported they had never discussed their out-of-pocket costs with their physician. This group of 408 patients included 56 of the 77 patients (73%) who reported cost-related medication nonadherence during the previous 12 months.”⁹⁴ Only a tenth of Pittsburgh patients remembered being told what care would cost.⁹⁵

Some data look more encouraging. Fronstin and Collins found that “[f]ifty-five percent of those in . . . [consumer plans] reported that they had discussed treatment

⁸⁹. A historical view of the ethics and practice of fees, see Fridolf Kudlien, *Medicine as a "Liberal Art" and the Question of the Physician's Income*, 31 *J History Med* 448 (1976).

⁹⁰. Alex D. Federman, *Don't Ask, Don't Tell: The Status of Doctor-Patient Communication About Health Care Costs*, 164 *Arch Intern Med* 1723, 1723 (2004).

⁹¹. See, e.g., Berkeley Rice, *How to Market Your Practice*, *Medical Economics*, March 4, 2005, at 53. “[P]hysician price advertising continues to be quite rare,” and “physicians are strongly opposed to price advertising.” John A. Rizzo & Richard J. Zeckhauser, *Advertising and the Price, Quantity, and Quality of Primary Care Physician Services*, 27 *J Human Resources* 381, 388 – 89 n 12 (1992).

⁹² John Fabre, *Medicine as a Profession: Hip, Hip, Hippocrates: Extracts from The Hippocratic Doctor*, 315 *British Med J* 1669 (1997).

⁹³. Howard F. Stein, *The Money Taboo in American Medicine*, 7 *Med Anthropology* 1, 11 (1983).

⁹⁴. G. Caleb Alexander et al, *Patient-Physician Communication About Out-of-Pocket Costs*, 290 *JAMA* 953, 955 (2003).

⁹⁵. Thomas P. O'Toole et al, *Full Disclosure of Financial Costs and Options to Patients: The Roles of Race, Age, Health Insurance, and Usual Source for Care*, 15 *J Health Care Poor & Underserved* 52, 56 (2004).

options and costs with their doctor, and 44 percent said that they had asked their doctor to recommend a less costly prescription drug.” Forty-three percent of the patients “in comprehensive plans discussed options with their physician, and one-quarter (27 percent) had asked their doctor to recommend a cheaper drug.”⁹⁶ Nevertheless, these patients were asked whether they had *ever* discussed cost, not whether such discussions were routine and productive.

Even if doctors balk at discussing their own charges, might they discuss the costs of services and supplies they order from others? Perhaps not. For instance: “Physician-patient discussions about new medication cost and other acquisition issues, especially medication affordability, occur infrequently.”⁹⁷ This is true even where discussion seems needed: “Few chronically ill patients who are at risk of or experiencing problems related to prescription medication costs report that their clinicians had asked them about possible medication payment difficulties.”⁹⁸

One major barrier to cost discussions is that doctors often do not know prices. Half a century ago we heard that the “doctor is seldom informed about the price” of drugs.⁹⁹ A quarter of a century ago we read that “doctors seldom have an accurate sense of drug costs” and that when asked “about common drug prices, they reveal ignorance more often than knowledge.”¹⁰⁰ Today we read that doctors “consistently overestimated the cost of inexpensive products and underestimated the cost of expensive ones.”¹⁰¹ Even primary-care and internal-medicine physicians are “no more knowledgeable about costs than their family practice, geriatrics, pediatrics, and neurology colleagues were a decade ago.” Eighty percent of them “were often unaware of actual drug costs, and most underestimated the cost of common brand-name medications we inquired about.”¹⁰²

Such costs are the easy case. Physicians cannot know what treatments cost until they know what treatments are required. But, for example, primary-care physicians

⁹⁶. Fronstin and Collins, 228 EBRI Issue Brief at 20 (cited in note).

⁹⁷. D.M. Tarn et al, *Physician Communication About the Cost and Acquisition of Newly Prescribed Medications*, 12 Am J Managed Care 657, 657 (2006).

⁹⁸. Michele Heisler et al, *Clinician Identification of Chronically Ill Patients Who Have Problems Paying for Prescription Medications*, 116 Am J Med 753, 753 (2004).

⁹⁹. Herman Miles Somers & Anne Ramsay Somers, *Doctors, Patients, and Health Insurance* 209 (1961).

¹⁰⁰. Peter Temin, *Taking Your Medicine: Drug Regulation in the United States* 103, 105 (1980).

¹⁰¹. G.M. Allan et al, *Physician Awareness of Drug Cost: A Systematic Review*, 4 PLoS Med e283 (2007).

¹⁰². Reichert et al, 160 Arch Intern Med at 2802 (cited in note). Nor did a third of them realize that Medicare did not (then) cover medications.

often forward patients to specialists and hospitals with little idea what the cost will be.¹⁰³

Furthermore, most doctors have patients with different insurers which negotiate fees “in a tumultuous market that regards prices as trade secrets. One Harvard surgeon’s group has a six-hundred page ‘master fee schedule’ with ‘twenty-four columns across the top, one for each of the major insurance plans, and, running down the side, a row for every service a doctor can bill for.’” Even a “superb office staff might not know who would pay what until the insurer completed claims ‘adjudication.’”¹⁰⁴ Yet

clearing a typical insurance claim involves, for starters, the following queries: (1) Is the patient a member of the plan? (2) Is this particular service covered by the patient’s benefit plan? (3) Is there secondary insurance that should cover this service? (4) Is this service related to an incident that may be subrogatable to a workers’ comp, disability, or accident event? (5) Is this service consistent with the patient’s clinical diagnosis, history, age, and sex? (6) Is the service, if covered, medically necessary? (7) Has the service, if covered, been preauthorized? (8) Is this submitting provider qualified to provide this service? (9) Is the provider a member of the network? (10) How much do we pay this particular provider for this particular service? (11) Has the patient’s deductible or major medical been met this year? (12) Did the patient pay upfront, and who are we reimbursing, patient or provider?¹⁰⁵

Can doctors be persuaded to discuss money regularly? Altering doctors’ preferences and practices is hard even where, for example, there is good evidence that change would benefit patients clinically.¹⁰⁶ Most relevantly, managed-care organizations have for years begged doctors to economize in exactly the ways consumerism contemplates. Those efforts provoked vehement resistance from doctors, less improvement than had been anticipated, and numerous retreats by health plans.

¹⁰³. See generally Goodson, 298 JAMA 2308 (cited in note).

¹⁰⁴. Hall and Schneider, 106 Mich L Rev at 657 (cited in note) (quoting Atul Gawande, *Piecework: Medicine’s Money Problem*, New Yorker, Apr. 4, 2005, at 44).

¹⁰⁵. Kleinke, 19 Health Affairs at 61 (cited in note).

¹⁰⁶. For an introduction to this unexpectedly challenging problem see Gro Jamtvedt et al, *Audit and Feedback: Effects on Professional Practice and Health Care Outcomes*, Cochrane Database Syst Rev 259 (2006); Peter J. Greco & John M. Eisenberg, *Changing Physicians’ Practices*, 21 NEJM 1271, 1271 (1993); Jacqueline Kosecoff et al, *Effects of the National Institutes of Health Consensus Development Program on Physician Practice*, 258 JAMA 2708 (1987); Lee A. Green & Colleen M. Seifert, *Translation of Research Into Practice: Why We Can’t “Just Do It,”* J Am Bd Family Prac 541, 541 (2005); Lee Green & David R. Mehr, *What Alters Physicians’ Decisions to Admit to the Coronary Care Unit?*, 45 J Family Prac 219, 223 (1997).

Can the law stimulate discussions about cost? Asked to change sellers' interactions with consumers, the law reaches first for mandated disclosure. Asked to change doctors' conversations with patients, the law reaches first for informed consent. But how would informed-consent work in this unusual context? Plaintiffs would be claiming that, properly informed, they would have foregone a test or chosen a cheaper treatment. But if doctors are giving reasonable advice, it would be hard for patients to prove they would have rejected it. Nor are damages likely to be juicy enough to induce contingency-fee lawyers to take such cases.¹⁰⁷

Doctrinally, another approach is neater. Patients might refuse to pay for treatments they would have rejected if properly informed. The claim would resemble the claim of customers whose brokers churned their accounts. This seems doctrinally ordinary but practically awkward. Patients would have to realize that they had been denied information about cheaper care and would have chosen it. A lawyer would ordinarily have to help formulate the claim and make it stick, since no billing office would listen to that kind of whining from patients.¹⁰⁸

In sum, doctors and patients sometimes discuss costs, but hardly as often or thoroughly as consumerism would need. Increasing those conversations is onerous, and the law is ill-suited to the task.

B. WILL DOCTORS EMBRACE THRIFT?

Suppose doctors and patients do discuss costs. Those conversations will be bootless if doctors aren't committed to economies. This is because doctors shape – often make – patients' choices about tests and treatments. As one court vigorously put it, the doctor

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

¹⁰⁷. For a helpful discussion of this issue, see Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 *Vanderbilt L Rev* 1207, 1224 - 32 (2006).

¹⁰⁸. For more on the difficulties patients face resisting medical bills, see Hall & Schneider, 106 *Mich L Rev* at 643 (cited in note).

complete monopoly.¹⁰⁹

And when patients enter a hospital, the doctor's influence over patients' expenditures intensifies. "Patients rarely abandon doctors, reject doctors' recommendations, or demand second opinions."¹¹⁰ So if doctors don't help patients economize – if they don't lead their patients to economize – patients will be sore pressed to do so well.

Much in doctors' training, culture, and situation diminishes their economizing zeal. First, remember how we got to consumerism in the first place – because doctors had little reason to control costs and much reason to drive them up. The more services doctors sold and the more they charged for a service, the wealthier they got. In a simpler day, doctors had fewer services to offer and modest market power, and fee-for-service medicine could be kept within patients' ability to pay, especially since doctors charged the poor less than the rich.¹¹¹ When employers made health insurance a basic benefit and when (over the "socialized medicine" lamentations of organized medicine) Medicare and Medicaid were instituted, fee-for-service remained standard. Fees, however, kept growing even while doctors' provision of services did not always correlate with need¹¹² and doctors used some of their market power to sustain their incomes.¹¹³ This dynamic drove us to managed care. This dynamic still operates, even if less forcefully, and fee-paid doctors are rewarded for keeping cost-savings off their agenda.

¹⁰⁹. *Magan Medical Clinic v. California State Board of Medical Examiners*, 57 Cal Rpt 256, 263 (CtApp 1967).

¹¹⁰. Hall & Schneider, 106 Mich L Rev at 652 (cited in note).

¹¹¹. For this history, see Mark A. Hall & Carl E. Schneider, *The Legal History of Billing for Medical Fees*, under review (2008).

¹¹². "[M]any studies have suggested . . . that physicians' decisions are influenced by a wide variety of factors that are unrelated to a patient's specific medical problem. These factors include practice setting, degree of specialization, and physician age." Lachlan Forrow et al, *Science, Ethics, and the Making of Clinical Decisions: Implications for Risk Factor Intervention*, 259 JAMA 3161, 3165 (1988). Furthermore, "[w]ide variations in the incidence of medical and surgical services are the *norm*, not the exception," Bradford H. Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals* 252 (Harvard U Press, 1991) (emphasis in original), although much of this variation is concentrated in areas where there is professional disagreement about the treatment. Further, "as much as 25 percent or more of expenditures for medical care is for unnecessary or inappropriate services." *Id* at 253. For vivid demonstrations of how much medical practices vary geographically, see John E. Wennberg et al, *Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?*, 1987 Lancet 1185; Mark R. Chassin et al, *Variations in the Use of Medical and Surgical Services by the Medicare Population*, 314 NEJM 285 (1986).

¹¹³. For the background, see Hall & Schneider, 106 Mich L Rev at 643 (cited in note).

Furthermore, managed care pushed and pulled doctors to control costs. Organized medicine and many physicians resented this challenge to their authority, and they remain resentful.¹¹⁴ “Under cover of the managed care backlash, physicians and hospitals began to reassert their prerogatives. With the erosion of stringent cost controls, physicians gained greater leverage in clinical decisions.”¹¹⁵ As Hyman bluntly argues, “The medical profession wants to regain its ability to dictate the terms of trade with regard to cost and quality.”¹¹⁶ In short, organized medicine and many doctors have fought long, stubbornly, and bitterly to preserve their unconstrained authority in general and their ability to avoid cost controls particularly.¹¹⁷

Dr. Bloche takes the point further. He writes that by the early sixties, physicians had “won consumers’ confidence” and that many physicians “took opportunistic advantage by acquiring ownership interests in hospitals, clinical laboratories, and other health care businesses.” Doctors’ “[a]nticommercial norms” eroded, so that doctors “now routinely advertise, accept discounted fees from managed health plans, take ownership interests in facilities financially affected by clinical utilization patterns, and sign contracts that reward them financially for withholding care.”¹¹⁸

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

Furthermore, doctors’ doubts about cost-containment are reinforced by admirable aspects of their culture. Doctors are moved by craft pride. Their norms call them to provide the best care available, to follow the best practices, to apply the gold standard of treatment.¹¹⁹ Part of the reason doctors loath managed care is that they feel it

¹¹⁴. “[P]hysicians provided some of the most vociferous opposition to managed care” Jacobson, 47 St. Louis U L J at 371 (cited in note).

¹¹⁵. Id 366.

¹¹⁶. David A. Hyman, *Accountable Managed Care: Should We Be Careful What We Wish For?*, 32 U Mich J L Reform 785, 801–802 (1999).

¹¹⁷. Nor can we count on organized medicine for constructive alternatives. “[P]roviders have spent too much of their time complaining about managed care and too little time considering whether alternatives to existing payment arrangements might make everyone better off.” David A. Hyman, *Medicine in the New Millennium: A Self-Help Guide for the Perplexed*, 26 Am J L & Med 143, 147 (2000).

¹¹⁸. M. Gregg Bloche, *The Market for Medical Ethics*, 26 J Health Politics, Policy & L, 1099, 1108 - 09 (October 2001).

¹¹⁹. The depth of their feeling is suggested by their occasional willingness to deceive insurance companies to obtain coverage. This superficially appealing but also

prevents them from giving that care.¹²⁰ And doctors are trained in “Hippocratic individualism,”¹²¹ a single-minded commitment to the interest of the patient seeking help. Much of this benefits patients, and in much of this doctors speak for patients. As individuals (if not as members of an insured group) patients want all the medical care their doctors think they need.

Furthermore, doctors' paternalism – less pejoratively, their role – accustoms them to persuade patients toward health. Patients often need persuading. They eat, drink, and smoke; they avoid doctors; they don't buy drugs they've been prescribed; they don't take drugs they've bought; they flee from burdensome treatment. Inducing patients to cooperate in their own care is part of the physician's stock-in-trade and part of what patients expect.¹²²

Little in all this inclines doctors to save money; much in this arms them to resist lowering standards. This commitment may bend to fit economic circumstances, but not easily.¹²³ Nevertheless, doctors are pragmatists. They want patients to receive the best care, but they are not flatly unwilling to help patients save money. Not at all. In our interviews and our work with medical colleagues, we encounter many physicians

destructive practice is discussed in Rachael M. Werner et al, *Lying to Insurance Companies: The Desire to Deceive among Physicians and the Public*, 4 Am J Bioethics 53 (2004); Victor G. Freeman et al, *Lying for Patients: Physician Deception of Third-Party Payers*, 159 Arch Intern Med 2263 (1999); Matthew K. Wynia et al, *Physicians Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 283 JAMA 1858 (2000).

¹²⁰. However,

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

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

¹²¹. Robert Zussman, *Intensive Care* (U Chicago Press, 1992).

¹²². Schneider, *The Practice of Autonomy* (cited in note).

¹²³. Gail Weiss, *A Patient's Coverage Takes a Back Seat to Clinical Factors, Say Most Respondents to our Ethics Policy*, Med Economics, Dec 1, 2006.

who are warmly anxious to assist patients who have trouble paying for care.¹²⁴ Scholarship confirms this. For example, three-quarters of the doctors in one national survey routinely consider insured patient's out-of-pocket costs in some kinds of clinical decisions, especially when prescribing drugs.¹²⁵ In one academic medical center, 88% of the physicians thought patients' costs were important in prescribing, and 71% would sacrifice some efficacy to save some costs.¹²⁶

What is more, sometimes doctors see reasons to economize better than patients. Doctors may see more realistically than patients that a treatment is futile or ineffective. Nor is economy always inimical to health. Thus we found in interviews with a convenience sample of seven primary-care physicians that doctors are most willing to save money when it promotes optimal care, as when a patient is likelier to take prescribed medication if the doctor chooses a cheaper even if less effective drug.¹²⁷

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

But where patients can't detect symptoms and where mistakes may be irreparable (controlling blood pressure, cholesterol, and blood sugar are classics)

¹²⁴. See also Samia A. Hurst et al, *Physicians' Responses To Resource Constraints*, 165 Arch Intern Med 639 (2005).

¹²⁵. Hoangmai H. Pham et al, *Physician Consideration Of Patients' Out-Of-Pocket Costs In Making Common Clinical Decisions*, 167 Arch Intern Med 663 (2007). In one small survey, doctors considered patients' insurance status in 47% of patients' visits. David S. Meyers et al, *Primary Care Physicians' Perceptions of the Effect of Insurance Status on Clinical Decision Making*, 4 Ann Fam Med 399 (2006). In another study, 31% of the doctors questioned sometimes or often did not offer "a useful service to patients because of health plan coverage rules." Matthew K. Wynia et al, *Do Physicians Not Offer Useful Services Because Of Coverage Restrictions?*, 22 Health Affairs 190 (2003).

¹²⁶. Reichert et al, 160 Arch Intern Med at 2800 (cited in note).

¹²⁷. Elizabeth A. Mort et al, *Physician Response To Patient Insurance Status In Ambulatory Care Clinical Decision-Making: Implications For Quality Of Care*, 34 Med Care 783 (1996), for example, finds that patients' insurance status influences doctors' clinical decisions more for discretionary than for necessary services.

doctors more readily urge treatments on patients or try to reduce costs. The physicians we interviewed gave examples of pushing reluctant patients to accept treatment that ranged from persuasion to manipulation to coercion. One doctor told a woman who balked at a mammogram that he was scheduling one anyway. Another called a taxi to take a patient to the hospital to prevent her from going home. Yet another doctor enlisted family members in convincing recalcitrant patients. Still another doctor asked a patient who was reluctant to leave her grandchild to come in for an exam who would take of her grandchild if she died. In sum, doctors dance a delicate dance to accommodate patients' ambivalent wants and ambiguous needs, and their own.

But if consumerism prevailed, might doctors see that patients were paying out-of-pocket and become thriftier? Might doctors decide that a reputation for economy would draw patients to their practice (an uncertain thing, given the way patients choose doctors), so that thrift served self-interest? Might doctors recognize a social duty to cabin costs? Perhaps, but, managed care's experience is not encouraging. Even doctors who tolerated managed care did not respond as consumerism expects. Doctors did not so much adjust recommendations to each patient's individual situation as change their style of practice across the board.¹²⁸ Economists celebrated this "spill-over effect," but consumerism expects patients and doctors to make efficient decisions tailored to each patient's circumstances and preferences.¹²⁹

Suppose now that doctors expect to help patients economize. Even such doctors face many practical problems in the examining room. For example, when should doctors propose thrifty treatments if thrifty means less effective? How much should doctors know about patients' financial situations? How much should doctors ask? Here we confront a problem with informed consent and all other kinds of mandated disclosure in medicine – time. Doctors often complain that managed care robbed them of time with patients. In fact, doctors apparently spend slightly *more* time with patients than they used to.¹³⁰ But doctors *feel* hurried because so much more is asked of them: medicine can do more things, treatments are more complex, chronic diseases requiring elaborate care proliferate, and medicine's jurisdiction has broadened

¹²⁸. Sherry Glied & Joshua Graff Zivin, *How Do Doctors Behave When Some (But Not All) of Their Patients are in Managed Care?* 21 J Health Economics 337 (2002); Rajesh Balkrishnan et al, *Capitation Payment, Length of Visit, and Preventive Services*, 8 Am J Managed Care 332 (2002).

¹²⁹. Similarly, the designers of Medicare's "diagnostic-related groups" imagined that they would cause hospitals to treat more and less profitable services differently. Instead, hospitals essentially economized across the board, even for non-Medicare patients. David M. Frankford, *The Medicare DRGs: Efficiency and Organizational Rationality*, 10 Yale J Reg 273, 293-96 (1993).

¹³⁰. David Mechanic & Donna D. McAlpine, "Fifteen Minutes of Fame": *Reflections on the Uses of Health Research, the Media, Pundits, and the Spin*, 20 Health Affairs 211 (2001).

as problems are “medicalized.”

So discussions of the cost must jostle for time with other urgent issues. “The ever-expanding repertoire of interventions, screening tests, vaccines, and devices has dramatically increased the work of patient care for all physician specialties.” For a GP to provide “all recommended preventive services to a panel of 2500 patients could require up to 7 1/2 hours a day of physician time. Generalist physicians report that roughly 4 separate problems are addressed at each office visit for patients older than 65 years and even more issues are addressed for patients with chronic illnesses such as diabetes.”¹³¹ One study concluded that doctors cannot “deliver all of the services recommended by the USPSTF [U.S. Preventive Services Task Force] to a representative panel of patients.” Nor is reducing the doctor’s panel “a very practical or realistic solution,” since “a 50% reduction in panel size is needed to reduce the time requirement to approximately 4 hours a day.”¹³² To put the problem differently: “Current practice guidelines for only 10 chronic illnesses require more time than primary care physicians have available for patient care overall.”¹³³ All this threatens consumerism and its dream of adding another topic – cost – to discussions.

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

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

*Warum soll es einfach sein, wenn es so leicht kompliziert sein kann?*¹³⁴

German witticism

¹³¹. John D. Goodson, *Unintended Consequences of Resource-Based Relative Value Scale Reimbursement*, 298 JAMA. 2308 (2007).

¹³². Kimberly S. H. Yarnall et al, *Primary Care: Is There Enough Time for Prevention?*, 93 Am J Public Health 635, 637 (2003).

¹³³. T Ostbye et al., *Is There Time for Management of Patients With Chronic Diseases in Primary Care?*, 3 Ann Fam Med. 209 (2005).

¹³⁴. “Why should it be simple, when it can so easily be complicated?”

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

A. LITERACY AND NUMERACY

The first problem in presenting health-care choices is that *many* people read and handle numbers poorly. Most information about health plans, much information about providers, and swaths of information about treatments are in writing. Yet the “1992 National Adult Literacy Survey . . . , the most accurate portrait of English-language literacy in the United States, found that 40 to 44 million Americans, or approximately one quarter of the US population, are functionally illiterate, and another 50 million have marginal literacy skills.”¹³⁵ Illiteracy matters in health care: A “third of English-speaking patients at 2 public hospitals could not read and understand basic health-related materials,” and 42% of the patients studied could not “comprehend directions for taking medication on an empty stomach, 26% could not understand information on an appointment slip, and 60% could not understand a standard consent form.” Patients’ difficulties understanding “information about disease management, prevention, and informed consent . . . [mean that] physicians are not successful in communicating essential health care information to their patients, particularly to those with inadequate health literacy.”¹³⁶ Furthermore, many literate people cannot manage complicated material. For example, to reach the 80th percentile in literacy you need only comprehend a (quite straightforward) definition of “peremptory challenge” given jury pools.

Consumers are also hobbled by innumeracy.¹³⁷ “Numeracy, or the ability to process basic probability and numerical concepts,”¹³⁸ has been shown to “influence

¹³⁵. Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, *Health Literacy: Report of the Council on Scientific Affairs*, 281 JAMA 552 (1999).

¹³⁶. *Id.*

¹³⁷. On the word and the problem, see John Allen Paulos, *Innumeracy: Mathematical Illiteracy and Its Consequences* (Hill & Wang, 2001).

¹³⁸. Judith H. Hibbard et al, *Consumer Competencies and the Use of Comparative Quality Information: It Isn't Just About Literacy*, 64 Med Care Res & Rev 379, 388 (2007).

comprehension of important health information”¹³⁹ Numeracy “is related to health literacy, but makes an independent contribution to comprehension and choices” and can even be “a stronger predictor of these outcomes than health literacy.”¹⁴⁰

Numeracy is evermore important because patients “are increasingly being exposed to quantitative information about risks for disease and benefits of treatment.” Yet (to put it mildly) “many persons do not work well with numbers.”¹⁴¹ For example, people were asked to: (1) guess how often a flipped coin would come up heads in 1,000 tries, (2) asked to calculate 1% of 1,000, and (3) turn a proportion (1 in 1000) into a percentage. “Thirty percent of respondents had 0 correct answers, 28% had 1 correct answer, 26% had 2 correct answers, and 16% had 3 correct answers.” This innumeracy hobbled respondents when they were given “quantitative risk reduction data” about mammography. In short, “few women were able to apply quantitative information about the benefit of mammography to their perceived risk for death from breast cancer.”¹⁴²

The gravity of innumeracy is confirmed by evidence that consumers misunderstand many kinds of purchases. For example, picking and using credit cards are simpler than understanding and buying health care. Yet “[w]hen thousands of adults from across the country were given tests of basic math and basic literacy, a significant portion of the population was unable to make the comparisons necessary to assess the cost of credit card debt.”¹⁴³

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

B. PRESENTATION

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

- (1) access (to chosen doctor, to specialists, length of time to get an

¹³⁹. Id at 380.

¹⁴⁰. Id at 388.

¹⁴¹. Lisa M. Schwartz et al, *The Role of Numeracy in Understanding the Benefit of Screening Mammography*, 127 Ann Intern Med 966 (1997).

¹⁴². Id.

¹⁴³. Block-Lieb & Janger, 84 Texas L Rev at 1538 (cited in n).

appointment, ability to get care when needed, telephone access); (2) amount of paperwork; (3) benefits; (4) choice of provider (of doctors, of hospitals, ability to keep one's own doctor); (5) communication/interpersonal skills/caring of provider; (6) convenience (of choosing doctor, getting care, location); (7) coordination of care; (8) costs; (9) courtesy and manner of physicians and staff; (10) hospital ratings; (11) good value for the money; (12) plan administrative hassles; and (13) quality (of care overall, of particular types of care, of providers).¹⁴⁴

Well, sure. Each item is reasonable, but the list is wickedly long and could easily be expanded. Most of the items comprise multiple elements. For example, "access" includes the "ability to get care when needed." This in turn subsumes things like how the plan decides when a treatment is covered (an issue that provoked complaints about and law suits over managed care). That issue, again in turn, is a fountain of questions about who decides what treatment is excluded on what grounds and how patients challenge exclusions.¹⁴⁵

All these things could – perhaps should – influence consumers' choices. But consumers cannot mean what they say, that they will use so many data. They do not reliably use even simple disclosures. For example, Blue Cross of California posted plan enrollees' ratings of hospitals' costs. It used the Zagat method, "where '\$' is assigned to the lowest-cost hospitals and "\$\$\$\$" to the highest. . . . But the plan discontinued this feature" because it was little used.¹⁴⁶

Wanting much but using little is normal. For example, patients characteristically over-estimate how much information they want in choosing treatments. In one large study, "[m]ost subjects (76.2%) responded that they would want to hear of *any* adverse effects [of a treatment], no matter how rare." And 83% wanted to know about *any* "serious adverse effect, no matter how rare."¹⁴⁷ Do people really want WebMD's whole list of one drug's side effects: excess stomach acid secretion, irritation of the stomach of intestines, nausea, vomiting, heartburn, stomach cramps, bronchospasm, stomach ulcers, intestinal ulcers, hepatitis, stomach or intestinal bleeding, inflammation of skin, redness of skin, itching, hives, rash, wheezing, trouble breathing, life-

¹⁴⁴. Lubalin and Harris-Kojetin, 56 Med Care Res & Rev at 72 (cited in note).

¹⁴⁵. Worse, people's view of the information they need for choosing a health-care plan or treatment changes rapidly as they acquire information.

¹⁴⁶. Ginsburg, 26 Health Affairs at w213 (cited in noted). This disclosure was also abandoned because it created "pressure for price increases from hospitals identified as low cost." *Id.*

¹⁴⁷. Dewey K. Ziegler et al, *How Much Information About Adverse Effects of Medication Do Patients Want from Physicians?*, 161 Arch Intern Med 706, 708 (2001) (emphasis added).

threatening allergic reaction, giant hives, rupture in the wall of the stomach or intestines, hemolytic anemia, large skin blotches, decreased blood platelets, decreased white blood cells, and decreased appetite? Will people still want the list when they learn that this alarming drug is aspirin?

But suppose we winnow out the information that most helps consumers. How do we present it? Many have tried. Many have failed. For instance, California posted a sample charge master. But, Reinhardt concludes, if it is “any guide, prospective patients would be hard put to make sense of these price lists.”¹⁴⁸ For another instance, Hibbard et al describe experiments with HMO “report cards” which “use several performance measures and plan characteristics to compare multiple plans.” Or again, “the Minnesota Health Data Institute distributed a 16-page, statewide report card that featured comparison tables and color-coded graphs of consumer satisfaction within categories of health plans and compared 38 plans based on 20 performance measures.” However, “less than half of those seeing the report thought it was helpful for deciding on a plan. Consumers found the report cards cumbersome, complex, and detailed.”¹⁴⁹

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

Why don't IRBs practice what they preach? Partly because in a given case no one can prove that one more datum might not be crucial to someone's decision and that it would be fair to deny that person that information. As we saw, if you ask patients how much they want to know, they say “everything.” If patients think they “want to hear of any serious adverse effect, no matter how rare,”¹⁵⁰ the slippery slope to interminable disclosure is slick and has no handholds.¹⁵¹ And bad as the information problem has been when IRBs review research, the problem may be worse when consumers choose plans and providers because much more information can be relevant. Research subjects are told the risks of one experiment; health-care consumers may need any kind of treatment for any kind of ailment.

¹⁴⁸. Reinhardt, 25 Health Affairs at 59 (cited in note).

¹⁴⁹. Judith H. Hibbard et al, *Informing Consumer Decisions in Health Care: Implications from Decision-Making Research*, 75 Milbank Q 395 (1997).

¹⁵⁰. Ziegler et al, 161 Arch Intern Med at 708 (cited in note) (emphasis added).

¹⁵¹. On the travails of IRBs with informed consent, see Simon Whitney & Carl E. Schneider, *Fog So Thick: The Case Against the IRB System* (forthcoming).

With health-care information, less is not more. Perversely, more is too much. First, who reads long forms?¹⁵² Second, the longer the form, the harder to understand. A “large body of empirical work suggest[s] that the integration of different types of information and values into a decision is a very difficult cognitive process.” For example, “people can process and use only a limited number of variables.” In one nifty study, Slovic asked expert handicappers to predict horse races using “from 5, 10, 20, and, later 40 variables.” The more information the handicappers had, the more confident they were. “However, predictive ability was as good with 5 variables as with 10, 20, or 40.” Worse, “reliability of the choices *decreased* as more information was made available. That is, when individuals had more information, their ability to use it ‘consistently’ declined.”¹⁵³

Not only does adding information not reliably improve understanding, it can actually *reduce* the amount of information people use. “An increase in the number of alternatives (three, six, and nine) being considered in this research has been shown also to increase the number of participants (21 percent, 31 percent, and 77 percent, respectively) who rely on elimination strategies . . . leading to a reduction in the amount of information used.”¹⁵⁴

The hopeless choice between enough and too much information pervades health-care decisions. Plans are irreducibly complex – they either cover or exclude every human ailment. They allocate costs among many players in elaborate ways. They are confusingly structured and mysteriously administered.¹⁵⁵

Even a single aspect of a plan can be too complex to be explained to people of ordinary patience. For example, a notoriously upsetting feature of managed care is capitation – paying providers a fixed sum per year per patient. This creates an incentive to undertreat patients. Explaining why this may be tolerable is an uphill battle, but that’s just the beginning, because “capitation” is exhaustingly complicated.

¹⁵². Apparently this is an old problem. “According to the statutes of the university, every student before he is matriculated must subscribe his assent to the Thirty-nine Articles of the Church of England, which are signed by more than read them, and read by more than believe them.” Edward Gibbon, *The Autobiography of Edward Gibbon* 82 (Meridian Books, 1961).

¹⁵³. Hibbard et al, 75 Milbank Q at 397–98 (cited in note) (emphasis added) .

¹⁵⁴. Hanoch and Rice, 84 Milbank Q at 41 (cited in note) .

¹⁵⁵. The complexity to which health-insurance can descend is exemplified by Medicaid, a “horribly complicated law” that is “almost unintelligible to the uninitiated.” So unintelligible that “millions of eligible people are not enrolled.” Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives* 69 Brook. L. Rev. 453, 467-468 (2004).

Its effects are “mediated by such variables as size of the patient panel, amount of the capitation sum, refinement of risk adjustments, dollar value of stop-loss provisions, and scope of risk (does it extend, for example, to specialist referrals and drugs?), not to mention such relative intangibles as the force of professional ethics and fear of malpractice suits.” So there “is no obvious informational middle ground between demonizing capitation and turning consumers into incipient health service researchers.”¹⁵⁶

Hall tried to solve this problem with “extensive efforts at disclosure.” Even then, disclosing incentives had “limited or no impact on patient trust of physicians and health plans.” No wonder that plan representatives Hall interviewed said that disclosures “have been a ‘big yawn,’ ‘useless,’ and have not caused ‘even a ripple’ of a reaction. One large plan which, like others, invites members to call if they have questions or want additional information, received only two inquiries in the first two years.”¹⁵⁷

Complexity has another aspect. Consumers cannot assess specifics unless they understand generalities. You can rate the Ritz because you’ve stayed at the Marriott and the Hôtel Misère. But people know little and misunderstand much about health care and health-care financing. Professor Sage is mild – “the American public is poorly informed about modern health care financing and delivery.”¹⁵⁸ People misunderstand even their own coverage. “Previous research has indicated that consumers do not understand many of the key concepts of managed care; our study results indicate that this lack of understanding also applies to their own health plan.”¹⁵⁹ Although plan members’ “accuracy of reporting on some individual attributes was fairly high, fewer than one-third of respondents (30.3 percent) correctly reported all four attributes. . . . [J]ust over half of respondents (56 percent) accurately reported both network attributes, while just under half (48.8 percent) accurately reported both gatekeeper attributes.”¹⁶⁰

¹⁵⁶. Brown, 56 *Med Care Res & Rev* at 161 (cited in note) (footnotes omitted). “We can tell people whether we have a withhold, bonus payments or capitation,” remarked Paul Langevin, president of the New Jersey HMO Association, “but there are literally over 100,000 ways to pay, and these systems are very proprietary. And, quite frankly, the plans change them all the time.” *Id.*

¹⁵⁷. Mark A. Hall, *The Theory and Practice of Disclosing HMO Physician Incentives*, 65 *L & Contemp Prob* 207, 229 (2002). “Similarly, under the Medicare rules, regulators and plans reported that beneficiaries who are told that they have the right to request information about physician incentives rarely or never do so.” *Id.*

¹⁵⁸. William M. Sage, *Accountability Through Information: What the Health Care Industry Can Learn from Securities Regulation* 23 (Milbank Memorial Fund, 2000).

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

¹⁶⁰. *Id.* at 163. Another example: “approximately one-third of patients correctly

This is not reprehensible; people have better things to do than becoming health-care experts. Nevertheless, consumers lack “baseline information that could provide context for required disclosure,” and they therefore “can easily misinterpret even accurate data. In one example, potential enrollees regarded report card data showing high hospitalization rates of health plan enrollees for pneumonia as showing leniency in approving inpatient treatment rather than demonstrating failure to administer vaccinations.”¹⁶¹

In sum, consumers must learn forbiddingly much and make forbiddingly hard comparisons to achieve good choices. This is why comprehensible report cards are necessary. And why they are so hard to write. We again can learn from similar problems in related areas. The “readability” of many kinds of mandated disclosures has been extensively studied, and the news is extensively bad: It is almost impossible to put complicated information in written language that most people can understand. For example, two-thirds of the privacy disclosure forms academic medical centers used “were written beyond the 12th grade reading level, and almost the entire sample (90%) fell in the difficult range of reading ease.”¹⁶² A similar study of hospitals found the average readability level “beyond the reading capacity of the majority of American adults.”¹⁶³ One review of forms IRBs *themselves* supplied found them well below the IRBs’ “own readability standards.”¹⁶⁴

So, you say, if report cards are unreadable, make them readable. If language is complex, simplify it. If text is dense, prune it. If pages are dull, brighten them. Of course people have been trying to do exactly this for decades. Attempts to improve the

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

¹⁶¹. Sage, *Accountability Through Information* (cited in note).

¹⁶². S. Walfish & K.M. Watkins, *Readability Level of Health Insurance Portability and Accountability Act Notices of Privacy Practices Utilized by Academic Medical Centers*, 28 *Eval Health Prof* 479 (2005).

¹⁶³. M.K. Paasche-Orlow et al, *Notices of Privacy Practices: A Survey of the Health Insurance Portability and Accountability Act of 1996 Documents Presented to Patients at US Hospitals*, 43 *Med Care* 558 (2005).

¹⁶⁴. M.K. Paasche-Orlow et al, *Readability Standards for Informed-Consent Forms as Compared with Actual Readability*, 20 *NEJM* 348 (2003)

information consumers receive about health insurance, like attempts to improve informed consent, have had *some* success, but not *enough* success to equip patients and consumers to make good decisions. For example, there were only “modest gains in Medicare-related knowledge” in both “a local and a national study.”¹⁶⁵ In short, nothing in the experience of mandated disclosure in other areas suggests that information about health plans can be presented to consumers in a form that will bring them up to consumerist standards. And nothing in the experience of telling consumers about health plans or patients about treatments suggests otherwise.¹⁶⁶

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

C. *DEUS EX MACHINA*: EDUCATION

Consumerists defend consumerism by invoking the same savior that will rescue us from so many other problems – education. If only patients can be taught more facts and more skills. As Kapp writes, the champions of informed consent place “much faith . . . in the potential effectiveness of various educational tools to empower patients to comprehend and manage adequately the basic information needed to satisfy informed consent aspirations.” These tools are numerous and include “more sophisticated decision aids in the form of information technology; the provision of written handouts to patients; presentation of information in qualitative, quantitative, and graphic formats, simplified to reach the lower literate patient; and the showing of videotapes.”¹⁶⁷

This is the triumph of hope over experience. Educating consumers to thrifty and intelligent choices has been part of the health-care ethos for a number of years. Yet

¹⁶⁵. Lauren A. McCormack et al, *Measuring Beneficiary Knowledge in Two Randomized Experiments*, 23 Health Care Financing Rev 47, 60 (2001).

¹⁶⁶. On some of the barriers to success, see Michele Heisler, *Helping Your Patients With Chronic Disease: Effective Physician Approaches to Support Self-Management*, 8 Seminars Med Prac 43, 49 (2005); Kimberley Koons Woloshin et al, *Patients' Interpretation of Qualitative Probability Statements*, 3 Arch Family Med 961, 965 (1994).

¹⁶⁷. Marshall B. Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice*, 11 J Health & Biomedical L 1, 13-14 (2006).

the results are dispiriting. For example, a decade ago Medicare beneficiaries chose between a fee-for-service plan and managed-care plans. They were asked about the important elements of their choice. In brief, “few” beneficiaries were well informed. Even those who used “multiple information sources to learn about health plans often . . . [had] less-than-adequate knowledge.”¹⁶⁸ Specifically, 30% of the group “knew almost nothing about HMOs. Thirty-one percent of HMO respondents and 30 percent of traditional Medicare respondents failed to pass the screening questions and could not go on to take the knowledge test.”¹⁶⁹ Of those who passed the screening test, “only 16 percent had adequate knowledge . . . to choose between traditional Medicare and an HMO. More than 41 percent scored in the ‘inadequate’ range . . . [, and] 7 percent scored in the lowest quartile (equal to or worse than guessing).”¹⁷⁰ In short, these consumers knew far too little to make good choices. As Cunningham puts it, “A considerable body of evidence indicates that early efforts to educate consumers have not been very effective”¹⁷¹

What, though, of the tools Kapp lists? With skill and labor, they can produce statistically significant improvements in understanding. But they have not brought and will not bring patients to *adequate* understanding. They have not overcome the problems we have been cataloging. Take one vital consideration for consumers. Lubalin writes, “With appropriate education, over time consumers may begin to understand the role that plan structure plays relative to doctor performance in affecting their care and plan experiences.”¹⁷² But researchers have long striven to create that “appropriate education” – with dismal results. And see how cautious Lubalin is. This education will take time. All this education over time “may” teach consumers something, but that “something” is only “beginning” to understand the subject.

Consumers remain poorly informed about their own plans even after extraordinary efforts to educate them. One study, for example, “surveyed adults a year after they were enrolled in a New York State pilot project aimed at expanding health care coverage for the uninsured.” The five plans “made extensive efforts to educate enrollees about the plans.”¹⁷³ These efforts included “individual in-person enrollment meetings, during which staff describe eligibility and benefits; brochures or videotapes; detailed enrollment contracts; question-and-answer documents in Spanish and English;

¹⁶⁸. Judith H. Hibbard et al, *Can Medicare Beneficiaries Make Informed Choices?*, 17 Health Affairs 181, 190 – 91 (1998).

¹⁶⁹. Id at 185.

¹⁷⁰. Id at 186.

¹⁷¹. Cunningham et al, 20 Health Affairs at 165 (cited in note).

¹⁷². Lubalin and Harris-Kojetin, 56 Med Care Res & Rev at 73 (cited in note).

¹⁷³. Deborah W. Garnick et al, *How Well Do Americans Understand Their Health Coverage?*, 12 Health Affairs 204, 206 (1993).

and, at one plan, a required educational seminar.”¹⁷⁴ Nevertheless, “fewer than a third of enrollees could answer all three questions correctly; for four of the five plans, fewer than one-fifth could answer all three questions correctly.” Discouragingly, for example, “as few as 29.2 percent of respondents in Brooklyn understood that their plan covered out-of-area emergency care despite explicit wording in the Health Insurance Plan of Greater New York (HIP) handbook,” and except “in Manhattan, fewer than 42 percent of respondents knew that their plan limited their choice of hospitals.”¹⁷⁵

Nor do the lessons of related areas make education a convincing Great Solution. Informed consent may be the closest comparison, and decades of struggle show that while skillfully created and energetically administered education can nudge up understanding, it regularly fails to prepare patients to make truly informed choices about complex issues. Nor has education worked wonderfully better in other areas in which consumers grapple with important, complex, and unfamiliar subjects. For example, “investment education does not significantly change investment behavior among 401(k) plan participants.”¹⁷⁶

Another point is regularly overlooked but plainly crucial. Education is the Great Solution not just to this problem, but to *many* serious problems. People are daily admonished to become better consumers and to take more responsibility for more decisions in more areas (to say nothing, for example, of being active citizens). An ever-more complex world generates ever-more things to learn. Choices about even standard products multiply madly.¹⁷⁷ Who, for example, can really master the choices presented by buying a telephone? Corded phone? Wireless phone? Cell phone? Internet phone? Which phone company, or cell phone company, or internet company? Which phone manufacturer? Which bells and whistles? A camera? Internet access? Which choice is cheapest (whatever that means)? Most useful? And surely there are other questions we are too elderly to know about.

Consumers must do more than just buying goods and services intelligently. For example, defined-contribution pensions oblige us to manage retirement accounts (and

¹⁷⁴. Id at 207.

¹⁷⁵. Id at 209.

¹⁷⁶. Colleen E. Medill, *Challenging the Four “Truths” of Personal Social Security Accounts: Evidence From the World of 401(K) Plans*, 81 NC L Rev 901, 947 - 948 (2003). On knowledge about Social Security benefits, see Ruth Helman et al, *Encouraging Workers to Save: The 2005 Retirement Confidence Survey*, 280 Issue Brief, Employee Benefit Research Institute 1, 27 (2005).

¹⁷⁷. One literature suggests that people are happier and make better choices when options are not too numerous. E.g., Sheena S. Lyengar and Mark R. Lepper, *When Choice is Demotivating: Can One Desire Too Much of a Good Thing?*, 79 J Personality & Social Psych 995 (2000).

“privatizing” Social Security would exacerbate things nicely). Other financial issues proliferate, like handling debt.¹⁷⁸ And think of all the (often changing) lessons about health and safety everyone should learn. No wonder it has taken so many decades of so much effort to bring home the information that has gradually convinced people not to smoke.

We are hardly enemies of education. Gladly would we learn, and gladly teach. But half a century as teachers has taught us that both teaching and learning are humbly difficult. This is a lesson consumerists seem not to have learned nor experience to have taught them.

VI. ANALYZING INFORMATION

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

Francis Bacon
Novum Organum

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

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

¹⁷⁸. These things are complicated enough that high schools now teach courses covering them. Alas, with dismal success. Block-Lieb & Janger, 84 Texas L Rev 1481 (cited in n).

A. HOMO ARBITER

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

The plausible assumption is that people demand “control.” The plausible inferences are that therefore people (1) want to make all the decisions that could affect their lives and (2) will make those decisions skillfully. In other words, consumerism, bioethics, and much law are intended for a world populated by *homo arbiter*, by people whose *raison d’être* is making decisions. *Homo arbiter* cherishes decisions, reaches out to make decisions, relishes making decisions. There is obviously crucial truth in the assumption, the inferences, and even this view of human nature. But the truth is only partial and leaves out much about human nature that is necessary for establishing workable policies.

First, the assumption. Of course “control” matters. But most people don’t want control of everything, at least if that means mastering difficult subjects to reach difficult conclusions. Control for its own sake may be comforting, and impotence would be misery. Nevertheless, people routinely acquiesce in decisions with relatively little information about them.

Next, the inferences. The first inference is that if people want control, they must want to tackle every decision in sight. But, ironically, seeking plenary control is inimical to enjoying the things that really matter to you. Complete control means making choices, and making choices well enough to achieve “control” is soul-sucking and time-absorbing. In real life, you can’t exercise plenary control and still devote yourself to, as Freud put it, work and love. Furthermore, who relishes decisions? The drudgery of learning, the agonies of indecision, the risks of responsibility – these are charms cheerfully foregone.¹⁷⁹

This leads us to the second inference: that given control people will make decisions capably. However, making good decisions is harshly harder than it looks. In fact, when we make decisions, the process is less rational and less under our control

¹⁷⁹. Barry Schwartz, *The Paradox of Choice: Why More is Less* (HarperCollins, 2004), develops many of these points.

than we think. Our decisions are driven by intuitions, intuitions which run deep in our minds. Yet intuitions are almost invisible to us. And “an enormous body of psychological evidence tells us that a person (such as you or I) has no reliable insight into the roots of his own intuition.”¹⁸⁰ We have little access to the process by which we make decisions. What seems like deciding is often finding a rationale for a choice we have made unknowingly.

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

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

B. LET THIS CUP . . .

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

Consumerism will only find them sporadically. In area after area of life, people say and show that they are less thirsty to choose than consumerists say they should be. Some of the richest evidence of this reluctance is in studies of one of the very decisions consumerist patients must make – choices about medical treatments. We

¹⁸⁰. Howard Margolis, *Dealing With Risk: Why the Public and the Experts Disagree on Environmental Issues* 33 (U Chicago Press, 1996).

study this example in detail, not only because it is a consumerist decision, but also because if people don't seize medical decisions, they are unlikely to seize the other consumerist decisions.

The evidence that patients do not long to make medical decisions is compelling. One study can stand for many.¹⁸¹ Ende and his colleagues¹⁸² concluded that "patients' preferences for decision making in general were weak." Where 0 meant no desire to make decisions and 100 meant an intense desire to do so, the mean score was 33. Worse, "as patients were asked to consider increasingly severe illnesses, their desires to make decisions themselves declined."¹⁸³

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

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

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

few patients either knew or tried to discover whether their health care could be purchased at different prices; prices were never published or advertised.

¹⁸¹. This reluctance to make medical decisions is discussed and defended in Schneider, *The Practice of Autonomy* (cited in note). Chapter 2 scrutinizes the empirical data with tiresome thoroughness.

¹⁸². Jack Ende et al, *Measuring Patient's Desire for Autonomy: Decision Making and Information-Seeking Preferences Among Medical Patients*, 4 J Gen Intern Med 23 (1989).

¹⁸³. Id at 26-27. See Chapter 2 of Schneider, *The Practice of Autonomy* (cited in note).

Patients generally had faith in their physicians and assumed the fees were fair and valid – whether or not they could afford to pay them. They obediently entered whatever hospital they were sent to and took their prescriptions to the pharmacy or provider that the physician suggested. Experience indicates that few patients, even those who complained about the costs, did any shopping around for better prices.¹⁸⁴

If consumers thought consumerism wonderfully advantageous, they might subdue their aversion to intimidating decisions. But “[a]mong the small number of American adults who do have these plans, few are satisfied with them.” They “are far more likely than people with comprehensive plans to report dissatisfaction with several aspects of their health care, including quality of care, out-of-pocket costs, and overall satisfaction with their plans. Moreover, one-third of those with the plans would change plans if they had the opportunity to do so, and only one-third or less would recommend the plan to a friend or co-worker.”¹⁸⁵

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

We said earlier that if people don’t want to make decisions, they won’t make them well. There is direct evidence that in making medical choices people do not do the things they say they need to do. People acknowledge that information is crucial. The same studies that say patients are reluctant to make medical decisions say that patients want information. For example, in the Ende study, “the mean score for information seeking was [on the 0-to-100 scale] 79.5 ± 11.5 .”¹⁸⁶

But while consumers protest that they want loads of information, they shrug off

¹⁸⁴. Benson Roe, *The UCR Boondoggle: A Death Knell for Private Practice?*, 305 NEJM 41, 43 (1981). And twenty years ago Judith H. Hibbard & Edward C. Weeks, *Consumerism in Health Care: Prevalence and Predictors*, 25 Med Care 1019 (1987), questioned whether patients would be willing to be consumers.

¹⁸⁵. Fronstin & Collins, 228 EBRI Issue Brief at 21 (cited in note).

¹⁸⁶. Ende et al, 4 J Gen Intern Med at 26 (cited in note). This remarkable contrast between an information score of 80 and a participation score of 33 is typical.

most of it. For example, only 54% of people in consumerist plans “that provided quality information on physicians said they had tried to use the information.” Nearly half of those “whose plans provided quality information about hospitals had tried to use it” And roughly a third “had tried to use plan-provided cost information about doctors or hospitals.”¹⁸⁷ For another example, a national study of Medicare beneficiaries who had undergone high-risk surgery (abdominal-aneurysm repair, heart-valve replacement, or resection of the bladder, lung or stomach for cancer) reported that, only “10% of respondents seriously considered going elsewhere for surgery. Few respondents (11%) looked for information to compare hospitals. Almost all respondents thought their hospital and surgeon had good reputations (94% and 88%, respectively), beliefs mostly determined by what their referring doctors said.”¹⁸⁸

We have presented evidence that people make medical choices less willingly than consumerism and the law assume and need. That evidence is confirmed by evidence that people avoid other consequential decisions. For example, in financial planning, “passive decision-making” is the norm. “[M]any households appear to passively accept the status quo.”¹⁸⁹ Thus companies that used different default choices for employee contributions to retirement plans found employees sticking with whatever default position they had been assigned.

Retirement planning provides a close and fruitful comparison to buying health-care plans. The former is relatively easy, since most people are too poor to have elaborate investment choices and need only a few simple principles – like “diversify!” – that are unendingly repeated everywhere you look. Nevertheless, many people have not even tried to plan for their retirement. “Only 42 percent of workers report they and/or their spouse have tried to calculate how much money they will need to have saved by the time they retire so that they can live comfortably in retirement.”¹⁹⁰ Gloriously unrealistic expectations about retirement abound. “[T]wo-thirds of workers say they expect to work for pay after they retire (66 percent). . . . However, just one-quarter of retirees report having actually worked for pay at some time during their retirement”¹⁹¹ Many people misunderstand the most basic facts and principles of retirement investing. A “1995 survey by John Hancock Financial Services found that a majority of respondents thought money market funds were riskier than government

¹⁸⁷. Fronstin and Collins, 228 EBRI Issue Brief at 18-20 (cited in note).

¹⁸⁸. Lisa M. Schwartz et al, *How Do Elderly Patients Decide Where to Go for Major Surgery?*, 331 BMJ 821 (2005).

¹⁸⁹. James J. Choi et al, *Defined Contribution Pensions: Plan Rules, Participant Choices, and the Path of Least Resistance*, Prepared for *Tax Policy and the Economy* 32 (2001).

¹⁹⁰. Ruth Helman et al, *Encouraging Workers to Save: The 2005 Retirement Confidence Survey*, 280 Issue Brief, Employee Benefit Research Institute 1, 6 (2005).

¹⁹¹. *Id* at 25.

bonds, and felt that their own company stock was safer than a diversified portfolio.”¹⁹² People often invest in notoriously perilous ways. For example, people who can buy company stock in for retirement accounts allocate “nearly 42 percent of the assets [to it], more than any other type of investment.”¹⁹³ Nevertheless, “investors often do not recognize how difficult these choices are and instead rely on a belief that their innate abilities will lead to a good investment result.”¹⁹⁴

In sum, consumerism needs willing consumers, but *many* people are unengaged consumers who resist making decisions in the full-throated way consumerism assumes. Brown writes wryly: “The public is not running to government demanding longer lists of plans and therewith more chances to ask more probing questions, sift more information, and wage a more valiant inner struggle against their suspicions of purchasers, plans, and providers.”¹⁹⁵

This should not seem strange when we think more carefully about how people actually live their lives. What people most basically want is not so much “control” over all the circumstances of their lives as doing the things that are important to them – working at rewarding activities with congenial colleagues, spending time with the people they love and like, enjoying their leisure, and so on. People have better things to do than make dicey decisions about risky subjects which would require burdensome work with little ascertainable reward. Furthermore, if people really tried to make independent decisions about everything in their lives, they’d do little else. Who wants to live in a world in which everybody must choose everything about everything? So in some senses, we are increasingly freed from paternalism, for we have proliferating choices about proliferating things. But in another sense we are increasingly prisoners of the need to learn enough to handle decisions that we make badly, that we would like to escape, and that divert us from things we would rather devote ourselves to. Getting and spending we truly lay waste our powers.

¹⁹². Shlomo Benartzi & Richard H. Thaler, *Naive Diversification Strategies in Defined Contribution Saving Plans*, 91 *Am Econ Rev* 79, 79 (2001).

¹⁹³. *Id.* at 95. “Perhaps the most disturbing aspect of 401(k) participants’ asset allocation choices is the large fraction of balances invested in employer stock. . . . For firms that offer company stock in their plans, . . . about 33 percent of plan assets are held in this asset class.” Choi et al, *Defined Contribution Pensions* at 27 (cited in note). (Investing heavily in your employer’s stock flouts the diversification principle, partly because you already rely on your employer for your economic welfare. The consequences are sadly shown by the fate of the Enron employees whose pensions were invested in Enron stock.)

¹⁹⁴. Stephen J. Choi & A.C. Pritchard, *Behavioral Economics and the SEC*, 56 *Stanford L Rev* 1, 12 (2003).

¹⁹⁵. Brown, 56 *Med Care Res & Rev* at 151 (cited in note).

This doesn't mean, of course, that people want or expect to avoid choices altogether. What it often means, rather, is that people confide themselves to experts (like doctors, of course). It also means that when people must make consequential choices, they hope (and generally expect) that they will be protected against disaster, that they will not be offered dangerous options. People expect doctors, regulated where necessary, to lead them to medical prudence. They expect employers, regulated where necessary, to offer them safe pensions. They expect credit cards terms to be fair. They expect cars to be safe. They expect to be offered safe mortgages.

So too with health plans, providers, and treatments. As Brown rightly says, people want "assurance that the plans they choose will not treat them badly and that some accountable body puts consumers' protection high on its agenda."¹⁹⁶ When these expectations are disappointed, they indignantly want action. Brown describes a common pattern. He says that "'choice' – process, symbol, theoretical linchpin of market visions – is now ubiquitous" in health policy. But it

is also richly ambiguous. Talk about "protecting and promoting consumer choice" often means two different things, namely, ensuring that consumers have the power to make appropriately abundant choices and ensuring that the products (health plans and providers) from among which consumers choose are safe and reliable. The first meaning expands the range of choices, depends on consumers to shop and buy prudently, and invigorates the market. The second eliminates harmful choices, invokes regulation to protect consumers, and expects government to police and discipline the market.¹⁹⁷

So "health policy debates tend to start out with hearty affirmations of the first version of choice, only to discover that many problems beset its realization. Reformers then look to the second set of connotations to discern the protections consumers need in order to reap the benefits of expanded choice"¹⁹⁸

To be sure, people want what they can't have. They want choice when they want it, but they want protection against over-reaching vendors and improvident decisions. They want cheap mortgages, but they want to be rescued when the terms that made the mortgages cheap backfire. They want "that consoling plenitude of option in which modern satisfaction really consists."¹⁹⁹ But they expect that all their options

¹⁹⁶. Id.

¹⁹⁷. Id at 145.

¹⁹⁸. Id at 146.

¹⁹⁹. Philip Rieff, *The Triumph of The Therapeutic: Uses of Faith After Freud* (Harper & Row, 1966).

will be good ones. This is not wicked; it is human nature. But it bodes ill for the consumerist vision of the vigilant and vigorous consumer.

C. THRIFT, THRIFT, HORATIO

We have argued that consumerism specifically, and the law of mandated disclosure generally, rest on the *homo arbiter* misconception of human nature. Consumerism assumes people make decisions willingly and well. We have demonstrated that people are less ardent consumers than consumerism requires. We now ask how well people reason their way through the kinds of decisions consumerism would present.

In their normal lives, in their normal spheres, people normally make normal decisions adeptly. But weighing health plans, providers, and treatments is not a normal activity (except to some extent for the chronically ill). A considerable literature now catalogs the many ways people working out of their normal spheres make decisions in ways that disserve their goals. That people analyze choices crudely and clumsily does not, of course, mean that we should take decisions away from them. But it has consequences for consumerism's prospects and for the extent to which people should be pressured into making decisions.

What, then, would it take for people to choose plans, providers, and treatments in the shrewd way consumerism demands? The standard prescription for medical decisions is that people should "critically assess their own values and preferences; determine whether they are desirable; affirm, upon reflection, these values as ones that should justify their actions; and then be free to initiate action to realize the values."²⁰⁰ This placid formulation hides a maelstrom of problems. An eminent student of medical decisions wrote a quarter of a century ago that "the stresses of making major decisions and the various ways people deal with those stresses . . . frequently result in defective forms of problem solving that fail to meet the standards of rational decision making."²⁰¹

Since then, psychologists have ingeniously shown how inaccurately people perceive the world and reason about it, especially in unfamiliar circumstances. A new subfield – behavioral economics – has arisen which incorporates into traditional economics this revised view of how people think. Behavioral economics acknowledges that people are not the utility maximizers of traditional economics. It suggests that

²⁰⁰. Arthur L. Caplan, *Informed Consent and Provider/Patient Relationships in Rehabilitation Medicine*, in *If I Were a Rich Man Could I Buy a Pancreas? and Other Essays on the Ethics of Health Care* 245 (Indiana U Press, 1992).

²⁰¹. Irving L. Janis, *The Patient as Decision Maker*, in W. Doyle Gentry, ed, *Handbook of Behavioral Medicine* (Guilford, 1984).

because people have limited resources (of all possible kinds) for making decisions, they do not even try to make optimal decisions. They “satisfice.” They use shortcuts in seeking and analyzing information; they settle for the adequate instead of the best. Satisficing usually, well, satisfices. However, “[s]ome of these shortcuts systematically color and bias the decisions that individuals reach”²⁰² And of course, the less familiar, more arcane, and more momentous a decision, the less satisfactory satisficing is. Consumerist decisions often fit that bill, yet consumerist consumers are supposed to change the health-care system by making decisions independently. Satisficing may not suffice.²⁰³

These literatures suggest that people will have more perplexities in fully analyzing medical purchases than we can canvass here. But a sampling suggests the seriousness of the problems. The standard prescription for making medical decisions assumes consumers *have* preferences. Not just preferences – “a set of preferences which are clearly-defined, well-understood, and rank-ordered so that people can make logical tradeoffs among them.”²⁰⁴ But, as Slovic nicely says, preferences are not “simply read off some master list.” We have no array of pre-formed preferences for all occasions. More than we know or like, we create preferences as we go along, preferences shaped by the very process of decision. As Slovic explains, “Preferences appear to be remarkably labile.” Slovic describes, then, “a new conception of judgment and choice in which beliefs and preferences are often constructed – not merely revealed – in the elicitation process.”²⁰⁵

²⁰². *Id* at 1531.

²⁰³. The vast literature on the sadly numerous defects in human reasoning is still well described in two classics: Richard Nisbett & Lee Ross, *Human Inference: Strategies and Shortcomings of Social Judgment* (Prentice-Hall, 1980); Daniel Kahneman et al, *Judgment Under Uncertainty: Heuristics and Biases* (Cambridge U Press, 1982). A more recent summary of evidence that was written for lawyers is Paul Slovic, *Rational Actors and Rational Fools: The Influence of Affect on Judgment and Decision-Making*, 6 *Roger Williams U L Rev* 163 (2000). Daniel Gilbert, *Stumbling on Happiness* (Alfred A. Knopf, 2006), surveys the issues with welcome wit. Barak Richman, *Behavioral Economics and Health Policy: Understanding Medicaid's Failure*, 90 *Cornell L Rev* 705 (2005), applies the literature to health-care policy. Block-Lieb & Janger, 84 *Texas L Rev* 1481 (cited in n), applies this literature to a problem with important parallels to the consumerism question. Howard Margolis, *Dealing With Risk: Why the Public and the Experts Disagree on Environmental Issues* 33 (U Chicago Press, 1996), applies the literature to a broader set of issues.

²⁰⁴. Lee Clarke, *Context Dependency and Risk Decision Making*, in James F. Short, Jr., & Lee Clarke, *Organizations, Uncertainties, and Risk* (Westview, 1992).

²⁰⁵. Paul Slovic, *The Construction of Preference*, 50 *Am Psychologist* 364, 365 (1995).

So as Hibbard puts it, “individuals may not have existing preferences or beliefs about self-interest, but, rather, construct them in the process of deciding.” This is true more often than people care to think. But it is particularly true of “choices among options that are important, complex, and unfamiliar, like those consumers face in the current health care environment.”²⁰⁶ So while consumers *do* have preferences about familiar purchases, “it appears that people in their roles as medical care consumers have no well-formed preferences.”²⁰⁷ No wonder: Few of us have worked out our beliefs so systematically, especially about what we do not know and avoid imagining.

Evidence of our inchoate and unsettled preferences is that people’s choices about even major medical topics are unstable. For example, in a group of chronically ill elderly patients “trajectories of preferences for potentially life-sustaining treatment, assessed in terms of participants’ willingness to endure high-burden treatment for a given chance to avoid death or risk disability to avoid death were frequently inconsistent. Many participants became more and then less willing (or vice versa) over time to undergo future high-burden therapy or to risk severe disability.”²⁰⁸ A famous picture of unstable desires is the study of a natural-childbirth class. It had well worked-out beliefs about anesthesia and pain before childbirth, but at “the beginning of active labor . . . there was a shift in the preference toward avoiding labor pains. . . . During the transition phase of labor . . . the values remained relatively stable, but then . . . the mothers’ preferences shifted again at postpartum toward avoiding the use of anesthesia during the delivery of her next child.”²⁰⁹

Instability affects choices of health plans as well as choices of treatments. Buying insurance requires imagining how you will feel about possible futures. But not only do “focus group studies with health care consumers suggest that preferences are not stable,” but “preference shifts have been observed within the time frame of a focus group”²¹⁰

²⁰⁶. Hibbard et al, 75 *Milbank Q* at 402 (cited in note).

²⁰⁷. Frank A. Sloan, *Arrow’s Concept of the Health Care Consumer: A Forty-Year Retrospective*, 26 *J Health Politics, Policy & L* 899, 899 (October 2001).

²⁰⁸. Terri R. Fried et al, *Inconsistency Over Time in the Preferences of Older Persons with Advanced Illness for Life-Sustaining Treatment* 55 *J Am Geriatrics Society* 1007, 1010 (2007). Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 *Hastings Center Report* 30, 33 (March/April 2004), reviews the literature on the instability of patient’s preferences.

²⁰⁹. Fagerlin and Schneider, 34 *Hastings Center Report* at 33 (cited in note) (quoting J. J. Christensen-Szalanski, *Discount Functions and the Measurement of Patients’ Values: Women’s Decisions during Childbirth*, 4 *Med Decision Making* 47 (1984).

²¹⁰. Ellen Peters et al, *Less Is More In Presenting Quality Information To Consumers*, 64 *Med Care Res & Rev* 169, 170 (2007).

Satisficing is risky for other reasons. People are susceptible to a cavalcade of well-studied failures in perception, anticipation, and reasoning. Several examples. First, people are led by the “availability heuristic” to over-estimate the likelihood of memorable events and to under-estimate the likelihood of mundane (even if more consequential) occurrences. Second, people’s reasoning is strongly affected by the “anchoring heuristic,” by being given a starting point, however arbitrary. For example, estimates of an item’s cost are changed by giving people an arbitrarily chosen number – like the last two digits of their Social Security number. Third, people are notoriously affected by the way a choice is “framed.” For instance, treatment looks better if described in terms of its chance of success rather than its chance of failure (even though both statistics describe the same likelihood). Fourth, once people have made up their minds, they interpret new evidence – however damning– as confirming their choice. Fifth, despite all these infirmities, people are invincibly confident that they make good decisions. “Doth any man doubt, that if there were taken out of men's minds vain opinions, flattering hopes, false valuations, imaginations as one would, and the like, but it would leave the minds of a number of men poor shrunken things, full of melancholy and indisposition, and unpleasing to themselves?”²¹¹

Decisions are distorted in a yet odder way. Decisions turn on how you think you will respond to possible futures. However, people chronically mispredict how they will react to experiences, especially unfamiliar experiences. This is the problem of hedonic forecasting, about which a bemusing literature is blooming. It says that people have trouble foreseeing even mundane feelings, have trouble anticipating what they will want and how they will like what they get. People mispredict which snacks they will prefer over the next three weeks, how happy election results will make them, how much happier living in California instead of Michigan will make them, how much criticism will wound them, and how painful visiting dentists and other tormenters will be.²¹² Predicting your reaction to insurance coverage, providers, illness, and treatment is surely more difficult.²¹³

We all succumb to these defects in reasoning, although experience making decisions moderates them. But this suggests another concern. Health-care choices are intellectually demanding. It takes intelligence, sometimes much intelligence, to make sense of what you are learning, organize it in your mind, anticipate your future, and dissect your choices. “[I]ntelligence is manifested in generic thinking skills such as efficient learning, reasoning, problem solving, and abstract thinking. High intelligence

²¹¹. Francis Bacon, *Of Truth*, in *The Essays* 61 (Penguin, 1985).

²¹². Garrison and Schneider, *The Law of Bioethics* at 306-307 (cited in note), reviews this research.

²¹³. For fascinating applications of these ideas to medical situations, see Peter Ubel, *You're Stronger Than You Think* (McGraw-Hill, 2006).

is a useful tool in any life domain, but especially when tasks are novel, untutored, or complex and situations are ambiguous, changing, or unpredictable.”²¹⁴ Medical decisions of all kinds fit that description, and “[a]nalyse[s] of the ‘job’ of being a patient show that it requires the same cognitive skills that . . . most jobs require for good performance: efficient learning, reasoning, and problem solving.”²¹⁵ Many people lack the intellectual skills needed to choose unfamiliar things well. But even people rich in intellectual and social advantage flinch and fail health-care choices.

People, then, do not choose plans, providers, and treatments in the methodical, meticulous way consumerism intends. They do not use the full range of relevant information, nor do they evaluate information meticulously, nor do they scrutinize their preferences. One way we know this is that people often choose so rapidly that they *cannot* be surveying, assessing, and weighing the options. In one typical study, almost two-thirds of kidney donors made “an immediate choice.” They “*volunteer[ed] immediately upon hearing of the need* without any time delay or any period of deliberation, and they themselves regard their choice as no decision at all.” Only “25% of the donors . . . seem to have approximated a classical decision-making pattern,” since they “had done some *deliberating* and weighing of costs and gains.”²¹⁶

How can people treat unfamiliar and complex issues so brusquely? They almost must: “Making trade-offs to integrate conflicting dimensions into an overall choice is such a complex cognitive task that people tend to use heuristic shortcuts that may not produce optimal decisions. These simplified strategies include selecting only one dimension and ignoring others or focusing on concrete, easy to understand concepts such as cost rather than more complicated and less precise factors such as quality indicators”²¹⁷ The more overwhelming a decision seems, the more likely people are to take such radical shortcuts.²¹⁸

For example, patients often base even classically controversial decisions on a single factor. Thus, one study of choices about treating breast cancer concluded that the leading “influence on decision-making behavior” was “perceived salience.” In other words, patients let their choice about one aspect of the treatment determine the whole

²¹⁴. Linda S. Gottfredson and Ian J. Deary, *Intelligence Predicts Health and Longevity, But Why?*, 13 *Current Directions Psych Sci* 1, 2 (2004).

²¹⁵. Linda S. Gottfredson, *Intelligence: Is It the Epidemiologists’ Elusive “Fundamental Cause” of Social Class Inequalities in Health*, 86 *J Personality & Social Psych* 174, 175 (2004).

²¹⁶. Roberta G. Simmons, et al, *Gift of Life: The Effect of Organ Transplantation on Individual, Family, and Societal Dynamics* (Transaction Books, 1987) (emphasis in original).

²¹⁷. Lubalin and Harris-Kojetin, 56 *Med Care Res & Rev* at 88 (cited in).

²¹⁸. Hanoch & Rice, 84 *Milbank Q* at 41 (cited in n).

decision. These patients “did not report conflict about what course to take or the need for further information or deliberation.”²¹⁹ Schneider observed “similarly truncated courses of decision” in prospective dialysis patients. They often listened until they heard some arresting fact and then based their decision on it. “For instance, as soon as some patients hear that hemodialysis requires someone to insert two large needles into their arm three times a week, they opt for whatever the alternative is. When some other patients hear peritoneal dialysis means having a tube protruding from their abdomen, they choose ‘the other kind of dialysis.’”²²⁰

Snap decisions are not confined to treatment choices; health plans seem often to be similarly chosen. Consider this *a fortiori* example. Employers are far better situated than individuals to choose plans. They have lots more time and lavishly better resources. Yet Hibbard et al say that even employers’ specialists make decisions poorly. “Half of the purchasers in our survey thought that it was difficult or very difficult to bring all of the variables together into a decision.”²²¹ Only about a fifth used “some kind of system for making trade-offs and identifying high-performing, cost-effective plans,” and the “system” could be as primitive as a four-cell matrix.²²² “Twelve percent reported that they made their choices on the basis of a single dimension such as cost or geographic access.”²²³ Purchasers tended to depend on inferior information about hospital quality. They used the best information (outcomes data) only about a quarter of the time it was available, for example.²²⁴ “Purchasers do not always understand the intent of the quality indicators and do not always interpret them correctly.”²²⁵ If this is how professionals fare, what hope for us amateurs?

Could people be taught to make decisions better? Hardly. This is characteristic of the way people operate. For example, the terms of loans vary scarily, but “the basic rule of thumb for borrowing seems to be: ‘Can I afford the monthly payment?’” This simplifies choice, but it obviates “any calculation or awareness of the cost of credit. It also obscures any comparison between the cost of credit and the cost of paying . . . out of savings, and any comparison of competing credit offers. Most importantly, it renders disclosure of APR and related credit terms interesting but irrelevant.”²²⁶

²¹⁹. Penny F. Pierce, *Deciding on Breast Cancer Treatment: A Description of Decision Behavior*, 42 Nursing Res 20 (1993).

²²⁰. Schneider, *The Practice of Autonomy* (cited in note). For an extended development of these points, see *id* at 92 - 99.

²²¹. Judith H. Hibbard et al, *Choosing a Health Plan: Do Large Employers Use the Data?*, 16 Health Affairs 172, 177 (1997).

²²². *Id* at 177.

²²³. *Id*.

²²⁴. *Id* at 175.

²²⁵. *Id* at 179.

²²⁶. Block-Lieb and Janger, 84 Texas L Rev at 1539 (cited in note).

Ultimately, what matters is whether patients can choose plans, providers, and treatments that give them the combination of quality and cost that best suits them and that helps restrain medical costs. Can they? Consumerism clearly produces some of its intended effects in some ways in some measure. Patients with less insurance and patients spending their own money behave differently from patients spending insurance money. Fronstin and Collins report that 60-70 percent of people enrolled in consumerist plans strongly or somewhat agreed that the terms of their health plans made them consider costs when deciding to see a doctor when sick or fill a prescription” By comparison, “less than 40 percent of those in comprehensive plans felt this way” Similarly, sixty percent of those enrolled in consumerist plans “said that they had checked whether their health plan would cover their costs prior to receiving care,” while 49 percent “of those in comprehensive plans had checked whether their plans would cover care and 23 percent had checked the price of a service.”²²⁷ While this suggests that consumerism can change people’s behavior, it is far from showing that enough people “consider costs” regularly enough and correctly enough to reduce costs significantly without impairing patients’ health.

So, do patients economize undesirably? There is *some* encouraging news on this front. Almost two decades ago, the RAND experiment found that “reduced service use under the cost-sharing plans had little or no net adverse effect on health for the average person”²²⁸ However, that experiment’s deductibles were lower than the upper range of deductibles today (inflation-adjusted, around \$2500-3000). And crucially, “[h]ealth among the sick poor—approximately the most disadvantaged 5 percent of the population—was adversely affected”²²⁹

There is also disquieting evidence about how well patients find the safe way between underuse and wasteful use of doctors and treatments. For example, one form of under-use is postponing consultation with a doctor. People often do so unwisely and expensively. “Over 30 percent of cancer patients . . . postpone seeking a diagnosis for three or more months after they first notice growths or other symptoms that they know could be danger signs.”²³⁰ Many people having heart attacks delay calling a doctor for four or five hours because “the decision making process gets jammed by the patient’s inability to admit that he is mortally sick.”²³¹

²²⁷. Fronstin and Collins, 228 EBRI Issue Brief at 20 (cited in note).

²²⁸. Joseph P. Newhouse, *Free For All?: Lessons from the Rand Health Insurance Experiment* 339 (Harvard U Press, 1993).

²²⁹. *Id.*

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

²³¹. T.P. Hackett & N.H. Cassem, *Psychological Management of the Myocardial Infarction Patient*, 1 J Human Stress 25, 27 (1975).

Some of the trouble is medical ignorance, but only some. For example, people who know cancer's danger signs are *likelier* to postpone seeing a physician than people who do not.²³² Cost deters some patients from seeking care, but again this is not the whole story. A study of English families with free medical care "showed that over one-third of the families had a member who was suffering from pain or discomfort but was not receiving medical treatment."²³³ Much of the story is fear, which can lead to seeking care both too aggressively and too timidly. As one man ruefully wrote, "In full health, I imagine minor ailments to be dangerous symptoms, or else, from fear, ignore them away. I do not submit routinely to preventive medicine. What may it not show up?"²³⁴

Most significantly, there is plentiful evidence that cost pressure on patients can lead them to damaging economies. For example, "incentive-based formularies are associated with lower costs and smaller increases in drug utilization and expenditures compared with control groups." However, those formularies are also "associated with undesirable effects." Patients confronted "with higher copayments are more likely to switch medications or to discontinue medications entirely. Moreover, studies have found that cost sharing may be followed by reductions in the use of 'essential' drugs, higher rates of serious adverse events, and increased use of emergency department visits and hospital days."²³⁵

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

[L]imits on drug benefits had consistently negative consequences. Beneficiaries whose benefits were capped used fewer prescription drugs overall and fewer drugs for the treatment of chronic diseases than those whose benefits were not capped. The differences in consumption between beneficiaries with and those without caps on their benefits were substantially larger during the months after the subjects exceeded the cap than during earlier months. . . . Overall, subjects whose benefits were capped had higher rates of non-elective hospitalizations, visits to the emergency department, and death. In addition, subjects whose benefits

²³². This is long established. See, e.g., B. Kutner et al, *Delay in the Diagnosis and Treatment of Cancer: A Critical Analysis of the Literature*, 7 J Chronic Diseases 95 (1958).

²³³. Janis and Mann, *Decision Making* at 230 (cited in note).

²³⁴. Richard P. Brickner, *My Second Twenty Years: An Unexpected Life* 197 (Basic Books, 1976).

²³⁵. Peter J. Neumann et al, *Do Drug Formulary Policies Reflect Evidence of Value?*, 12 Am J Managed Care 30, 30 (2006).

were capped had lower pharmacy costs but higher hospital and emergency department costs, with no significant difference in total medical costs between the two groups.²³⁶

These findings were

consistent with those of previous survey-based studies. Nearly a third of Medicare beneficiaries reported taking fewer drugs than were prescribed in order to save money, and less generous drug benefits were associated with lower rates of drug adherence. In non-Medicare, low-income populations, drug limits increased nursing home admissions. High patient cost-sharing levels in Canada were associated with a lower rate of use of essential drugs and higher rates of visits to the emergency department and hospitalizations. The lack of any drug coverage has been associated with poor outcomes.²³⁷

Rice and Matsuoka summarize the literature similarly: “Nearly all of the 22 relevant studies examined that have been published since 1990 – 16 focusing on cost-sharing for prescription drugs and 6 on cost-sharing for medical services – conclude that increased cost-sharing reduces either or both the [appropriate] utilization and health status of seniors.”²³⁸

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

We have asked how well even well-informed consumers make decisions. Contemporary scholarship finds a festival of ways people stumble in making decisions. This is true, but it is easily misunderstood. So let us clarify our point with three reminders. First, we are not saying that nobody ever makes good decisions. We are saying that people have trouble with unfamiliar and complex choices, like selecting health plans, providers, and treatments. Second, we are not implying that people’s decisional reluctance justifies usurping their decisional authority. On the contrary, we are evaluating a program – consumerism – intended to compel people to make decisions willy-nilly.

²³⁶. John Hsu et al, *Unintended Consequences of Caps on Medicare Drug Benefits*, 354 NEJM 2349, 2356 (2006).

²³⁷. *Id.* at 2356-2357.

²³⁸. Thomas Rice & K.Y. Matsuoka, *The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors*, 61 *Med Care Res & Rev* 415, 415 (2004).

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

VIII. CONCLUSION

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

William James
What Makes a Life Significant

A. CONSUMERS ON THE CLATTERING TRAIN

Consumerism inspires zeal in a few proponents²³⁹ and hope in a few quarters. To return to our clattering-train metaphor, consumerists envision putting us consumers in charge of the providers and insurers who seem to run the train. We have not tried to evaluate consumerism globally, to survey every kind of issue it raises. Rather, we have singled out one crucial question: What would the consumer's world and the patient's life be like in a consumerist world? Would people succeed at the tasks they would have to perform for consumerism to subdue health-care costs and to help patients get the care they want?

Our technique for answering these questions has been to identify consumerism's prerequisites and to see if they can be met. The prerequisites are

²³⁹. As one reviewer says of one zealot and her book, "She and the majority of her 92 contributors . . . are convinced that a new age is dawning. As a consequence, this book projects an almost messianic fervor; it brims with the confidence and enthusiasm of converts to a great cause." Arnold S. Relman, Review of *Consumer-Driven Health Care: Implications for Providers, Payers, and Policy-Makers*, Regina E. Herzlinger ed, 350 NEJM 2217, 2217 (2004).

disconcertingly many. First, consumers must have choices that include the coverage, care-takers, and care they want. Second, reliable information about those choices must be available. Third, information must be put before consumers, especially by doctors. Fourth, consumers must receive the information. Fifth, the information must be complete and comprehensible enough for consumers to use it. Sixth, consumers must understand what they are told. Seventh, consumers must be willing to analyze the information. Eighth, consumers must actually analyze the information and do so well enough to make good choices.

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

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

When we think back on our clattering train, the consumer's situation looks even more parlous. The train is impelled by forces strong and many. Consumerism leaves most of them unaltered. It does directly address the moral-hazard problem, but most other dynamics of the health-care system remain unchanged. Insofar as consumerism addresses those dynamics, it is by asking you and us to manage them. This task overwhelmed managed care. Managed care was motivated in large part by market forces, especially the desire of employers to contain health-care costs. Like consumerism, managed care counted on market forces. Will consumers fare better with those forces?

Partly, this depends on the politics of consumerism. For example, consumerism needs the cooperation and even commitment of employers and employees. But a "recent study of employers' attitudes toward such programs suggests some ambivalence on their part. They are uncertain about the effect of such programs on costs and quality, and most significantly, perhaps, whether such programs will in fact be popular with employees" ²⁴⁰ The Community Tracking Study recently found "deep skepticism" among a full range of market participants that consumerism can "produce urgently needed improvements in the efficiency and quality of the nation's health care system. As much as these predominantly private-sector leaders dread the prospect of deeper interventions by government, few of them seem to be able to

²⁴⁰. Callahan and Wasunna, *Medicine and the Market* at 77 (cited in note).

imagine other alternatives.”²⁴¹ And the “few people who currently use consumer-directed health-care are not enthusiastic about their plans.”²⁴²

Discouragement, distrust, and dislike are not conclusive, but they are critical. First, the history of managed care teaches that if people detest a health policy, it is politically toast. Managed care was less culpable than people thought and deserves more esteem than it enjoys. Yet its body resembles St. Sebastian’s, twisted in agony as it is pierced from all sides with arrows. The revolt against managed care was remarkable: legislation aimed at particular cost-saving measures (including so-called “drive-by pregnancy” legislation),²⁴³ legislation prohibiting “gag-rules” said to restrict what doctors could tell patients,²⁴⁴ patients’ “bills of rights,” legislation limiting the ability of managed-care plans to exclude doctors from their networks, legislation that “would amend ERISA and permit patients to sue their MCO and states to regulate managed care,”²⁴⁵ and so on. The number, breadth, intensity, and success of these attacks on managed care suggest how powerfully and effectively doctors and patients can insist on the control over medicine they have recently enjoyed, even in the face of a consensus that health-care costs must be constrained.

To be sure, the public has itself (partly) to blame for consumerism and may well have boxed itself into a consumerist corner. That public can’t bear government regulation of expenditures. It can’t agree on universal health-care. It helped sabotage managed care. In other words, “as the 1990s’ HMO debate showed, [the public] wants fine health care benefits with no bureaucratic cost-control measures to limit that care”²⁴⁶ but not to pay what such benefits cost. So “[g]overnment, booted off the field,

²⁴¹. Len M. Nichols et al, *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence Is Waning*, 23 *Health Affairs* 8, 8 (2004).

²⁴². Fronstin and Collins, 228 EBRI Issue Brief at 28 (cited in note).

²⁴³. For an acidulous argument that Congress had it wrong, see David A. Hyman, *Drive-Through Deliveries: Is “Consumer Protection” Just What the Doctor Ordered?*, 78 *NC L Rev* 5 (1999).

²⁴⁴. “After condemnation of such clauses by every member of Congress who spoke on the subject, the General Accounting Office determined that there were no true gag clauses in any of the 1,150 contracts they examined Opponents of managed care also have yet to produce a single true gag clause” David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 *Vill L Rev* 409, 409 n142 (1998). Nor have providers presented any “proof that any of these provisions are being enforced in a way that systematically restricts communications between providers and patients.” David A. Hyman, *Managed Care at the Millennium: Scenes from a Maul*, 24 *J Health Politics, Policy & L* 1061, 1064 (1999).

²⁴⁵. Jacobson, 47 *St Louis U L J* at 381 (cited in note).

²⁴⁶. Callahan and Wasunna, *Medicine and the Market* at 50 (cited in note).

handed the ball to market forces,” Brown says dryly. Those forces did “what they are supposed to do – squeeze waste, change payment systems, redefine necessary and appropriate care, favor primary care, and the rest. Yet the general public and special groups increasingly demand closer regulation of the new system,” a demand government is “ever more willing to meet.”²⁴⁷

This self-defeating approach is understandable; *tout comprendre, beaucoup pardonner*. Health-care organization, regulation and finance are so Byzantine and baroque that a sophisticated political discussion of them is unimaginable.²⁴⁸ And faced with illness (their own or someone else’s), people reflexively want it cured, and damn the price (especially since the price has so long been so obscured by insurance). And the public has been incited to misunderstanding and indignation by institutions less easily pardoned – particularly the medical establishment. Organizations like the AMA have served their members’ economic interests and desires for professional autonomy by resisting managed care and other promising attempts to control medical costs, not least physicians’ fees.²⁴⁹ And doctors have shown as a profession that they can be willing to exalt their guild interests at the expense of their patients’ welfare.²⁵⁰ This is important because, as we have shown, patients’ spending will usually be directed by doctors. Patients’ problems in presenting, receiving, and using information are generally overwhelming. If doctors do not whole-heartedly devote themselves to helping patients economize, consumerism cannot cool health-care costs. If doctors do not make economizing a priority, patients cannot pull us out of our problems.

We have tested consumerism against its proponents’ claims. Would consumerism look better if those claims were moderated? Surely. First, any plausible approach to American health-care finance will use some consumerist devices. Such devices already proliferate in the form of shared premiums, co-payments, and deductibles.

Second, patients care greatly about and are well situated to evaluate some

²⁴⁷. Brown, 56 *Med Care Res & Rev* at 151-152 (cited in note).

²⁴⁸. For a sobering example, see Theda Skocpol’s analysis of the collapse of the Clinton reform – *Boomerang: Health Care Reform and the Turn Against Government* (Norton, 1997).

²⁴⁹. For the history, see Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (Harper Collins, 1982).

²⁵⁰. “But if I had served God as diligently as I have done the King, he would not have given me over in my grey hairs. Howbeit this is the just reward that I must receive for my worldly diligence and pains that I have had to do him service, only to satisfy his vain pleasures, not regarding my godly duties.”

aspects of care. In particular, patients want to be treated with respect and solicitude.²⁵¹ Prudent providers might respond to consumerism by trying to accommodate them. “The healthcare industry – as ironic as it may seem – has not functioned as a true customer-oriented service industry. It is now seeking to shift models and to better understand the phenomenon of patient satisfaction.”²⁵² Some providers are using “survey research methods to obtain customer (patient) feedback with respect to service, process, and facilities. This is especially true within the fastest growing sector associated with the family-centered practice.”²⁵³

Third, at least consumerism does bring some costs home to patients, however clumsily. Could this help consumers realize that costs won't be controlled until they get help persuading doctors to attack costs systematically and until they acquiesce in a system that does not give them everything they want?²⁵⁴ People do realize now that, in various ways, health costs are a severe problem.²⁵⁵ Can consumerism help them realize that better cost-control might be possible with managed care run in the patients' interests. Can consumerism induce them to apply enough political pressure for such a reform?²⁵⁶ We dearly hope so.

²⁵¹. For a discussion of what patients want and patients get in today's bureaucratized medicine, see Schneider, *The Practice of Autonomy* at 181 – 231 (cited in note).

²⁵². Barry Eisenberg, *Customer Service in Healthcare: A New Era*, 42 *Hospital & Health Services Admin* 17, 20 (1997).

²⁵³. Raj Arora et al, *Influence of Key Variables on the Patients' Choice of a Physician*, 13 *Quality Management in Health Care* 166, 166 (2004).

²⁵⁴. This argument is made in detail in Mark A. Hall & Clark C. Havighurst, *Reviving Managed Care With Health Savings Accounts*, 24 *Health Affairs* 1490 (2005).

²⁵⁵. Asked to describe the few “most important health care problems,” people first mentioned the “cost of health care services, the lack of or inadequate health insurance coverage, and the cost of prescription drugs. In combination, costs were the top issue for approximately half of respondents.” Robert J. Blendon et al, *Americans' Health Priorities: Curing Cancer and Controlling Costs*, 20 *Health Affairs* 222, 227-228 (2001).

²⁵⁶. People emphatically endorse health-care reform. But their support can “be quickly tempered by messages implying that personal sacrifices might be required to deal with the broader problems.” Support “plummeted if Americans heard that reform would limit their choice of doctors or hospitals, would require rationing, would reduce the quality of care most persons now receive, or would require more than a modest tax increase.” Robert J. Blendon et al, *What Happened to Americans' Support for the Clinton Health Plan?*, *Health Affairs* 7, 12 (1995).

B. RICHER RICH AND POORER POOR

Consumerism embodies two of the central preoccupations of contemporary health law and policy – controlling costs and extending patients’ authority over their care. We have shown that many unlikely things have to happen for consumerism to achieve its advocates’ expectations. But there is another problem with consumerism. It not only fails to address the continuing scandal of American health policy – the fact that almost 50 million people are wholly uninsured and at least as many are inadequately insured²⁵⁷ – it moves in the opposite direction. It benefits most those who least need help and most disadvantages those most in need.

Of course it does. The prosperous do better in markets than the impecunious. The poor, the ill-educated, the elderly, the really sick, stand to benefit least from consumerism, while to benefit substantially you may need to be quite well off, quite well educated, and quite healthy. For example, the federal government’s way of promoting consumerism specially benefits the well-paid, healthy, and childless. HSAs are tax-advantaged, but that is useless to people with modest income. HSAs can accumulate from year to year, but sick people and families with children rapidly expend each year’s allotment. And, of course, consumerism leaves to their fates the unemployed and the under-insured. Even people whose employers provide good insurance often find high deductibles hard to handle. *Many* of them are economically marginal and strain from paycheck to paycheck.²⁵⁸ But what are high deductibles to wealthier patients?²⁵⁹

Consumerism’s favors are for the well-off in another way. Like mandated-disclosure generally, it works best for “the well educated and well situated far more than the illiterate and poor. Disclosures are more useful to the former than the latter because the former are better able to understand them and understand how to use them.”²⁶⁰ Consumerism puts a premium on fending for yourself and negotiating for the best deal. The well-off have experience and resources to do so that the badly off lack.

For example, “functional health literacy was worse among the elderly and individuals who reported poor overall health. Thus, groups with the highest prevalence

²⁵⁷. For some specifics, see Jessica H. May & Peter J. Cunningham, *Tough Trade-Offs: Medical Bills, Family Finances and Access to Care*, 85 Issue Brief Center for Studying Health System Change 1, 1 (2004).

²⁵⁸. The 2006 median household income was \$48,201. U.S. Census Bureau, *Current Population Survey*, http://pubdb3.census.gov/macro/032007/hhinc/new04_001.htm (accessed September 21, 2007).

²⁵⁹. For a forceful statement of ways the health-care system already favors the well-to-do, see Havighurst and Richman, 69 L & Contemp Prob 7 (cited in note).

²⁶⁰. Carl E. Schneider, *After Autonomy*, 41 Wake Forest L Rev 411, 443 (2006).

of chronic disease and the greatest need for health care had the least ability to read and comprehend information needed to function as a patient.”²⁶¹ There were “striking differences between the Medicare and the younger sample in ability to use information accurately. Medicare beneficiaries made almost three times as many errors as the younger respondents did (25 percent versus 9 percent)”²⁶² People in “poorer health” and people “with less education” also “tended to make more errors.”²⁶³ The people who understood Medicare information least were also the people most likely to want to delegate decisions and to see “more information and options as unwelcome burdens.”²⁶⁴ In another study, the people who knew the least about Medicare choices “were older, had lower incomes, lower education, more nights in the hospital, and fewer doctor’s office visits.”²⁶⁵ Similarly, “less than half of the uninsured (48%)—or about 18 million people—use or are aware of a safety net provider in their community,” suggesting “that many uninsured people do not know of an affordable source of care to turn to when they need medical attention.”²⁶⁶ Yet “the least educated users of health care often have the greatest health needs and are vulnerable both to risk-selection in insurance and to substandard provision of care.”²⁶⁷

Thus we come to a final observation. We are grateful to be living in a market economy. We cherish the market’s ability to provide – so often – good things at good prices. If consumerism could deliver what its apostles promise, we would cheer the experiment. Any successful health-care system will use market devices.²⁶⁸ But when a resource so basic to human well-being – to human life – is so scarce for so many people, we need to think more broadly about our social responsibilities. The attempt to give individuals more control over their health care – whether through the market or through various mandated disclosures – has its moral merits. But it has come to

²⁶¹. Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, *Health Literacy: Report of the Council on Scientific Affairs*, 281 JAMA 552 (1999).

²⁶². Judith H. Hibbard et al, *Is The Informed-Choice Policy Approach Appropriate For Medicare Beneficiaries?*, 20 Health Affairs 199, 200 (2001).

²⁶³. Id at 200 - 01.

²⁶⁴. Id at 201.

²⁶⁵. Hibbard et al, 17 Health Affairs at 185 (cited in note).

²⁶⁶. Jessica H. May et al, *Most Uninsured People Unaware of Health Care Safety Net Providers*, 90 Center for Studying Health System Change Issue Brief 1, 1 (2004).

²⁶⁷. Sage, *Accountability Through Information* at 23 (cited in note).

²⁶⁸. “All health care systems are a mixture of public and private elements: the rise of the market in healthcare involves an incremental shift and the selected application of various market ‘tools’ or instruments to different parts of the health system, rather than a wholesale move from one kind of system to another.” Callahan and Wasunna, *Medicine and the Market* at 42 (cited in note).

dominate the ethics and law of health care, to the detriment of a developed sense of our responsibilities to our fellow citizens. “By its emphasis on choice, its eschewing of visions of the common good (much less social solidarity), and its focus on individual preferences as the (almost) final arbiter of political acceptability,”²⁶⁹ consumerism shares the moral failing of much contemporary health policy. It speaks powerfully to the claims we make for ourselves but barely whispers about the claims others make on us.

²⁶⁹. Id at 261.