Medical Malpractice on Trial

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The Malpractice Crisis

As 1987 drew to a close, the *Wall Street Journal* carried a story that provided a vivid metaphor for the crisis atmosphere then enveloping malpractice litigation for medical injuries.[1] A Dallas plastic surgeon who had been sued several years earlier had begun videotaping all his conversations with his patients, as well as his treatment of two thousand or so patients each year. Pleased with this innovation in his own practice, the surgeon had licensed his video system to at least a dozen doctors in the area and confidently predicted that video equipment would be as commonplace as the stethoscope in the doctor's office of the future.

This story epitomizes both the similarities and the differences between medical malpractice and other forms of tort liability. Medical malpractice shares with product liability, for example, the economic dislocation of soaring claims rates, damage awards, and insurance premiums. But there is a personal, emotional cast to a lawsuit between patient and doctor that gives medical claims an edge that is not present in suits filed against large, remote corporate manufacturers of defective products. The therapeutic relationship between sick person and physician should not require the kind of unimpeachable documentation that might seem desirable in the adversarial situation of a police officer interrogating a prisoner in custody.

This combination of financial and psychological factors led physician organizations to press strongly for reform of the tort doctrines governing malpractice claims. Doctors enjoyed considerable political success in their efforts in the mid-seventies at the time of the first malpractice "crisis"; they returned to the state legislatures for even broader and deeper reforms as the problem dramatically resurged in the mid-eighties.

One result of these efforts is that medical malpractice has served as a testing ground for most of the legal changes sought by those (most

notably in the Reagan administration)[2] who deplored the way that contemporary tort litigation was operating generally. Understanding the arguments and the experience in the medical context is indispensable, then, for developing sound policy for dealing with all disabling injuries, not simply those caused by medical treatment. Such understanding is especially important now, when some of the protagonists in the medical malpractice debates have become skeptical about whether legal reform of the tort regime will be a sufficient cure for its ailments. More fundamental changes are being proposed—in particular, dismantling the tort/fault system and replacing it with something quite different. Whether and how such radical surgery should be performed are matters I shall take up only after I have recounted the evolution of medical malpractice law over the last two decades.

Sources and Dimensions of the Contemporary Crisis

The most immediate, most obvious source of the perceived crisis in medical malpractice[3] is the increase in total expenditures on medical liability insurance in the United States from about $60 million in 1960 to more than $7 billion in 1988.[4] These national expenditures reached a plateau in 1988, and in many states even dropped in 1989, evoking newspaper headlines that heralded the end of the "malpractice nightmare."[5] But doctors understandably feared that the malpractice system was experiencing no more than a remission in its critical condition, already at an expenditure level that was more than a hundred times higher than it had been little more than a quarter-century earlier.

The costs of legal liability are a function of two variables: the frequency of initiating successful claims and the amount ("severity") of damages collected in successful claims. Both the frequency and the severity of medical malpractice claims have soared over the last two decades.

Frequency. The conventional measure of frequency in the medical context is the number of tort claims filed per 100 doctors. This ratio rose from about 1 per 100 doctors around 1960 to an estimated high of 17 per 100 doctors by the mid-eighties before settling back to around 13 per 100 at the end of the eighties.[6] These higher claims rates do not simply represent a host of additional, largely spurious claims that doctors' insurers can successfully fend off. Nearly half of all medical practice claims generate some payment,[7] and this proportion has not

dropped as the absolute number of claims has risen. According to even conservative estimates of claims frequency, roughly 1 in 25 doctors in the United States is now successfully sued for malpractice every year.

Severity. It is plausible to surmise that the large number of additional claims are a function of less severe and costly cases entering the tort system. Yet the evidence is again to the contrary. Amounts paid on successful claims rose sharply from the sixties into the eighties, making an even bigger contribution to the increase in premiums. The most eye-catching numbers are those reported by the RAND Civil Justice Project on jury verdicts in malpractice litigation in Chicago and San Francisco. The respective average jury verdicts (in constant 1984 dollars) in the two cities rose from $50,000 and $125,000 in the early sixties, to $600,000 and $450,000 in the early seventies, to $1.2 million in each city in the early eighties.[8] Admittedly, the absolute amounts paid in these two cities as a result of jury verdicts are not representative of settlements nationally, and even in these jurisdictions jury verdicts are often cut back by trial judges and appellate courts.[9] Nationally, however, the average malpractice settlement more than doubled from under $12,000 in 1970 to over $26,000 in 1975, then jumped to $45,000 by 1978, nearly doubled again to $80,000 by 1984, and topped $100,000 by 1986—an aggregate increase far in excess of inflation.[10] Moreover, in states like New York and Florida that had among the highest claims frequency levels, the average settlement on paid claims was well over the national average.[11] And there is, of course, a direct relationship between currently rising jury verdicts and the amounts that will be required to settle cases in the future, and consequently the likelihood of attracting even more patients to file claims in a system that promises them more generous recoveries.

Another disturbing feature of the trend in claims severity is epitomized by the fact that in 1988 and 1989 malpractice litigation produced among the very highest personal injury awards in those years—$52 million from a hospital in Houston, Texas, and $54 million from a hospital in Los Angeles.[12] In the eighties, aggregate liability expenditures were driven up by a relatively small number of extremely high damage awards (which included large sums for pain and suffering or punitive damages), rather than by payments awarded in more typical cases, in which the focus was on tangible financial losses.[13] The effect of this divergence between the median and the far higher mean award is that the premiums charged *ex ante* by insurers to bear the relatively unpredictable risk of a huge award are likely to

be considerably higher than the amount eventually necessary to pay for total expenditures calculated after the fact

Considered by themselves, these figures and trends appear terribly alarming; placed in the context of the overall health care system, they seem much less so. Although malpractice premiums are initially paid by the insured doctors and hospitals, these practice expenditures are incorporated into fees charged to patients, who are in turn typically covered against such charges by health care insurance. At the same time that total malpractice expenditures soared from $60 million to $7 billion, health care expenditures spiraled as well—from around $25 billion (or 5 percent of the GNP) in 1960 to $540 billion (more than 11 percent of the GNP) in 1988.[14] In other words, malpractice insurance as a share of the nation's total health care bill actually rose from just under 0.5 percent to a little over 1.0 percent during that period (though the $5 billion in doctors' malpractice premiums was a much higher proportion of the $105 billion paid to physicians for their services). Indeed, because one of the key items of economic loss in malpractice cases is the medical expense incurred in treating the injury, awards (and consequently claims) have had to rise substantially simply to accommodate the much higher cost of doctors' fees and hospital charges.

In that broader perspective, current malpractice insurance premiums—which in 1988 averaged about $16,000 per doctor (up from $8,000 in 1984), or 6 percent of the average practitioner's gross revenues[15]—might appear affordable, at least as a general matter. This optimistic judgment is subject, however, to three qualifications.

Specialty and location. The costs of malpractice premiums differ sharply, depending on the specialty and the location of the practitioner. For example, while a general practitioner in Arkansas or an allergist in Indiana spends less than $2,000 in annual malpractice premiums, the total malpractice insurance bill for a neurosurgeon in Dade County, Florida, or an obstetrician on Long Island, New York, is approaching $200,000 a year, a differential that is not necessarily matched by a comparable cushion in doctors' revenues.[16] Because these insurance costs are typically fixed, rather than variable according to the level or the quality of individual practice, every doctor who wishes to open an office must pay the premiums or risk facing serious personal exposure to liability.

Revenue lag. Studies of the experience in the seventies show that doctors recover most, if not all, the increased costs of malpractice insurance (now running as high as 25 percent of their gross revenues) by charging higher fees to their patients.[17] However, the time lag that is inevitable in the process of adjusting medical fees to costs has been a special problem given the pattern of change in malpractice premiums. From the early sixties to the early seventies, premiums rose steadily and substantially, then suddenly doubled from $500 million to $1 billion between 1974 and 1976. After leveling off in real terms in the late seventies and early eighties, total premiums skyrocketed again, from $2.5 billion in 1983 to $7 billion in 1988. Physicians forced to absorb such erratic and unpredictable increases in what for many had become a substantial cost of practice took little consolation from macrostatistics that showed malpractice insurance premiums to be a comparatively insignificant component of the nation's total health care bill.[18]

Program constraints. An additional element of the problem emerged in the eighties in the form of a variety of cost-containment programs adopted to stem the growth in the nation's health care budget. One consequence of these programs is that doctors faced with sudden, huge malpractice premium increases (which are often retroactive for a year or more because of delays in the insurance regulatory process) are prevented from unilaterally increasing the fees billed to patients to cover this additional cost of practice by regulations adopted by Medicare, Blue Cross, and other modes of patient insurance. Their frustration at being caught between two bureaucratic regimes helped motivate doctors to adopt vigorous collective action, which in turn prompted state governments to respond with tort reforms. This happened, for example, in New York in 1985, in Massachusetts in 1986, and in Florida in 1987.

It would be a mistake, however, to assume that these financial trends are the only important source of the current crisis atmosphere. In fact, for most physicians malpractice premiums are still only a minor component of their expenses, and an even smaller fraction of their gross revenues. Even though the startling percentage increase in malpractice costs has been disturbing, the absolute dollar amounts have been smaller than the increases in other office expenses (except for doctors practicing in the highest-risk specialties and locations).[19] In reviewing the eighties, the National Academy of Science's Institute of Medicine found that doctors, on average—including surgeons and obstetricians—had preserved their real net income position by the end of the premium spiral.[20]

As a further basis of comparison, consider the statistics for workplace injuries. Workers' compensation premiums rose from $2 billion

in 1960 to over $34 billion in 1986, including a huge $9 billion jump from 1984.[21] Over the last decade the business community has expressed serious concern about these trends, and many state legislatures have been moved to reform their workers' compensation system. But little sense of crisis emerged about the basic structure of the workers' compensation program. Most of the debates took place at a fairly low level of political visibility; equally important, most of the legislative packages contained measures that also addressed special concerns of injured workers. This is in stark contrast to the atmosphere and the tone of debates about medical malpractice in both the mid-seventies and the mid-eighties.

One major difference is that a workers' compensation claim is made on a no-fault basis against an employer—typically a large corporate firm—while the vast majority of malpractice claims are filed against individual doctors and others who are charged with personal negligence.[22] From the doctor's point of view, such a claim arises out of a relationship in which he or she was trying to care for the patient, something happened to go wrong, and the patient decided to blame the doctor for the unfortunate event that was simply a risk endemic to modern medical treatment. Even an innocent doctor is forced to spend considerable time and emotion in defending his or her judgment in the unfamiliar formal surroundings of a courtroom dominated by lawyers, in front of what the doctor perceives to be a lay jury that will be naturally sympathetic to the plight of the injured patient and inclined, if at all possible, to reach into the deep pocket of the doctor's insurer to provide relief to the victim. Even if hindsight suggests that a mistake was made in the treatment provided, the morality play of the tort/fault system reacts to what was in most cases the momentary lapse of a doctor acting under the pressure of a busy practice—occasionally in a life-threatening emergency—by legally condemning the professional character and reputation of the unlucky doctor whose mistake happened to cause a serious injury to a patient who was prepared to sue him.

Not surprisingly, then, physicians who are sued feel deeply resentful about the way they are treated by the legal system. They sense that their relations with patients must be less trusting and more guarded, and they experience greater stress, even demoralization in their professional career.[23] To physicians generally, the looming presence of a tort regime in which lawyers and juries in the courtroom purport to second-guess the judgments of doctors in their offices or hospitals, constitutes an offense to the medical profession's sense of its own independence, status, and self-respect. The tort system may

well be a lightning rod for broader discontent felt by many doctors about a world in which government bureaucrats and corporate employers wield increasingly more authority over medical decisions.[24] As the dean of the Yale School of Medicine put it:

> The quality of medical care today is threatened by the pervasive, unwelcome, crushing embrace of the law. Every participant in the health care system . . . is beset by an onslaught of new laws and regulations . . . Worst of all, because it is the most personal, physicians are forced to live with the spectre of malpractice litigation constantly in their mind's eye. This legal assault has occurred so swiftly and has been implemented so harshly that it has begun to erase some of the very attractions long associated with pursuing a medical career—autonomy, independence, approbation, inquiry.[25]

In sum, it is this peculiar combination of financial cost and psychological stress that has generated the passionate resentment that so many doctors feel toward the malpractice regime.[26] Physicians are not the only ones with a vital stake in malpractice law, however. Even considering the burden of tort litigation alone, it is regularly observed that the broader community must pay for unnecessary modes of "defensive medicine" that cost two to three times the amount paid by doctors and hospitals for malpractice premiums.[27] Equally if not more important are the legitimate concerns of patients, the people who eventually become plaintiffs in the tort system. Some of these patients seek compensation for losses suffered on account of medical negligence in the past, others need the protection of tort incentives trained on doctors to practice more careful medicine in the future. The real issue, then, is not whether doctors are upset about malpractice suits and premiums—we know they are—but whether the present tort system, a revised tort system, or an alternative liability system can actually produce sufficient savings in patient losses, in patient anguish and suffering, and even in patient lives to warrant the substantial direct and indirect expenditures that American law now imposes on American health care. This crucial question is the major theme of this book.

The Interplay of Medical, Legal, and Insurance Institutions

Changes in liability premiums alone are only a barometer of innumerable actions taking place in one or more of the key spheres that operate in the malpractice universe: the health care system, in which med-

ical injuries occur; the legal system, which transforms patient injuries into tort claims and payments; and the insurance system, which translates legal expenditures into liability premiums. If it is true that something disturbing has been happening to malpractice premiums—their sudden lurching, if not their absolute increase in size—then in order to respond intelligently to the problem, it is important to have a clear idea of what precisely are the trouble spots within these overlapping spheres.

Liability Insurance and Tort Litigation

Many observers consider the insurance industry, the immediate source of premium increases, to be the major culprit. Patient attorneys and consumer advocates, in particular, are wont to blame insurer ineptitude, even insurer exploitation, for the current ills of medical malpractice—indeed, for undesirable trends in tort litigation and liability insurance generally. That analysis, if true, would make the quest for changes in tort law, rather than in insurance practices, misguided as well as retrograde. As Gerry Spence, one of the country's most prominent and colorful personal injury lawyers, lamented in his 1987 testimony against tort reform in Florida, "The insurance industry in this country has a gun to the head of doctors and the doctors, in turn, have a gun to the head of legislatures."[28]

Several deficiencies are commonly attributed to the liability insurance system, one of which appears in the pattern of premium increases depicted in the previous section. Recall that malpractice premiums crept up slowly but steadily for fifteen years, before suddenly doubling from 1974 through 1976; then they plateaued in real terms for the next half-dozen years before doubling again in the mid-eighties; they have now paused once again, even retreated. It seems implausible that anything happening in tort litigation during the same period could match that extremely erratic pattern of premium hikes.

The charitable interpretation of this development is that premiums are subject to a natural cycle that is endemic to the insurance system.[29] Lines of insurance such as medical malpractice have a "long tail," that is, an interval of perhaps ten years or more between the period for which coverage is purchased and premiums paid and the time at which all the tort claims for that year are eventually settled. In the interim the carrier is able to invest and earn a sizable return on the funds initially collected as premiums. As a result, an apparent "loss"

experienced by the insurer in its underwriting account (the account that simply matches premiums received and expenditures made on claims) will be balanced by gains in the investment account, with the difference used to pay for the carrier's general cost of doing business and earning a target profit rate. Given these features of long-tail casualty insurance, a standard diagnosis of what happened in the eighties is that premiums were artificially low at the beginning of the decade because interest rates (and consequently investment earnings) were so high; but when interest rates dropped in the mid-eighties, premiums had to increase sharply to make up the difference on the insurers' balance sheets.

To the extent the foregoing account is valid, there is of course little that should or even can be done to the tort system to smooth over uncomfortable lurches in the premium charges borne by the insured. Yet I believe that although the insurance cycle may be part of this story, it fails to explain the huge swings that occurred in malpractice premiums in the eighties.

It is a mistake to focus on changes in *nominal* interest rates. Although it is true that the higher these rates are, the greater the carriers' investment earnings are, the major component of the high interest rates is a premium designed to offset the inflation expected to occur during the life of the investment. However, inflation equally affects the projected awards that insurers will have to pay out for tort victims' medical costs and lost earnings. So upward or downward inflation-driven trends in insurer interest earnings are largely matched by the same trends in underwriting expenditures. Only changes in net *real* interest rates can cause the difference in the insurance premium cycle described above. But even though real interest rates moderated somewhat in the mid-eighties, one cannot focus on that factor in isolation. Insurers are not limited to investing in interest-bearing assets: they can and do invest in equity stocks, for example. And although interest rates dropped in the mid-eighties, the phenomenon was associated with (indeed, helped to produce) a steadily rising stock market, which served to sustain the insurers' overall yield on their investment portfolios.

If the insurance cycle theory cannot explain the magnitude of the premium increases experienced by doctors and others in the eighties, let us consider an alternative hypothesis—that carriers have been exploiting their allegedly quasi-monopoly power to charge exorbitant prices for their essential service.

This argument can be stated quite simply. Medical malpractice in-

surance is a comparatively concentrated industry. Although throughout the country there are a large number of carriers, none of which dominates the industry (Saint Paul's, the largest, has only 20 percent of the national market), malpractice insurance is actually bought and sold in more segmented state or regional markets, in each of which only a few carriers operate. At the same time, on the other side of the relationship are doctors who must practice medicine in order to live and who must have liability insurance in order to practice (because of the requirements of either state law, hospital regulation, or simple financial self-preservation). In this context, it would seem easy for a small group of insurers offering this indispensable product to collude in charging inflated prices in order to earn excessive profits. To the extent this alternative explanation for soaring premiums is valid, the remedy can hardly be found in diluting the tort rights of patients. A more appropriate measure would be better enforcement of antitrust protections for doctors, the purchasers of malpractice insurance, whether by lodging an antitrust suit against the insurance industry or by repealing the McCarran-Ferguson exemption of certain insurance rate-making practices from antitrust scrutiny.[30]

In an industry like casualty insurance, in which revenues and costs are heavily dependent on projections of future trends, it is always difficult to determine with certainty whether carriers are earning above-market returns that warrant suspicion of anticompetitive behavior. Extensive investigation and analysis of the crisis of the eighties, however, indicates that insurer monopoly is an unlikely culprit in the premium explosion, for the following reasons.

Comparative premiums. The increases in malpractice premiums in the eighties were paralleled by comparable hikes in product, environmental, governmental, and other modes of casualty insurance. Yet documented findings of very low levels of industry concentration in these nonmalpractice lines mean there is little potential monopoly power over insurance prices in these sectors.[31]

Competition. Even in the medical malpractice realm, the observed level of insurer concentration is only a static phenomenon. Nationally there are a large number of carriers; moreover, because relatively little start-up cost is required to enter the malpractice line in any one state, firms regularly enter and leave these markets.[32] As a result, if premiums were raised to unwarranted levels by the incumbent insurers in any region, other carriers would likely appear to compete for that business with lower prices at which reasonable profits could still be made.

Self-insurers. The monopoly-exploitation thesis is undermined by a phenomenon peculiar to the malpractice area. Unlike the situation in the seventies in which malpractice coverage was provided largely by for-profit commercial carriers, by the eighties a sizable share of the market was held by not-for-profit carriers owned and operated by the doctors and hospitals themselves. By one count more than 40 such "bedpan mutuals" were operating in 33 states, covering half the physicians in the country; such "captive" insurers are an even more prominent feature of the hospital liability insurance field.[33] So even if the incumbent malpractice carrier in a particular area enjoys some market leverage in the short run—before competitors appear to lure away some of the carrier's customers—why would a bedpan mutual use that market power to charge excessive prices to the very parties who own and control it?

Empirical evidence. In any event, it is unnecessary to rely solely on analytic refutations of the plausibility of the monopoly theory, because in-depth empirical investigations have been carried out under government auspices in Florida and New York, two of the highest-premium states.[34] Using different methodologies, each of the studies concluded that, viewed over the longer run, major premium hikes in the eighties were warranted by the trends in tort claim frequency and severity that had occurred in the previous couple of decades. Stating the proposition from the other point of view, casualty insurers have not earned a higher rate of return than carriers in other insurance lines that did not experience the same kinds of premium hikes; moreover, insurer returns are in line with the earnings of American business generally.[35]

Tort Litigation and Medical Care

Just as it should, then, the malpractice insurance system has been absorbing and passing on the steadily rising costs of more numerous tort claims and higher awards for each successful claim. To say this is not to deny the dislocation created by the extremely erratic pattern through which insurers and their actuaries incorporate higher tort costs in the malpractice premiums they charge. But in the longer run it would be a mistake for policymakers to assume that they can solve the problem of higher premiums with measures designed only to prevent excess profits in a supposedly noncompetitive insurance industry.

Doctors, in turn, have their own favorite culprit: the American tort

system. Their familiar refrain, echoed by many pundits and politicians, is that tort costs have soared because patient attorneys seeking hefty contingent fees are filing far too many spurious allegations of medical negligence, and because unsophisticated juries, moved by the plight of often seriously disabled plaintiffs, too often give in to the temptation to use the doctor's insurer to award huge damage sums as redress for the patient's needs, irrespective of whether there is any tangible evidence of fault on the part of the doctor.

This indictment of the tort system, however ingrained the list of its vices may be in the popular mind, is based largely on myth rather than fact. Two major studies of medical malpractice claims have documented rates of patient injury caused by negligent treatment that are far in excess of tort claims made by the patients, let alone claims eventually paid.

Each of these studies used essentially the same methodology, a careful review of the medical records of hospitalized patients (who make-up the vast majority of patients with any kind of significant injury). The first study, done in California in the mid-seventies,[36] examined the records of roughly 20,000 patients. It was discovered that 1 in 22 of these patients suffered a disabling iatrogenic (treatment-generated) injury from hospitalization; of these injuries, 1 in 6 was caused by careless treatment as judged by the reviewing doctors. When these injury estimates were compared with another data set of closed malpractice claims reported to the National Association of Insurance Commissioners (NAIC), rough calculations indicated that only 1 tort claim was actually filed for 10 such events, and only 1 in 25 was actually paid.[37]

The California study was replicated in New York State in the late eighties by my colleagues and me in the Harvard Medical Practice Study Group.[38] We reviewed more than 31,000 hospitalizations in New York in 1984, a carefully stratified sample of patients and hospitals that permitted extrapolation of our findings to the population at large. Our results showed a somewhat lower rate of patient injuries than in California (roughly 1 in 27 hospitalizations) but a much higher proportion of injuries due to negligence (slightly more than 1 in 4) and a bottom line estimate that 1 negligent adverse event (1 "tort") occurred for every 100 patients hospitalized. Extrapolating our New York population estimates to the nation as a whole implies that every year there are more than 150,000 fatalities and 30,000 serious disabilities precipitated by medical treatment in this country.

But when a comprehensive effort was made to locate every tort suit arising out of medical treatment in New York in 1984, we concluded that for every 8 potentially valid claims, only 1 claim was actually filed; of the claims filed, we estimated that no more than 1 in 2 would eventually result in money paid to the plaintiff. Of course, much of that shortfall is due to the fact that our group's (and California's) definition of adverse event was deliberately broad: a prolongation of the hospital stay by at least one day. Our figures included, then, a large number of moderately disabling injuries, as well as injuries to people who suffered little in the way of compensable losses. However, even when we narrowed our focus to the more serious and "valuable" tort claims—iatrogenic injuries to patients under seventy that produced disabilities (including death) lasting six months or more—we still found that for every 3 such events there was only 1 tort payment. And this situation exists in the context of the malpractice insurance regime in the state of New York, under which, after the surge of the mid-eighties, doctors pay among the highest premiums in the entire nation.

The immediate implication of these two systematic and mutually corroborative studies is that it is wrong to charge the tort system with inflating the true incidence of medical negligence. In fact the contrary is true: a large gap obtains between the number of tort events taking place inside hospitals and those that eventually filter into the court system. William Ira Bennett, editor of the Harvard Medical School Health Letter, recently observed that

> [t]here are, for the doctor, two kinds of malpractice claims to be feared: the valid and the false. The valid claim is a public, painful and expensive declaration of failure or bad faith. The false claim may be equally public, painful, expensive to defend, and may or may not lead to vindication. Less discussed, no doubt less feared, *and certainly most common*, is a third possibility: lack of any claim at all when malpractice has in fact occurred.[39]

Indeed, the extent of this litigation gap makes it easier to understand the malpractice litigation spiral that has occurred over the last two decades. It is difficult for a patient to discern negligence in and to lodge a tort claim about his medical treatment; it is also difficult for a lawyer to prove even a meritorious malpractice case. But what seems to have happened over the last twenty years is that injured patients, especially in urbanized areas,[40] have become much more willing to

sue their doctors when they perceive that something has gone wrong; in addition, the personal injury bar has displayed a much stronger technical capacity for documenting such claims in court.

Nor should we assume that these trends are peculiar to doctor-patient or lawyer-patient relationships in the United States. Although they started from much lower absolute levels, both Canada and the United Kingdom experienced the same steep increases in malpractice claims, payments, and premiums in the seventies and the eighties. Unlike the United States, however, both countries have comprehensive medical insurance, and neither uses juries or contingent fees in tort cases (in fact in both countries legal fees for unsuccessful claims are assessed against the patient).[41]

It would be a mistake for policy makers to leap from these empirical findings to the confident judgment that a culprit has been found: the doctors. As I discuss in detail below, the reason so many "torts" occur in the hospital is that modern medical treatment is an inherently risky enterprise.[42] Recall that for every negligent medical injury there are three non-negligent patient injuries. Most of these failures consist simply in momentary mishaps caused by inadvertent inattention, but when doctors make these all-too-human mistakes, the consequences can be severe and irreversible, unlike the mistakes made by lawyers or law professors. Even within the realm of medicine the rates of suits and premiums are much higher among obstetricians than among pediatricians, higher among surgeons than among internists. The explanation is not that surgeons or obstetricians are characteristically more careless or accident-prone, but rather that the types of conditions these specialists must treat and the kinds of procedures they must use entail a level of risk that is significantly above what their medical counterparts normally experience.

It is important also to recognize the significant imperfections in the tort and liability insurance systems. In New York State, for example, when we attempted to match the tort claims we found recorded in the insurers' files against the treatments we appraised in the hospital records, we discovered that a substantial proportion of the claims actually filed were for cases in which we had concluded on the basis of hospital records that no medical injury at all had occurred, much less one caused by medical negligence. (This finding, by the way, enlarged even further the gap between the total of torts that occurred in the hospital and claims that were filed for *those* torts.) Because our sample of claims arising from 1984 hospitalizations is still far from fully disposed of, we are unable to say whether the tort litigation/settlement

process will successfully winnow out the spurious from the valid claims. But a recent study of a large sample of anesthesia claims that were closed in the last two decades found considerable imprecision in the tort system.[43] While only a fairly small percentage (10 percent) of the claims appraised as negligent were not paid, a larger percentage (42 percent) of the cases that were paid were judged not to be the result of negligence (though the amounts actually paid by the insurer to settle these non-negligent disabilities appear to have been heavily discounted because the patient's case was weak on the liability side). The tort system, then, just like the medical system, inevitably falls somewhat short of the ideal standards that it sets for itself.

Finally, although I defended the insurance industry earlier against the charge of extracting excessive premiums and profits, it is true that the industry's price adjustments have taken an extremely erratic course. Even if malpractice premiums were roughly at the appropriate level by the end of the eighties, the path they took to get to that point is hardly justifiable. An endemic problem for the insurance industry is the unpredictable expansion and contraction of capital available for its use, with corresponding sharp swings in price from periods of surplus to periods of shortage. In addition, liability insurance is a peculiar product in that the bulk of its costs of production—the payments made on tort claims—will be incurred long after the product is priced and sold. Actuaries must try to project from past trends what will likely be the incidence and costs of future claims. The last decade has thoroughly demonstrated how imperfect is "actuarial science." However, the consequence of such insurer misjudgments about tort trends—first an underreaction, then an overreaction—is especially troublesome for a doctor who must rely on his professional income to support himself and his family, but who, in the short run at least, is deprived of fully effective insurance protection against swings in the tort system when he is charged steep hikes in premiums for which he cannot immediately adjust his medical fees. (And recall that this burden is imposed equally on doctors who have *not* been the target of a meritorious tort suit.)

To a considerable extent, these imperfections in liability insurance have been aggravated by uncertainties in contemporary tort law, especially on the damages side.[44] Both in medical malpractice and tort litigation generally, insurers have rightfully been concerned about wild card factors such as pain and suffering and punitive damages. Because these items are not tied to tangible and reasonably predictable lost earnings or treatment costs, they are intrinsically more sus-

ceptible to swings in the popular (and consequently a jury's) mood. Whether it is possible to rationalize these elements of damages while preserving whatever legitimate value they have in malpractice law is a challenge I will have to confront later.

For the moment, however, let us consider some sobering implications from the empirical material sketched in this chapter. Reflecting on the history of the last two decades, and considering this history in tandem with the malpractice gap disclosed in the New York and California studies, suggests that it is a gamble to assume that our troubles are behind us.[45] A safer bet is that we are now in the midst of a period of uneasy calm and are likely to face yet a third malpractice crisis in the nineties. It behooves us, then, to have a sounder legal structure in place before the next storm hits. Unfortunately, there are no obvious culprits nor easy measures to call on for that effort. Medical care is a hazardous enterprise, the injuries inflicted on patients are real and painful, and careful analysis and design is required before we tackle the network of health, legal, and insurance institutions that have evolved to address these problems.

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The Stages of Managed Care Regulation: Developing Better Rules

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Abstract The managed care industry is at a crossroads. Belief in the ability of market forces alone to create an environment fostering quality health care at lower cost is eroding. Regulators across the country are confronted with a growing consumer backlash against managed care. As a result, states have passed managed care reform legislation at unprecedented rates. In doing so, states are confronted with a patchwork of federal intervention and preemption. We examine the stages of these recent state and federal developments and evaluate them in terms of the traditional objectives of a reasonably functioning health care system: quality care, access, and cost containment.

Recent developments in the regulation of managed care reflect an industry that is very much at a crossroads. Nearly 75 percent of U.S. workers with health insurance now receive that coverage through some form of managed care organization, as compared with 30 percent a decade ago (Jensen et al. 1997). Some predict that within the next ten years all insured Americans will be enrolled in managed care plans (Bureau of National Affairs 1995). Consistent with this prediction, the federal government is moving toward making managed care an even more significant form of health care delivery for Medicare and Medicaid recipients (Kinney 1996; Iglehart 1997; Lamphere et al. 1997). However, now that costs appear to be under control and more people are enrolled, the quality of the health care provided by managed care organizations is being questioned (Gosfield 1997). According to a recent survey by the Kaiser Family Foundation and Harvard University, 51 percent of individuals surveyed believe managed care has lowered the quality of care for the sick (Blendon et al. 1998).

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The belief that market forces alone can create an environment fostering quality health care at reduced cost is eroding. As a result, since early in the 1990s, states have passed legislation at unprecedented rates aimed at ameliorating physician and consumer dissatisfaction (Miller 1997). Many HMO statutes passed in the 1970s are being reexamined in view of the explosive growth of managed care, organizational changes, and, perhaps most significant, the perceived dissatisfaction among consumers. The federal government has also become active in this area, most notably through the Health Care Finance Administration (HCFA). Congress has been considering a number of managed care bills. A consumer backlash is thus shaping the managed care debate at both the state and federal levels (Bodenheimer 1996; Budetti 1997). While these state-based initiatives were originally adopted in an a la carte fashion, with significant variation from state to state, a pattern has now begun to emerge, as legislation seems to reflect more settled expectations of what managed care should provide. This pattern of legislation will likely continue to be on the menu of pro-consumer legislation in many states. Various proposals before Congress contain many consumer protections from this menu as well.

Other recent developments, although not as widely publicized, are subtly molding this evolution of managed care. Examples of such influences include calls for greater oversight of risk-bearing entities and of physician incentive plans as well as congressional proposals for a more broad-based and uniform regulatory scheme for managed care. Also, federal preemption of state oversight, particularly by the Employee Retirement Income Security Act (ERISA) (29 U.S.C. secs. 1001–1461) has created uncertainty about the role of state versus federal regulation. Finally, statutes imposing liability on managed care plans for negligent utilization review and patient care, although too recent a development to constitute a trend, cannot be ignored. We submit that as the immediate "backlash" against managed care gives way, these developments, taken together, may signal a new stage in which proposals with the potential to make a more subtle and longer-lasting impact are emerging.

A growing awareness that quality problems are not unique to managed care may also serve to moderate reflexive, anti–managed care regulation. Two influential groups—the Institute of Medicine National Roundtable on Health Care Quality (Chassin, Galvin, and the National Round Table 1998) and the President's Advisory Commission on Consumer Protection in the Health Care Industry (Advisory Commission 1998)—have concluded that quality problems of overuse, underuse, and misuse of health care occur with the same frequency in fee-for-service and managed care systems. Thus *managed care* quality can be seen as part of a more generalized focus on quality problems that has emerged as concerns about rising health care costs have abated (Chassin, Galvin, and the National Round Table 1998).

From the vantage point of this managed care crossroads, we describe and analyze the four stages of managed care regulation. This analysis will focus on how well each stage meets what we deem the most salient objectives of a reasonably functioning health care system: quality care, access, and cost containment. We will also evaluate the responsiveness of proposed regulation. Because market forces continue to be important to the balance of cost containment and quality, regulation that can adapt to fit the new forms and influences in health care delivery without stifling innovation (i.e., "responsive regulation") is essential (Brennan and Berwick 1996). After providing some background discussion, the article considers stages of managed care regulation—from the relative calm of the 1970s to the more tempestuous atmosphere of the present. We then discuss these developments, the trends in regulation that they may portend, and we offer our recommendations for improving regulatory oversight.

Background: The Context of Managed Care Regulation

The hallmark of managed care is the integration of health care finance and delivery. By combining these functions, a managed care organization can monitor quality across a population and provide incentives, both rule-based and financial, to maintain the health of enrollees while controlling costs. Managed care first gained prominence in the 1970s. At that time rising health care costs, emerging theories supporting deregulation, and a greater deference to market forces in health insurance and health care delivery enhanced the appeal of managed care that, by definition, would address the risk of excess medical expenditures (Enthoven 1993). Also, the science of quality and outcomes measures and information technology had matured to such a point that the ability of managed care to provide internal incentives that would promote quality health care and discourage costly inappropriate care now seemed feasible.

Given the desire to promote HMO development and the incentives inherent in the HMO structure to self-regulate, governmental regulation

of managed care was initially limited and deferential to the market. Throughout the 1990s, however, we have seen an increased governmental activism in managed care regulation. Today it is recognized that market forces, the government, and private sector initiatives (such as accrediting bodies) all have a role in managed care regulation (Enthoven and Singer 1997; Moran 1997). This governmental activism emanates from both the state and federal levels, creating some tensions and uncertainties for both regulators and regulated entities. The following discussion of the federal and state division of labor may provide some insight into the regulatory developments we examine in subsequent sections.

Under the U.S. Constitution the scope of federal power is defined by certain enumerated powers. The Tenth Amendment provides that whatever powers are not delegated to the federal government are reserved to the states, or to the people. According to the operation of the Supremacy Clause, Art. VI, when Congress acts pursuant to one of its enumerated powers, such law is the "supreme Law of the Land," capable of preempting state law. Traditionally, health care regulation was regarded to be the province of the states. However, over the past thirty years the federal government has increasingly regulated the field (see Parmet 1993). This is significant because when Congress has expressed an intent to occupy a field exclusively, state laws—whether consistent or inconsistent with federal law—are preempted. Moreover, if Congress has not actively legislated in the preempted area, states are preempted from filling that regulatory vacuum. The operation of ERISA, a federal statute adopted pursuant to the congressional commerce clause power that expressly preempts state law, has created just such a vacuum (Chirba-Martin and Brennan 1994).

ERISA was enacted in 1974 to provide for national uniform administration of employee pension and health plans through federal legislation, and to promote the growth of these private plans by freeing them from state laws, which unnecessarily complicate employee benefit administration. To achieve the goals of uniformity and plan autonomy, ERISA specifically preempts state laws that "relate to" any employee benefit plan (29 U.S.C. sec. 1144[b][2][B]). A limitation on federal preemption can be found in ERISA. Consistent with the McCarran-Ferguson Act (Pub. Law 79-15, codified at 15 U.S.C. secs. 1011–1015 Lexis 1998), which was enacted in 1945 to preserve the state power to regulate insurance, state laws that regulate insurance are exempted from preemption by ERISA's "savings clause" (29 U.S.C. sec. 1144[b][2][B]). However, the regulation of insurance left to the states by the savings clause has been interpreted very narrowly by the Supreme Court (see *Group Life and Health Insurance Co. v. Royal Drug*, 440 U.S. 205 [1979]). These developments have been reviewed in great detail elsewhere (Mariner 1996; Farrell 1997).

Further, this insurance exception is limited by the "deemer clause." Under the deemer clause an ERISA self-insured plan cannot be deemed to be in the business of insurance simply to allow the state to regulate it. At the time of the enactment of ERISA, only a small number of large employers had begun to self-insure. However, the deemer clause has provided a strong incentive for employers to self-insure to avoid more burdensome state regulations. It is estimated that of the approximately 150 million Americans enrolled in ERISA plans today, approximately 55 million are enrolled in self-insured plans. The ERISA vacuum has created a patchwork system that prevents state law regulating managed care from being uniformly enforced, and this deprives ERISA health plan enrollees of the benefit of state-enacted consumer protections and other legal remedies (Farrell 1997; Mariner 1996; Polzer and Butler 1997). For example, many managed care regulations—such as disclosure requirements, utilization review standards, solvency requirements, mandated benefit laws, and grievance procedure requirements—are arguably preempted as "relating to" ERISA plans. Also, some courts interpret ERISA as preventing patients from bringing malpractice actions against managed care or utilization review organizations.

In contrast to this laissez-faire approach of ERISA, and the federal deference to state insurance regulation, Congress has taken a more active role in some aspects of health insurance regulation. The most significant of these are the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which allows for the continuation of employee health coverage benefits in certain circumstances, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires insurance portability from job to job (see Furrow et al. 1997). Unlike ERISA, the COBRA and HIPAA regulatory schemes acknowledge state expertise by setting minimum federal standards to be enforced by the states. The examples of federalism previously outlined demonstrate the uncertainty of the federal-state division of labor. Moreover, the question of federal and state roles, as demonstrated by ERISA, may not only involve a question of jurisdiction but of significant policy differences as well. With this background in mind, we consider the stages of managed care regulation.

Stages of Managed Care Regulation

The First Stage: Regulation in the 1970s and 1980s

As one of us has discussed elsewhere in some detail, the regulation of managed care is now more than twenty-five years old (Brennan and Berwick 1996). The promotion of managed care began in earnest with the federal Health Maintenance Organization Act of 1973 (42 U.S.C. sec. 300e et seq.). Much of the growth of managed care can be traced to incentives contained within this federal HMO Act. The act did not completely preempt state regulation. Thus some states were equally active in managed care regulation, creating a variety of laws to oversee the financial health of the managed care industry. Following a number of relatively high-profile insolvencies in the managed care industry in the mid-1980s, rules regarding the reserving and reporting of financial statistics that had previously only applied to traditional insurers were extended to the managed care industry (Brennan and Berwick 1996).

Also, there were efforts to increase information given to potential beneficiaries at the time that they enrolled in HMOs. States extended physician credentialing responsibilities to managed care organizations (Kopit and Lutes 1993). Related to this, managed care organizations were required to demonstrate that they had sufficient numbers of participating physicians in each specialty and that they were geographically dispersed in reasonable proximity of enrollees (Moran 1997). Health carriers also had to certify that they had means for continuing to check the efficiency of their networks. Health plans were also expected to have specific grievance procedures in place, including expedited review for specific rapidly developing illnesses (PPRC 1995).[1]

Drawing on traditional modes of regulation—such as reporting, disclosure, credentialing, and due process requirements—in addition to borrowing regulatory techniques from other industries, states addressed quality and access concerns by devising "new rules" for the new industry. This first stage of regulation has demonstrated staying power. Indeed, many of the requirements have been incorporated into private regulatory programs, such as the National Committee for Quality Assurance (NCQA) oversight mechanisms.[2] Also, the National Association of Insurance Commissioners (NAIC) has recently consolidated many of the elements of these regulations into model acts that are being closely examined by many states (NAIC 1996a). As states continued to rely on, to modify, and to develop these early regulatory structures, other influences emerged (namely, a perceived consumer dissatisfaction). Fueled in part by growing provider (most notably, hospital and doctor) concern about the affect of managed care on income, pressure increased on state legislatures to address the "evils" of managed care.

1. A typical grievance procedure law requires plans to inform enrollees of grievance procedures, remind them of these procedures at the time of denial, and set deadlines for resolving grievances, depending on medical urgency (Page 1996).

The Second Stage: "Anti–Managed Care" Regulations of the Mid-1990s

The second stage of managed care regulation is marked by a surge in the number of reactive managed care laws, as state legislators responded swiftly to the growing consumer backlash against managed care. These measures are typically narrowly targeted and reflexive, with no discernible regulatory game plan or uniformity, yet reflecting an anti–managed care proclivity (Bodenheimer 1996; Bureau of National Affairs 1995, 1996a). Examples of such laws include maternity length-of-stay bills, bans of gag clauses, and mandated access to specialists. Criticism has been leveled at the incremental or a la carte approach to regulation as being dominated by anecdotes of "horrors" committed by HMOs, and leaving gaps in the regulation of health plan quality (Horvath and Snow 1996; Riley 1997).

The most prominent reform mechanism that captures the anti–managed care sentiment of this stage of managed care regulation was the "any willing provider" (AWP) law. Such laws, enacted in approximately twenty-three states, require managed care plans to accept any provider who is willing to accept the terms and conditions of participation in the plan (Laudicina et al. 1998). The most common AWP statutes are aimed at opening panels to pharmacists, but some AWP laws apply to most or all providers (ibid.: appendix). Because the laws seek to fundamentally

2. The NCQA is an independent, nonprofit organization that assesses, measures, and reports on the quality of care provided by managed care organizations. The NCQA's standards focus on six fundamental areas: utilization management, credentialing, quality management and improvement, members' rights and responsibilities, preventive health services, and medical records. As of May 1996, more than half of HMOs were involved in the NCQA accreditation process. The quality-improving aspects of accreditation are based on performance measures developed by the NCQA known as the Health Plan and Employer Data and Information Set (HEDIS) (see, generally, Gosfield 1996: 111–132).

after managed care techniques, such as the gatekeeping function and limited provider panels, they prompted an unlikely alliance of both business and the managed care industry in lobbying against these laws with apparent success (Bureau of National Affairs 1996c). While thirteen such laws were passed in 1993 and 1994, by 1998 only a handful of additional AWP laws had been enacted (ibid.; Jaklevic 1996; Laudicina et al. 1998). Although fifteen states may be considering AWP laws in 1999 (Bureau of National Affairs 1998), ERISA case law has demonstrated that preemption poses a serious hurdle to the viability of such measures.

Decisions by the U.S. Fifth Circuit Court of Appeals, holding that AWP laws of Louisiana and Texas were preempted by ERISA, may at least partially explain the decline in state passage of AWP laws. These cases—*Cigna Healthplan v. State of Louisiana* (82 F.2d 642 [5th Cir.], cert. denied, 117 S. Ct. 387 [1996]) and *Texas Pharmacy Association v. Prudential Insurance Company* (105 F.3d 1035 [5th Cir.], cert. denied, 118 S. Ct. 75 [1997])—both held that the AWP laws in question "relate to" ERISA plans because the statute eliminates the choice of one method of structuring benefits, by prohibiting plans from contracting with networks that exclude any willing provider.[3]

States have given these holdings much weight, especially in light of the fact that they were decided shortly after the U.S. Supreme Court opinion, *New York Conference of Blue Cross and Blue Shield Plans v. Travelers* (514 U.S. 645 [1995]), which was expected to make such findings of ERISA preemption less likely. In *Travelers* the Supreme Court for the first time considered the preemptive reach of the "relate to" clause. The Court rejected a literal interpretation of this clause as being essentially limitless in breadth (see Jordan 1996). Speaking generally, after *Travelers* the door is slightly ajar for state regulation. What will fit through this opening is not certain and is subject to interpretation by the courts.

The subsequent Supreme Court decision of *DeBuono v. NYSA-ILA and Clinical Services Fund* (117 S. Ct. 1747 [1997]) affirmed and elaborated the *Travelers* holding.[4] Relying on both *Travelers* and *DeBuono*, a more recent decision by the Eighth Circuit Court of Appeals in *Prudential Insurance Company v. National Park Medical Center* (154 F.3d 812 [8th Cir. 1998]) held that ERISA preempted the AWP law in question. It

3. See also *Blue Cross and Blue Shield of Alabama v. Neilsen* (917 F. Supp. 1532 [N.D. Ala. 1996]).

4. At least one court has relied on the *Travelers* and *DeBuono* cases to conclude that an AWP statute does not "relate to" ERISA plans and is not preempted by ERISA, *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.* (973 F. Supp. 60 [D.C. Mass. 1997]).

would appear that AWP laws put a premium on the regulatory objective of access. Some would argue that such laws would increase access while jeopardizing quality and cost, since limited provider panels may allow plans greater control over the quality of physicians and their productivity. However, the market may have a greater influence here than state regulations. A 1995 study found that an equal number of health plans were opening their panels to all providers meeting credentialing requirements as were those limiting their panels (Gold et al. 1995). As Robert Berenson (1997) notes, consumer demand for choice of physician continues to be a powerful force in the market.

The Third Stage: A Legislative Pattern Emerges

In stage three, specific trends have taken shape. States have begun to emulate one another with regard to certain generic types of oversight of managed care. In doing so, states seem to be focusing on more narrow battles, such as gag clauses and patient access, and regulating rather than mandating provider selection. As will be seen, this stage is also marked by a growing federal presence in managed care regulation. The following sections describe what appear to be the most salient trends of state regulation.

Mandates on the Standard of Care. A controversial new breed of statute mandates benefits and sets medical policies for health plans. In essence, it creates standards of care by legislation that reflects a growing consensus that managed care's emphasis on cost containment has pushed the standard of care in a direction thought to be too parsimonious. Perhaps above all, these statutes reflect a concern that plan administrators, rather than physicians, are making medical decisions.

Maternity length-of-stay bills may be the most publicized of this type of regulation. Departing from its traditional hands-off approach to managed care regulation, Congress passed the Newborns' and Mothers' Health Protection Act of 1996, requiring ERISA plans to allow a forty-eight-hour hospital stay for normal deliveries.[5] At least forty states have passed similar statutes or variations thereof. Two states, Iowa and Maine, require adherence to American College of Obstetricians and Gynecologists (ACOG) guidelines, rather than mandating specific lengths of stay

5. ERISA has also been amended to allow for parity for mental health coverage (Mental Health Parity Act of 1996, 29 U.S.C. sec. 1185a, 42 U.S.C. 30088-5).

(Kertesz 1996). Legislation of this type often misses the mark. For example, bone marrow transplantation is not medically indicated for many breast cancer patients, yet Minnesota law requires bone marrow transplantation be available to all breast cancer patients (Minn. Stat. Ann. sec. 62A.309). Similarly, legislation mandating specific lengths of stay for a mastectomy ignores the fact that *mastectomy* describes a wide range of procedures with differing needs for hospitalization. The approach taken by Iowa and Maine demonstrates moderation in this standard-of-care legislative trend. The role of the physician, albeit with the standardizing influence of practice guidelines, may be put back into the treatment decision. States then set boundaries for, not prescribe, treatment. This approach also allows for changes in the standard of care due to medical advances. Such flexibility, or responsiveness, is often lacking in regulatory structures.

Access to Care. The issue of "direct access" is of increased interest to state legislatures. In response to aggressive denials of payment by health plans for emergency room treatment, many states have taken up measures to provide direct access to coverage for emergency room screenings. At least sixteen states have passed standards requiring insurers and MCOs to pay for emergency room screenings if a "prudent layperson" would believe that such care were necessary (Laudicina et al. 1998). Direct access statutes also permit health care plan members to bypass the primary care physician and go directly to a specialist without a referral. The vast majority of states now require managed care organizations to allow women to bypass the primary care physician for certain obstetrics and gynecology care. Other access statutes vary widely as to the conditions covered or the type of specialist to whom direct access is granted. It is not clear why one state may mandate access to dermatologists (as in Florida), while another mandates access to doctors of oriental medicine (as in New Mexico). Similarly, a small number of states have begun mandating coverage for individual disorders (such as growth-cell stimulating factor injections, prostate screening, and treatment for phenylketonuria [PKU], for example).

Gag Clauses. A strong movement is afoot at both the state and federal levels to prohibit so-called gag clauses from managed care contracts with physicians. Such clauses seek to restrict physicians from discussing all appropriate medical options with their patients, particularly those not covered by the health plan. Most states now ban such clauses and

according to the HCFA, gag clauses in Medicare and Medicaid contracts are a violation of federal law (Bureau of National Affairs 1996b). Also, at least one court has held that a gag policy by a health plan may constitute a breach of a fiduciary duty under ERISA (see *Weiss v. Cigna*, 972 F. Supp. 748, 750 [D.C. S.D. N.Y. 1997]). Meanwhile, a 1997 study by the U. S. Government Accounting Office demonstrates that gag clauses are disappearing from provider contracts. However, this report points to an even more significant barrier to physician-patient communication that may be much more difficult to eliminate. It is the physician-HMO contractual relationship itself that may make physicians feel constrained to limit communication with patients. The growing economic dependence of physicians on managed care is enhanced by the short duration (typically, one year) of the terms of most provider-HMO contracts and the use of "without cause" termination clauses.[6]

Physician Deselection. Many now see that the emphasis has shifted from AWP laws that mandate the selection of physicians to the more narrow issue of deselection, as part of a growing concern with patient and physician due process rights (Miller 1997; Laudicina et al. 1998; Bureau of National Affairs 1996c). This emphasis fits within the pattern of patient access laws now favored by states. In general, states are beginning to regulate the provider relationship with the managed care organization by requiring provider access to information about standards for acceptance into a network, reasons for termination, and access to economic profiles of the physician's practice patterns (Miller 1997; Terry 1998). However, even the states most active on this issue have not addressed the continuity and access hurdles created by industry-wide contracts that are renewable annually. Only Maine requires reasons for nonrenewals and the opportunity for physicians to appeal (1997 Me. Laws 163 sec. 2) (not applicable to cases involving "imminent harm to patient care"). (See also Terry 1998). Hand in hand with restraints on deselection, some states now require that for certain conditions, physicians must continue to be paid for treatment rendered even after termination of the contract with the managed care organization (Families USA 1998). Typically, such continuances may range from 60 to 120 days and cover a variety of medical conditions. However, with the exception of third-trimester preg-

6. Nearly all of the contracts surveyed by the U.S. GAO (1997) were for a one-year period, renewable for a one-year period, and 72 percent of the contracts surveyed contained a termination "at will" or "without cause" clause.

nancy and a limited number of acute conditions, such protections will only provide a brief transition period for most patients with more chronic conditions.

While less than satisfying, this stage of regulation is generally regarded as an improvement over the blunt anti–managed care approach of a few years earlier. Legislatures have become more active in addressing consumer concerns, particularly those related to access and quality. Certain measures adopted during this period—such as emergency room access, broad access to obstetrics and gynecology services, and some limited post-termination care—may continue to be part of the menu of managed care reforms. This notwithstanding, we note three problems. First, the regulatory initiatives are targeted too narrowly. Measures mandating standards of care or access to seemingly randomly selected specialists may peel away specific anticonsumer practices, but they ignore the far greater number of quality and access concerns of consumers who lack lobbying clout or a sympathetic media. Ironically, drive-through deliveries and mastectomies received so much negative publicity that they disappeared from health plans even before mandatory length-of-stay statutes were in place (Moran 1997).

Second, these initiatives ignore more deeply rooted barriers to improved quality and access. Generally speaking, the statutes adopted attempt to address consumer disquiet over the shift in the locus of medical decision making in managed care. To a certain extent, outlawing gag clauses and adopting due process standards for physician deselection do address such concerns. However, such broad-based requirements as requiring a physician to oversee the development of the organization's medical policies and practices, or holding health plans liable for medical decisions through tort law, may provide an incentive for medical decision making that will enhance the access to and quality of care for the benefit of all plan members. Similarly, outlawing gag clauses, which have largely disappeared from provider contracts anyway, does not ensure free communication between patient and doctor or enhance patient access to medically necessary care; rather, this leaves more pervasive industry practices unchecked. Physician economic reliance on managed care, the nature of managed care provider contracts, and physician incentive plans may infringe these communications to a far greater extent. Third, mandating standards is a particularly troubling development. The embrace of this approach, especially for obstetrics, has created second thoughts. It is better in the long run, for both quality and cost, to manage care

through the creation of guidelines, where feasible, but to leave individual decisions up to individual doctors and patients.

The Fourth Stage: Toward a Regulatory Middle Ground

New approaches to managed care regulation are being advanced that seem to be carving out a middle ground between the consumer backlash and the market forces approaches. Regulation in each of the following areas contains more uniform, flexible, and nuanced regulatory structures and brings managed care regulation closer to its objectives of promoting quality, access, and cost containment.

Regulation of Risk-Bearing Provider Groups. As managed care evolves, perhaps the most significant new development is that of the risk-bearing provider group (RBPG) (Overbay and Hall 1996). RBPGs take a variety of forms, including integrated delivery systems, independent practice associations, physician hospital organizations (PHOs), and provider-sponsored organizations (PSO), leading to a welter of acronyms (Burns and Thorpe 1993). As James Robinson (1996) points out, as managed care organizations reinvent themselves, they seem to be abandoning the traditional vertically integrated staff or group model for the "virtual integration" model. Rather than the unified ownership and employed physicians that characterize vertical integration, *virtual* integration entails contractual relationships between health plans and integrated medical groups or independent practice associations. Under virtual integration the physicians, rather than the HMO or the hospital, bear much of the financial risk of managed care. Also, a growing number of hospital and physician groups are bypassing the health plan and seeking to contract directly with employers for their services on a risk-bearing basis.

Physician members of these new organizations share in the financial risk of treating patients, yet they are only beginning to be regulated in any significant fashion. Although regulators in most states claim that fully capitated RBPGs are subject to state licensure under HMO licensure laws, in reality, very few (if any) appear to be licensed (Kaufman and Webster 1995). Only a few states have developed laws specific to provider-sponsored organizations. This may be due, in part, to state concerns of ERISA preemption. Minnesota, for example, has addressed this development by adapting its HMO licensure to authorize the establishment of community integrated service networks (CISNs). CISNs are

licensed by the insurance commissioner to provide health services to 50,000 or fewer enrollees. CISNs must maintain a minimum net worth of at least $1 million. The same minimum threshold applied to HMOs, but CISNs have a three-year phase-in to meet the net worth requirement (see Minnesota Integrated Services Network Act, Minn. Stat. Ann. sec. 62N.309).

Regulation of RBPGs is controversial. The NAIC (1996b) characterizes RBPGs as in the "business of insurance" and argues that they should comply with state solvency and consumer protection regulations. Their definition of the "business of insurance" would include capitated payments as well as risk corridors, withholds, or pooling arrangements.[7] Opponents of NAIC's position on regulation of RBPGs argue that providers who contract directly with employers only assume the limited risk for the specific services they agree to provide. If made to comply with insurance regulations, RBPGs will be shut out of the market entirely, and competition, as well as innovation, would be stifled. While we leave an in-depth examination of these emerging entities and market dynamics to others (e.g., Berenson 1997; Gabel 1997; Robinson 1996; Shortell 1994, 1996), the market will likely play a significant role in the viability of these emerging RBPGs. Therefore, regulation that can adapt to these entities, such as the Minnesota CISN approach, may provide a safety net that promotes quality as it protects the fiscal integrity of these organizations as they compete in the market place.

At the federal level, under the Balanced Budget Act of 1997 (Pub. Law 105-33 sec. 1851 [a][2][A], 1855 [d]), PSOs may contract directly with Medicare to provide services. Solvency requirements have recently been developed for these PSOs through a process of negotiated rule making (63 Fed. Reg. 25360, et seq.), whereby a committee of representatives of stakeholders was convened. The committee included representatives of the insurance industry, consumer groups, and provider and medical associations. As developed further later in this article, this ability to draw experts from across the country, generally unique to the federal system, provides an opportunity to learn about the issues confronting the entities

7. In capitation, the provider accepts a set per-patient fee regardless of the amount of services that the patient requires. The corridor of risk is the amount of risk assumed by the provider before a stop loss policy attachment point is reached. Where withholds and risk pools are in place, the managed care organization deducts a certain amount from each provider's payment and places the money in a pool to pay for costs of referrals that exceed the managed care organization's budgeted amount. If the cost of services exceed, the provider loses those funds. See NAIC Draft White Paper (1996b: 79–80); see, generally, Latham 1996.

to be regulated, allowing for "responsive" regulatory oversight. States may find such rules an important starting point for their own requirements. Also, organizations such as the NAIC may allow greater communication among states and thereby broaden the forum for debate.

Disclosing and Regulating Provider Incentives. In the past year we have seen some evidence of new methods of regulation that may define the oversight of the future. Perhaps the most thoughtful contribution is that of the HCFA. The HCFA has had legislative responsibility for regulating physician incentive plans (PIP) since the passage of the Omnibus Reconciliation Acts of 1990 (OBRA) (Pub. Law No. 101-508, 104 Stat. 1388, codified at 42 U.S.C. sec. 1395 mm [1998]) [Medicare]; *id.* sec. 4731, codified at 42 U.S.C. sec. 1396 m [1998] [Medicaid]). This legislation required that any PIP, defined as "any compensation arrangement between a managed care organization and a physician or physician group that may directly or indirectly have the effect of reducing or eliminating service furnished to Medicare beneficiaries or Medicaid recipients enrolled in managed care organizations," be the subject of rules promulgated by the HCFA (42 U.S.C. 1395 mm [1998]). In general, PIP rules (see Fed. Reg. 69,035 [1996]), now require plans that place providers at substantial financial risk for referral services to meet stop-loss insurance requirements, to comply with patient survey requirements, to disclose physicians incentive plans, and to survey patients.[8] Substantial financial risk is defined as 25 percent of potential payments for covered services. Large plans (25,000 patients) are not considered at financial risk because the risk is spread over a large number of patients.

The greatest problems with managed care are likely to occur in the cost-quality trade-offs that result from placing physicians at risk for providing further care. The HCFA's approach to balancing these trade-offs has much to emulate. First, the disclosure requirements recognize the importance of monitoring the risk for both managed care organizations and physician groups, and of maintaining actuarially adequate pools of patients. Second, it is innovative. The use of patient surveys, a requirement for stop-loss insurance, and the encouragement of disclosures are all evidence of a more mature stage of regulation of managed care. Requiring full disclosure of risk-sharing arrangements enables a regulatory agency to target its oversight. The disclosure requirements apply to *all* Medicare and Medicaid contracting health plans, allowing for broader

8. See Dallek and Hasenberg 1997 for a description of the regulatory requirements.

comparisons. Moreover, the regulations require that when there is more than one level of contracting, the financial arrangement that is to be reported is the tier under which the treating physician is operating. A summary of the PIP must be provided to enrollees upon request.

The use of patient surveys to understand how patients perceive the care they are receiving is an exciting development. To get a complete picture of patient opinion, plans must survey current enrollees and disenrollees. Regulation that enables consumers to give voice to their complaints may be a potent force in prompting the organization to remedy situations giving rise to such complaints (Rodwin 1996). To maximize its usefulness, careful state or employer coordination with other information collection strategies should be carried out. Mandating the use of surveys developed by the Agency for Health Policy and Research for both Medicare and Medicaid as part of the Consumer Assessment of Health Plans Study would allow for more productive comparisons of data.

Using other developing quality measures in a similar fashion would allow full evaluation of the cost-quality trade-offs. For example, the government could require that there be much more specific attention to monitoring adverse events compliance with HEDIS-quality criteria, and specific outcome measures in those areas in which physicians are being placed at greater risk. It is likely that permutations of this approach will be much more effective than many of the oversight forms that the states are now pursuing. State legislation in this area tends to be vague, prohibiting plans from using financial incentives that will directly or indirectly induce physicians to limit medically necessary care, and it provides uneven case-by-case enforcement mechanisms.

Changing Interpretations of ERISA Preemption. Our earlier discussion of federal preemption of AWP laws notwithstanding, ERISA case law following *Travelers* and *DeBuono* demonstrates a shift toward a more narrow view of ERISA preemption of state law. While many of the cases cited here and in the following section were decided during earlier stages of regulation, the significance of these various strains of interpretation will likely coalesce and begin to be felt during *this* stage as the trend toward the middle continues. Recent jurisprudence suggests that states may be able to avoid ERISA preemption by innovative interpretation of their own laws. In *Napoletano v. Cigna Healthcare of Conn.* (680 A.2d 127 [Conn. 1996], cert. denied, 117 S. Ct. 1106 [1996]), claims centered on alleged misrepresentations made by the plan as to the status and eligibility of the physicians as members of Cigna's provider network. The court held that such claims brought under the state unfair trade practices and unfair insurance practices act, the managed care act, and common law did not "relate to" an employee plan, but the court sought to have the defendant enforce the plan it had chosen to create and administer. Significantly, the court acknowledged that it would apply an admittedly narrow test for ERISA preemption, limiting preemption to state action that *demonstrably burdens* ERISA plans (680 A.2d at 140). Holdings such as this may encourage Connecticut and other states to further regulate managed care. However, the breadth of state jurisdiction in these matters, given ERISA, is still very uncertain.

Perhaps mindful of ERISA's "vacuum," federal courts are beginning to interpret the ERISA statute itself as entailing protection for consumers. In the case of *Shea v. Esensten* (107 F.3d 625 [8th Cir. 1997], cert. denied 118 S. Ct. 297 [1997]), the court held that financial incentives that discourage a treating doctor from providing essential health care referrals for conditions covered under the plan must be disclosed, and the failure to do so is a breach of ERISA's fiduciary duties (see also *Drolet v. Healthsource, Inc.*, 968 F. Supp. 757 [D.C. N.H. 1997]). A recent opinion took *Shea* a step further and held that where physicians own and control the health plan, an incentive structure that influences physicians to withhold care to save money *for themselves*, may rise to the level of a breach of the ERISA fiduciary duty (*Herdrich v. Pegram*, 154 F.3d 362 [7th Cir. 1998]). As noted above, *Weiss v. Cigna Healthcare* held that a gag clause may violate the plan's fiduciary duty. In previous cases federal courts had been unwilling to make such a substantive interpretation of a relatively thin regulation existing under ERISA. These cases likely indicate more willingness to engage in reasonable federal oversight of managed care on the part of the federal court and, in this roundabout and limited way, may accomplish some state consumer protection goals.

Managed Care Liability. Perhaps the most controversial aspect of ERISA preemption is its impact on managed care tort liability. Both ERISA preemption and certain state laws have served to immunize managed care organizations from tort liability. Recently, however, these barriers to liability have showed signs of weakening. A number of court decisions, most notably *Corcoran v. United Health Care, Inc.* (965 F.2d 1321 [5th Cir. 1992], cert. denied, 113 S. Ct. 812 [1992]), have held that compensation for injuries resulting from health plan negligence are preempted by

ERISA.[9] The civil enforcement scheme set out in section 502(a) of ERISA allows only for reimbursement of benefits promised and not received. Thus the Corcorans were left without a remedy for the allegedly negligent utilization review decision that resulted in the death of their unborn child. However, courts now seem less willing to interpret ERISA as insulating managed care organizations from liability for negligence.

The influential case of *Dukes v. U.S. Healthcare, Inc.* (57 F.3d 250 [3d Cir. 1995], cert. denied, 116 S. Ct. 564 [1995]), presented a new way to look at such cases.[10] Where claims of plan negligence are raised, the court must distinguish between claims that focus on the "quality" of medical benefits received and those that concern the "quantity" of benefits received. The latter is completely preempted, but with regard to the former, the *Dukes* court stated that because ERISA is silent, complete preemption cannot be found. This *Dukes* quality-quantity distinction was applied in the case of *Pappas v. Asbel* (675 A.2d 711 [Pa. Super. 1996]), petition for allowance for appeal was granted (686 A.2d 1312 [Pa. 1996]), and the court rejected an ERISA preemption argument. In that case the plaintiff was allegedly injured as a result of the HMO's cost-conscious delay in authorizing emergency room personnel to transfer the plaintiff to a facility equipped to treat the plaintiff's condition. The court pointed out that ERISA was enacted prior to the invention of the cost containment system used in the review at issue and concluded that Congress could not have intended to foreclose recovery to plan beneficiaries injured by negligent medical decisions based on cost containment rationale.[11] In general, courts are split as to whether the *Dukes* or *Corcoran* rationale applies.

9. See also *Kuhl v. Lincoln National Health Plan* (999 F.2d 298 [8th Cir. 1993]), in which ERISA preempted a claim of negligent denial of precertification for surgery; *Elsesser v. Hospital College of Osteopathic Med.* (802 F. Supp. 1286 [E.D. Pa. 1992]), in which a claim against an HMO for failure to fund the use of diagnostic medical device was preempted by ERISA, but a claim of HMO negligence in selecting, retaining, and evaluation of physician was not preempted; but compare *Kearney v. U.S. Healthcare, Inc.* (859 F. Supp. 182 [E. D. Pa. 1994]), which holds that ERISA preempted a plaintiff's direct negligence claim against U.S. Healthcare, but not vicarious liability claim.

10. In that case claims of vicarious and direct negligence against an HMO were not completely preempted by ERISA.

11. See also *Bauman v. U.S. Healthcare, Inc.* (F. Supp., Civ. Act. No. 97-2905 [Dist. N.J. March 31, 1998]), where a newborn died as result of alleged failure to diagnose meningitis; the claim that the health plan was negligent in structuring its plan to allow for only a twenty-four-hour maternity-newborn hospital stay was not completely preempted by ERISA; and *Ouellete v. Christ Hospital* (942 F. Supp. 1160 [D.C. S. D. Oh. 1996]), in which a malpractice claim that an HMO breached its duty to the beneficiary by limiting hospital stays, and by enforcing such limits through unreasonable financial incentives with hospitals, was not completely preempted under ERISA. Both cases were removed to state court to determine ERISA conflict preemption.

The breadth of ERISA preemption is being further tested as states pass statutes permitting suits against managed care plans. In many states the "corporate practice of medicine" doctrine may work to shield managed care organizations from such liability (Butler 1997). Under this doctrine, because health plans cannot practice medicine, they cannot be held liable for negligent medical decisions. However, recent legislation, most notably in Texas and Missouri, has been enacted to abrogate that doctrine (see Texas Health Care Liability Act, Tex. Civ. Prac. and Rem. Code Ann. secs. 88.001–88.003; Mo. H.B. 335, repealing Rev. St. Mo. sec. 345.505.3, adding sec. 345.627).

The Missouri statute simply removes the barrier to suits, leaving it for the courts to determine the type of lawsuits that can be brought and the standard of care required. The Texas statute takes an additional step in creating a new cause of action when a plan fails to use "ordinary care" in denying or delaying payment for care recommended by a physician or other provider. The law appears to make health plans liable for their own "health care treatment decisions," as well as for actions by employees and agents who make coverage decisions or directly deliver care (sec. 88002[B]). Prior to bringing a lawsuit, the enrollee is required to exhaust the appeal remedy (external to the plan) established by the statute.

The recent case of *Corporate Health Insurance v. Texas Department of Insurance* (12 F. Supp. 2d 597 [D.C. S.D. Tex. 1998]) involved an ERISA preemption challenge to the new Texas statute. Although an analysis of the opinion is beyond the scope of this article, it upheld those aspects of the statute that permit a cause of action against managed care plans.[12] The court noted that such actions would be evaluated on a case-by-case basis. Those claims based on the *Dukes* quality of care rationale are not

The opinions in *Pappas*, *Bauman*, and *Ouellete* raise the question as to what extent a health plan's causing its providers to act negligently toward beneficiaries overcomes the hurdle of ERISA preemption, making way for the beneficiary's common law cause of action.

For contrary holdings, see *Jass v. Prudential Health Care Plan, Inc.* (88 F.3d 1482 [7th Cir. 1996]), in which ERISA completely preempts a malpractice claim of negligent utilization review; and *Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.* (958 F. Supp. 1137, 1147 [E.D. Va. 1997]), where, despite allegation that health plan guidelines and cost standards prevented a complete assessment of the plaintiff's medical condition and proper and timely diagnosis, complete preemption under section 502(a) was found because the claim "challenged an administrative decision that has the effect of denying benefits."

12. The court also held that ERISA preempted three statutory provisions that have been implemented by a number of states: a provision mandating an external review process (sec. 88.0003), a prohibition of the use of "hold harmless" clauses in provider contracts (sec. 88.002[g]), and an anti-gag clause provision (sec. 88.002[f]).

preempted, while those claims asserting negligent denial of medically necessary benefits, such as in *Corcoran*, are preempted. Whether such a distinction is workable will be established by subsequent cases. However, redress by the statute may well be stymied by ERISA preemption.

An increasing number of states are considering similar legislation (Laudicina 1998: vii). Moreover, not all states bar suits against managed care plans, nor, as previously noted, is preemption always an insurmountable hurdle to suit in the ERISA context. For example, a recent Pennsylvania appeals court case recognized a cause of action for corporate negligence against an HMO for allegedly negligent advice given to the enrollee through the HMO's emergency medical advice line (*Shannon v. Health America*, 718 A.2d 828 [Pa. Super. 1998]). Acknowledging that medical decisions are made by managed care organizations, physician licensure boards in some states are applying greater scrutiny to coverage decisions made by medical directors of managed care organizations (see *Murphy v. Board of Medical Examiners of Arizona*, 949 P.2d 530 [1997]). The Maryland Board of Physician Quality Assurance is currently contemplating specific regulations allowing that body to take actions against medical directors (Page 1998).

Current Legislative Action on the Federal Level. Given the breadth of ERISA preemption, what really matters, of course, is how this debate is resolved at the federal level. Over the past two years, widespread support for federal managed care legislation has been in evidence. The health care consumer bill of rights was developed by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998) and is viewed by many as a blueprint for needed reform. A number of bills sponsored by both political parties, by public and private sectors, and by those inside and outside of managed care have been introduced. However, despite predictions that managed care legislation would be enacted by Congress in 1998, preoccupation with the presidential impeachment and the events leading up to it precluded fulfillment of such legislation. Moreover, some interpret the midterm election results as falling short of a voter mandate for broad federal reform (Nather 1998).

As of this writing, two bills have been offered by the Republican and Democratic leadership—the House Republican Patient Protection Act (H.R. 448), and the Democratic Patients' Bill of Rights Act (S. 6), which has recently been reintroduced. Prospects of either bill being passed are uncertain. A description of these bills is beyond the scope of this article. However, these bills demonstrate basic differences of opinion as to what role the federal government should play in regulating managed care. The Patient's Bill of Rights Act contains wide-ranging consumer protections and would amend ERISA to allow for negligence actions against managed care plans. The Patient Protection Act is more narrowly drawn, however, and does not provide for suits against managed care plans. How and how far governmental activism in the regulation of managed care will proceed at the federal level thus remains to be seen. Interestingly, the presidential commission deadlocked on just these issues (Pear 1998). Consumer advocates, doctors, and some labor leaders on the commission favored recommending a federal enforcement mechanism of the bill of rights. Commissioners from insurance companies, managed care organizations, and businesses opposed increased industry regulation and argued that voluntary compliance would accomplish the same result. Not surprisingly, the commission was similarly split over the right of enrollees to compensation for injuries due to improper denial of benefits.

This fourth stage of regulation has shown the potential to increase quality and access while balancing costs by overseeing physician incentives and by moving toward the adoption of tort-based incentives for managed care. Efforts are also afoot to promote quality by protecting the fiscal integrity of organizations, especially emerging entities. However, recent reports of rising managed care costs—and premiums—may lead to a reexamination of certain cost-quality trade-offs and limit the number and types of reforms that succeed (Kilborn 1998). Efforts to extend liability to managed care organizations and the trend to broader provider panels may be closely examined by states and health plans. State activism during this stage seems likely, as there is legislation pending in every state for 1999 (Bureau of National Affairs 1998).

Discussion and Recommendations

Broader-based regulatory structures that avoid mandating standards of medical care hold more promise for accomplishing the objectives of managed care regulation. But what particular regulatory structures seem the most promising? From the legislative and regulatory initiatives reviewed, we note six regulatory approaches that demonstrate particular promise in reaching these goals society has set for managed care.

Setting a Federal Floor

Although the issue of legal enforceability of the Consumer Bill of Rights and Responsibilities was hotly debated and failed to produce a consensus, we believe that an enforcement mechanism is needed, given the rapid evolution of health care and the risk of inattention to matters of quality. The significant level of state legislative activity in this area, and its gaps in areas of quality assurance, supports our proposal. To this end, we recommend that a set of minimum requirements concerning patient information and protections be set at the federal level to be administered by the states. The task of enforcement is simply too large an undertaking for the federal government. States are much better positioned to enforce the minimum requirements, as they possess the expertise to tailor regulation to their populations' concerns and to the specifics of their health care organizations. To permit states to experiment, ERISA should be amended to remove the preemption barrier to state regulation. The federal-state division of labor will thus be better defined but with opportunity for collaboration.

In general, the federal floor should be comprised of those elements on the regulatory menu that society has appeared to decide by consensus should be included in managed care regulation. Broadly stated, the floor should require disclosure of information to consumers; choice of providers and plans; access to care, including a "prudent layperson" standard for emergency room services; reasonable access to specialists; some safeguards for those in need of continuity of care following physician terminations for reasons other than quality; a gag clause ban; informed consent; patient confidentiality protections; nondiscrimination against enrollees; grievance and appeals procedures; and quality assurance mechanisms. Again, we recommend against those elements from this menu that mandate standards of care or seek to appease random interests. Once the federal floor is established, states would remain free to require more of health plans.

Meaningful and Standardized Reporting Requirements

As the HCFA PIP reporting requirements demonstrate, the collection of data from plans and patients provides an important opportunity to learn about the regulated entities and about the effect the regulations may be having, both positive and negative. The Democrat-sponsored Patients' Bill of Rights Act appropriately encourages uniform reporting. Under section 112 of the act health plans must collect uniform quality data that include a "minimum uniform data set" and report such data in a standardized format. This data set includes aggregate utilization data, the demographic characteristics of members, disease- and age-specific mortality rates, satisfaction of enrollees (including data on voluntary disenrollment and grievance and appeals data), and quality indicators. More specific measures should not be overlooked. Readmissions, rates of complications, as well as consumer complaints provide important information on quality. The challenge of quality regulation is to keep pace with developments in the science of quality measurements so that regulations dovetail with quality tools as they are developed. Others have documented the potential for quality measures as well as the difficulty in arriving at them (Gosfield 1997; Cleary and Edgman-Levitan 1997; Brook 1997). One potentially powerful tool for translating developments in this area into more effective regulations is the establishment of a federal quality commission, such as that proposed by the Patients' Bill of Rights Act.

A Federal Quality Commission

The rapidly changing area of health care quality and its measurement is ideally suited to the employment of a federally-based commission. The Patients' Bill of Rights Act would establish such a commission. This approach is not new. The Balanced Budget Act of 1997 established the Medicare Payment Advisory Commission (MPAC), whose membership includes prominent experts in a variety of relevant fields. MPAC brings its considerable expertise to bear in weighing the implications of policy change across the many components of the Medicare program, working toward consistency in the policies it recommends.

As with MPAC, a federal quality commission would be free to consider short-term as well as long-term implications of existing policy and regulation, an important function, given the often politically charged topics for which their advice is sought. The continuing evaluation and input of the commission should increase the likelihood that regulation will innovate rather than stagnate when addressing the complex area of health care quality. Given a regulatory structure with a federal floor, states are able to benefit from the commission's work. However, it is incumbent on state regulators to voluntarily communicate with their counterparts in other states to share information so as to maximize the

quality of health care institutions. Involvement of nongovernmental organizations, such as medical societies and the NAIC, in the exchange of information should also be encouraged.

Understandable and Uniform Enrollee Disclosure Information

Many states and the Patients' Bill of Rights Act of 1998 list specific information that must be disclosed to participants and beneficiaries at the time of initial coverage under the plan. To maximize the usefulness of this information, however, it should be made available to potential enrollees who are in the process of choosing a health plan. A uniform and understandable method of providing this information will enhance the ability of the consumer to make an informed choice at that more critical juncture. The scope of the information provided says much about the perceived role of the consumer in making choices about health care coverage. In addition to the "nuts and bolts" of accessing health care (obtaining referrals, prior authorizations, grievance procedures, etc.), an informed consumer also needs to know what financial incentives are offered to providers. Making information available to patients about cost containment strategies, as the new HCFA regulations and the proposed bill require, is an important step in involving patients more directly in decisions about their health care. Such measures could also play a role in restoring consumer trust in managed care.

Researchers are beginning to measure consumer interest and understanding of quality data (Cleary and Edgman-Levitan 1997; Schneider and Epstein 1998). Until we know more, common sense and the strong tradition of informed consent tell us to provide uniform and understandable information. However, there are some limits on disclosure. For example, the Patients' Bill of Rights Act provides that enrollees be informed of the plan's medical loss ratio (MLR). This is the statistic that measures the percent of managed care premium revenue that is spent on medical care, as distinct from administration and profit. Despite significant public interest in this statistic, critics question its value as an indicator of managed care quality or efficiency (Robinson 1997). According to Robinson (1997), the MLR is a poor indicator of both quality of care and administrative waste since it fails to take into account physician choice, a key ingredient of patient satisfaction. Staff model HMOs that provide the least provider choice typically have lower administrative expenses. Conversely, those plans that provide the most choice are those with higher administrative expenses.

Further undermining the reliability of the MLR is a lack of standardized accounting practices in arriving at the ratio. According to a study by Turnbull and Kane (1999), nearly one-third of the difference in MLR values reported by HMOs could be attributable to accounting differences. The authors argue convincingly that if greater significance is attributed to MLRs, there will be increased incentive to employ whatever accounting strategies will create the most favorable MLR. Supplying this particular raw statistic would thus constitute a regulatory cop-out. By contrast, when the Joint Commission for Accreditation of Healthcare Organizations team completes an inspection, the team does not simply post scores, but translates its inspection results into meaningful information to guide the health care facility in improving quality. The concept of "responsive regulation" posits regulation as a learning experience.

Even mandating the disclosure of meaningful and easily interpreted information may constitute a regulatory cop-out. Merely publishing quality data does not prevent low-scoring health plans from remaining in business (Epstein 1998). Because most private purchasers choose health plans based on cost and size, not quality, and most consumers are limited to health plans selected by their employers, receiving information that a plan has a poor quality rating is not helpful. Thus, in the absence of market incentives to select for quality, alert and responsive regulation should go beyond disclosure and set a tolerance level for health plan quality. Barring new enrollees from joining health plans below the tenth percentile of the industry may not only spare potential enrollees from substandard care; this may succeed in raising the standards of the industry.

Managed Care Accountability

The debate over managed care liability echoes the long-standing question of cost-quality trade-offs under managed care. Tort liability extended to managed care plans is a positive step toward addressing the need for an analytical framework for ascribing liability, given the industry's influence on treatment decisions. Individuals within managed care that make "medical" decisions may be less likely to err on the side of cost over quality if personal liability in tort or disciplinary action may result from such decisions. Liability may also reduce consumer perception that coverage denials are often arbitrary and unfair (Butler 1997).

Although medical malpractice, in general, is not regarded as a significant factor in deterring substandard medical care by individual physicians, empirical research has demonstrated that its deterrence signal is felt at the organizational level (Brennan 1995). As the organizational

structure becomes more important, as in the managed care setting, the threat of malpractice liability to the organization will more likely be translated into greater concern for quality of care (Abraham and Weiler 1994; Studdert and Brennan 1997). Thus theories of no-fault and enterprise liability are particularly suited to the managed care organization. By focusing the organization on prevention, this type of liability would bring about greater deterrence of medical injury than the present system, especially if experience rating is employed (Studdert and Brennan 1997; Brennan and Berwick 1996). The extension of malpractice liability to the managed care organization will most likely require amending of ERISA. We encourage such an amendment.

Encouragement of Innovation

An area of promising regulation is the development of short-term projects for pilot-testing new regulatory mechanisms. An example of a regulatory mechanism suitable for such testing is the ombudsperson concept contained in a number of regulatory initiatives at both the state and federal levels. As set out in section 123 of the Patient Bill of Rights Act, the function of an ombudsperson is "to provide counseling and assistance to enrollees dissatisfied with their treatment by health insurance issuers and group health plans in regard to such coverage or plans and with respect to grievances and appeals regarding determinations under such coverage or plans." The ombudsperson represents a new approach to addressing patient grievances and has lent itself to experimentation in a small number of states. If certain benchmarks of consumer, provider, and health plan satisfaction are met on an experimental basis, broader use would be indicated. The opportunity for smaller scale experimentation would also encourage innovation. Pilot-testing is not feasible for all circumstances; however, responsive regulation is always testing methods of regulation. Regulators should evaluate the effectiveness of such mechanisms on the quality, access, and cost as well as its success in encouraging innovation. Where possible, this should be done on an ongoing basis.

Conclusion

As the regulation of managed care proceeds, we can only hope that there will be continued focus on more nuanced approaches to regulations. Throughout the article, we have described what we believe to be important factors in creating regulatory structures that will meet the traditional

objectives of regulation while not discouraging the influence of market forces in helping to achieve these same objectives. After all, managed care may only be the start of a more effective health care market (Drake 1997). Regulation should acknowledge that quality, not managed care itself, is the problem. We should therefore move beyond reflexive anti–managed care legislation. Utilization and quality review may provide some improvement, especially as the development of quality indicators continues to mature. We need to acknowledge that managed care organizations make medical decisions and that holding them accountable may enhance quality and patient trust in the system. The goal of maintaining consumer trust in the doctor-patient relationship, as well as in the triangular relationship of doctor-patient-plan, remains vital.

A greater understanding of the impact of physician economic dependence on managed care organizations is needed. Also needed is a federal and state division of labor that plays to the strength of each while promoting collaboration. A continued ERISA vacuum may thwart state and federal regulators in assuming such optimal roles. Despite these hurdles, regulators should continue to embrace better rules that seek to infuse a collaborative sensibility, a mutual learning experience, into the relationship between the regulator and the regulated. Working together, emphasizing the critical element—physician risk—and applying techniques of quality measurement and quality improvement would seem to be our best bet to assure patient safety and help doctors ethically care for patients.

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Duncan Kennedy

TORTS SYLLABUS

PART III

TORT LIABILITY WHERE THERE IS A PRE-EXISTING RELATIONSHIP BETWEEN THE PARTIES

Version of 1977

For a more developed version of the pro-con arguments canvassed here, see "Distributive and Paternalist Motives in Contract and Tort Law: With Special Reference to Compulsory Terms and Unequal Bargaining Power."

OUTLINE, 1977

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III. The Impact of Pre-Existing Relationship on Tort Liability

At the beginning of these materials, I described tort law as a collection of rules that judges follow in deciding whether or not to grant compensation for injuries not arising from a breach of contract. While such a definition is useful, it is also misleading. In this section, we will examine in much greater detail the relationship between contract law and tort law, and in the process explore the impact on the rules of tort law of the necessity of taking into account a prior relationship between the parties to the lawsuit.

When the parties have entered a contractual relationship, and one party breaches, it is common for the victim to bring an "action on the contract for breach," or an "action in quasi-contract for recission and restitution." These two actions are subject to a host of special rules with a host of special exceptions, and these rules are (a) different according to whether the action is for breach of contract or in quasi-contract, and (b) different from the rules that govern a "cause of action in tort." There are three particularly important differences between the rules governing actions in contract and actions in tort. (a) The torts statute of limitations is likely to allow more time for the bringing of actions than the one governing contracts. (b) In a tort, but not in a contract action, it is normally possible to collect damages for pain and suffering or emotional harm caused by the violation of duty, and, if the tort is intentional the rule of Hadley v. Baxendale does not apply (cf. Vosburg). (c) In order to succeed in an action on the contract, but not in a tort action, it is usually (but by no means always) necessary to show that the parties intended to create the obligation which the plaintiff claimed the defendant breached.

The existence of different rules for these two causes of action would not pose a serious technical problem if there were also a set of rules that allowed us to say of a given fact situation: "Here, because the following elements are present in the fact situation, the plaintiff must bring an action on the contract and may not bring an action in tort. If the plaintiff fails in her contract action, she is without a remedy and her loss

is damnum absque injuria (damage without infliction of a legal wrong)." In most jurisdictions in the United States, there are no longer any general rules of this kind. It is still true that a plaintiff who claims simply that she lost money because she had to cover when a defendant seller did not deliver the goods will not be allowed to sue in tort. But there are now no valid generalizations that can be made about when courts will react in this way to injuries within relationships.

This is a fact of enormous importance to lawyers who deal with such injuries. It means that as time passes it has become more and more frequently possible to bring tort actions, under tort statutes of limitations, seeking tort damages, for injuries that arise within or on the borders of contractual relationships. To win such actions, it is not necessary to show that the defendant breached an obligation that the parties had previously created, expressly or by implication, in the contractual process. On the contrary, it is often possible to win such actions in spite of the fact that there is a good argument that the parties expressly or impliedly agreed that the defendant would not be liable for injuries of the kind he has inflicted on the plaintiff. From the point of view of contract law, the tort invasion means (a) new remedies for injuries that have all along been remediable in contract actions; (b) remedies for injuries within the contractual relationship that previously would have gone unrecompensed; (c) new limitations on the ability of the parties to control their relationship, according to their respective bargaining power, by limiting their duties to one another.

There are no logical limits to the expansion of tort duties within contractual relationships. Suppose we define a tort as an unprivileged invasion of a legally protected interest. As we saw in our discussion of intentional torts, the judges must then decide what interests are protected. The judges could define all contractual rights as legally protected interests to be vindicated through tort actions, and dispense with contract altogether. There would still be special rules governing injuries inflicted by refusing to abide by agreements, just as there are special rules for automobile accidents, competitive torts and defamation. But all the special rules would be part of a one general legal category of "civil wrongs," rather than divided into the mutually

exclusive categories of contract and tort. Something quite close to this actually occurred in Renaissance England when the action of trespass on the case expanded to include most contract breaches. In the process, case both displaced the actions of debt and covenant and created liability for many injuries that had previously been without remedy.

Conversely, judges could just as well accomplish the expansion of liability that is now occurring through tort law through the incremental modification of contract law. "Implied" obligations within a contractual relationship are sometimes imposed because it is quite clear that the parties actually intended them. But they are also imposed "as a matter of law," quite independently of intent, and the courts sometimes refuse to allow the parties to effectively disclaim these obligations. The process of "implying" obligations in contract is not significantly different from that of creating "legally protected interests" in tort. Indeed, there is now a considerable body of scholarly opinion that holds that the recent expansion of semi-voluntary or involuntary obligation within the contract cause of action has already almost abolished the distinction between contract law and tort law. (Gilmore, The Death of Contract, ch. 4, 1974).

The absence of logical limits to the expansion of liability (whether from within contract or through the tort invasion) does not mean that the expansion ought to occur. The point is merely that what limits there are derive from our ideas of policy, exactly as was the case in our discussion of compensation for intentional economic harm in Section I of the course. As we have seen throughout the course, there are a rather small number of policy arguments that recur on each side of the debate about the expansion of liability. There are special versions of these arguments that are customarily employed when the issue of liability arises within a relationship whose legal content the parties can easily vary by contract. There is also a special version of the economists' claim to be able to "resolve" the policy conflict by reference to the concept of "efficiency." I have divided these materials as follows:

A. Relationships Short of Formal Contract

B. Contractual Relationships

1. Insurance contracts
2. Landlord's duty to repair
3. At-will employment contracts
4. Fraud and products liability
5. Malpractice

A. Obligations Arising From Relationships Short of Formal Contract

In the late 19th century, is was a common view that tort law consisted or ought to consist only of obligations that were sufficiently minimal and sufficiently abstract so that they would apply between strangers. Such, for example are the obligations to avoid intentional or negligent invasion of another's interest in bodily security. The existence of a relationship with another person did not create any new tort duties, indeed it was more likely to extinguish them (as in the case of privity). Of course, relationships constantly lead to other kinds of legal obligations that had not existed when the parties were strangers, but these must be derived either from agreement (contract) or from the specifically fiduciary character of the relationship (e.g. guardian and ward).

This view was implicitly individualist. It meant that there was a gap in the legal system: the courts treated people whose actual relationship might be highly developed, with consequent feelings of moral obligation going far beyond what would exist between strangers, as though they were in fact strangers, on the ground there was no legal category lying between strangerhood and formal contract. Over the last 75 years, this gap, which was never total anyway, has gradually filled. The judges have operated from both sides, so to speak. On the contract side, a variety of doctrinal shifts have made it easier both to establish the existence of formal contractual obligation (relaxation of rules of offer, acceptance and consideration) and to establish the borderline causes of action in quasi-contract and promissory estoppel. From the tort side, the important developments have been (a) the abolition or limitation of defenses based on non-contractual relationship (assumption of risk; duty of landowners to licensees and social invitees; intrafamily immunity) and (b) the expansion of liability in situations where there has been no "act," but the existence of relationship makes the failure to act as morally reprehensible as an act would be between strangers. This section traces both of these developments.

C. Contractual Relationships

We will take up five kinds of contractual relationship within which the issue of tort liability has begun to arise frequently. These are insurance contracts, employment contracts, leases, contracts for the sale of consumer goods, and contracts for the provision of medical services. Each of these fields has its own specialized body of legal doctrine, and the developments we will examine have occurred under different rubrics and at different rates from field to field. As a result, it has traditionally been possible for those who deny that change is occurring or ought to occur to argue that each is "exceptional," or that some four of the five are exceptional, while the fifth "used to be governed by sound principles" but is unfortunately now moving in directions "foreign to the common law" (i.e. it is becoming "exceptional" as well). The problem with this attitude is that, taken together, insurance, employment, leases, sales of consumer goods and malpractice cover a very large proportion of the total legal experience of the average person. If they are all to be treated as exceptional, it is hard to see where we will find the "normal" law of contracts affecting normal people.

The cases demonstrate not that there is a uniform and harmonious process of change going on across all doctrinal boundaries, but that the same conflict, resolved sometimes one way and sometimes another, recurs from area to area. There may be good reasons why the tort invasion should expand liability more or less in one field by contrast to another. Or it may be that differences in treatment reflect not a meta-principle of "appropriate tortification," but merely differences in the judges' understanding of the issues, or differences in the strength of the two sides of the argument at different times and in different jurisdictions. It will come as no surprise that the evidence suggests to me that what is involved is the gradual and uneven emergence of a consciousness of contradiction that cuts across doctrinal boundaries.

For all five issues, it is important to try to assess the lengths to which the court is willing to go to impose its conception of how the

parties ought to behave. It is a commonplace that there are many degrees of interventionism: (a) the court may use tort law to impose more extensive damages to recompense the plaintiff for actions by the defendant that are clearly in breach of contract under existing contract law; (b) or it may use tort law to add to the already substantial list of contractual duties that the law impose on contractual parties in the absence of a specific disclaimer; (c) or it can add to the list of duties that the parties are not free to disclaim or otherwise modify by contract.

These different kinds of intervention shade into one another by imperceptible degrees, as the cases will show. A particularly frequent kind of ambiguity arises because the decision to impose liability for a particular kind of conduct in the absence of explicit contractual provision to the contrary may be tantamount to imposing a non-disclaimable duty. This will be the case where the behavior in question is of a type that it would be very costly or perhaps embarrassing for the parties to deal with in advance through contractual language. An equally frequent situation is that in which the contractual language might be construed as a disclaimer of liability of a particular kind, but is susceptible of a forced but not altogether crazy interpretation in the opposite direction. When the court chooses the strained construction, or imposes a duty while simply ignoring the arguable language of disclaimer, it is doing more than merely interpolate a new term, though less than imposing a clearly non-disclaimable duty.

It is crucial to distinguish between two arguments against the interpolation of a new obligation into a contract. One argument is good only for the particular case before the court, and does not apply to the new rule in general: it is that the parties entered the relationship with the then-existing law in mind. To change the law ex post facto, after the defendant had relied on the pre-existing rule that absolved him of liability for the damage he has caused, is at least unfair, and may fall only a little short of a taking of property without compensation. I will call this the "reliance/surprise argument." It applies only to the retroactive effects of the decision, and should be sharply distinguished from the argument that the imposition of a new duty will, in the general run of future cases, put an unfair burden on the party obligated. In this second, future-oriented argument, it is of course crucial to know whether defendants as a class

will simply pass the costs of the new burden on to someone else, and, if so, to whom.

In each case of intervention, the court will have a choice between imposing a duty merely to refrain from intentional harm of the kind in question, a duty to refrain from both intentional and negligent harm, and the imposition of strict liability. There will also be a choice between casting the new duty as one in tort or one in contract. Although we will deal here only (or almost only) with cases in tort, it is important to keep the contractual alternative constantly in mind, since in some jurisdictions it may offer a better or the only argument on a given issue.

Two Outlines on Compulsory Terms

These are two outlines of issues, designed to help you to sort out, rapidly, the pros and cons of legal rules specifying compulsory or semi-compulsory terms in contractual relationships. The first outline deals with issues that arise for all compulsory terms. The second deals with the differences between negligence and strict liability as the duty of care for the performance of a compulsory term. Both outlines are rather summary and abbreviated. Much of the detail is filled out in the readings; I will deal with the rest in class, to the extent time permits. Please try to use the outlines as checklists to make sure you have fully considered the cases.

FIRST OUTLINE: COMPULSORY TERMS IN GENERAL

A. Analyzing the legal situation

1. What is the legal form of the compulsory term?

   a. a rule defining certain conduct within a relationship of a particular kind as tortious

      i. when engaged in intentionally
      ii. when engaged in negligently
      iii. whenever engaged in (strict liability)

   b. a rule defining some set of contractual expectations as a legally protected interest, whose invasion is a tort

   c. a general tort rule (applying both outside and inside contractual relations) particularized to govern a constellation of facts that only arises within a particular contractual relationship (intentional infliction of emotional harm; outrageous conduct; deceit)

   d. an implied contractual term treated as though it were an inference of the actual intent of the parties

2. Possible differences between a contract and a tort action

   a. disclaimability of the duty may be greater in contract action.

b. damages for mental suffering or outrage generally not available in contract

c. the rule in Hadley v. Baxendale vs. proximate cause

d. statute of limitations often runs longer in tort

e. willingness to create new duties may be greater in tort

f. standard of care in performance of duties is generally strict liability in contract, varies in tort.

g. other

3. Is the obligation created by the rule disclaimable?

a. are there legal obstacles to disclaimer

i. the term is illegal and will never be honored
ii. there is a rule of construction that makes it difficult to draft an effective disclaimer (contra proferentem)

b. are there practical obstacles to disclaimer

i. it would be more expensive than it would be worth to try to draft a way out, either because it would be technically difficult or because the obligation is so insignificant

that it can be ignored.

ii. the disclaiming party would be embarrassed to disclaim

B. The Gains and Losses from Enforcement of Compulsory Terms

1. Who bears the cost?

a. buyers in general

i. higher price
ii. some forced out of the market and spend money on next most favored good

b. sellers in general

i. lower returns per unit
ii. fewer units sold

c. third parties

i. the industry factors of production
ii. dependents of buyers & sellers

2. Who gains?

a. injured buyers who would not have self-insured

b. buyers in general, who would have had to pay more to self-insure

c. the people who would have had to pay more social insurance if society (the state) had chosen to compensate the victims

d. other industries, which gain by the purchases of buyers forced out of the market by the compulsory term

C. Why Would Anyone Ever Favor Interference with Freedom of Contracts (Transaction Costs, Paternalism, Regulation)

1. In order to force the parties to the agreement that they would have reached if they hadn't been prevented by transaction costs, and thereby make everyone (almost) better off than they would have been under freedom of contract.

2. Paternalism: In order to force the beneficiaries of the duties imposed into the "correct" choice, rather than letting them make the "incorrect" choice.

a. the notion here is that one party does not know his "real best interests," and should not be allowed to injure himself by entering into the

contractual relationship without the protection afforded by the compulsory term. If a person will not enter into the relationship if she has to pay the price of protection, then it is "better for her" not to enter it at all.

b. This argument is often supplemented by reference to the interests of third parties, for example family members who may be injured, or the people who will have to pay to compensate victims who do not insure themselves.

3. Bargaining Power, Regulation, Redistribution

(Note: compulsory terms designed to eliminate the effects of transaction costs--1 above--and those motivated by paternalism--2 above--have redistributive effects, making some people better off and others worse off. But those are "side effects" rather than motivating purposes for imposing the compulsory term. Here we are dealing with a positive argument that actually justifies the compulsory term by reference to redistribution)

a. "Unequal bargaining power"

i. The basic problem with the idea of inequality of bp is that it is meaningless unless you can point to a situation in which bp is not unequal. There are three ways in which people try to do this: (1) there is equality of bargaining power when the market is competitive because of the presence of many buyers and many sellers; (2) there is equality of bargaining power when the good being bargained over is not a necessity, but there is inequality where the good is a necessity; (3) there is equality of bp when the outcome of the bargaining process corresponds to a just (or natural) price and fair terms for the commodity--deviation from just price and/or fair terms is conclusive evidence of inequality. I want to argue here that the use of the concept of inequality of bargaining power is almost always confused or obfuscatory.

ii. If there is inequality of bargaining power in any market which is less than perfectly competitive, then there are precious few markets anywhere in the U.S. that ought not to undergo intensive judicial scrutiny to determine the substantive fairness of contract terms. I am no partisan of free market economics and I would be more than willing to contemplate a large increase in social control of prices and terms. But the people who propose this criterion for intervention never seem to be willing to take the idea to its logical conclusion. They don't want to propose a criterion of fairness that would put the whole economic system in jeopardy. Furthermore, if one

is willing to contemplate a large scale attack on the exercise of monopoly or oligopoly power in the economy, it is not usually because one thinks that the prices and terms that result from perfect competition are somehow a priori the "right" ones. If the economic system is unjust (and I think it is), it is not because it operates through imperfect markets, but because the distribution of welfare, power and access to enlightenment is skewed by the class system, race and sex. If compulsory terms are desirable, it is because of their impact on these substantive inequalities, not because they "rectify unequal bp."

iii. The notion that a good is a "necessity" and that buyers of it therefore have less bargaining power than sellers has no more than a grain of truth to it, even assuming that we can come up with a meaningful definition of what goods are necessities. If the market for the necessity is competitive, then the price and terms are determined by the mutual pressure of supply and demand, on the basis of the preexisting distribution of income. If there are only a few sellers, then they may be able to charge higher prices than they could if there were many sellers. Food, shelter and clothing are no different in this respect than other commodities like yachts or ostrich feathers. When people say that bargaining power is unequal "because the commodity is a necessity," they usually mean something like "the poor should have more money so they could buy more of this kind of commodity, since they really need it badly." Or they might mean, "sellers ought to sell necessities to buyers at lower prices than prevail in the existing market, and on good terms, because sellers as a class are better off than buyers and should share some of their wealth with them." Once again, the real objection is to the underlying distribution of income, and the "necessities" rubric is just a way to make a fundamental attack into a limited and superficial one.

iv. The final notion is that of just price and fair terms. It is very hard to figure out what people mean by just or "natural" prices and terms. The notion is often invoked in response to a "shortage" producing an "artificially inflated" or "extortionary" price. In this context, it is sometimes meaningful to argue against a price on the ground that sellers have a moral obligation not to take advantage of "temporary" variations in supply and demand. Rather, according to this notion, they should devise some non-price method for rationing the short good, keeping prices steady until "normal" conditions return. I tend to favor this idea, but on income distribution

grounds: the sellers have no particular claim to get rich when everyone else is getting poorer, and poor buyers should not suffer more than rich ones from market fluctuations. But this is an income distribution argument about equity between social classes during periods of retrenchment, and should be acknowledged as such. Another aspect of the just price notion is that certain groups have a claim to maintenance of their old welfare positions when changes in technology or tastes threaten to reduce their wealth permanently. They have a right to a particular level of income, and that demand gets put in terms of a "just price for farm products," or a "fair return for labor," or "shelter at prices all can afford," or "food prices are outrageous." It seems to me simply a mistake to think the real issue is the price or terms in question: the real issue is income distribution, and particularly the distribution of income <u>losses</u> between relatively richer and poorer groups in the population.

v. The concept of bargaining power is perfectly intelligible when it is used to make comparisons <u>between buyers</u> or <u>between sellers</u>. One can say that a starving person dealing with a monopolost has less bargaining power, if the issue is food, than a middle class buyer in a perfectly competitive grain market. Or that a non-English speaking immigrant who does not understand the market is more likely than the "average citizen" to be ripped off the first time they rent an apartment. Or that a motorist in a broken down car on a Sunday night on an interstate has less bargaining power vis-a-vis a towing service than the same motorist on a weekday in a built up suburb. But none of this has to do with equality <u>between</u> buyer and seller, which seems to me a meaningless notion.

vi. The argument from inequality of bargaining power is nonetheless enormously popular, since it makes it sound as though there is a "neutral" standard for deciding when we can intervene with compulsory terms to help one party at the expense of the other. Liberal judges want to be able to impose compulsory terms in favor of some buyers at the expense of some sellers without having to attack the whole economic system, and without being accused of being radicals. The inequality formula sounds as though it will apply in some cases and not in others, and it sounds as though it identifies cases where any right-thinking person would want to help out the weaker party. But, in fact, if you take it seriously, it just means that the judge is free to try to redistribute income from some people to other people, on the ground that the existing distribution is unfair.

b. The redistribution of income and wealth from one group in the population to another. This is a perfectly intelligible goal (unlike "equalization of bargaining power"), and it is possible to accomplish it, in some situations and to some extent, by the insertion of compulsory terms into bargains. But if one wants to justify a compulsory term on the ground that it redistributes income in a desirable way, it is necessary to first establish the following:

i. that the actual effect of imposing a compulsory term will be to redistribute income (the problems of "pass along", forcing people out of the market, and forcing people to buy goods that they don't want to spend their already limited income on).

ii. That redistribution between the groups involved in the transaction is in fact "desirable."

iii. That there is no better way to accomplish the redistributional goal.

D. Objections to Interference with Freedom of Contract

1. The Transaction Costs Argument: The objection to interfering with freedom of contract in order to force the parties to make the agreement they would have made absent transaction costs is "wrong on the facts."

a. This objection sometimes takes the strong form of asserting that it is simply impossible to determine what the parties "would have" agreed to: the only valid evidence of people's preferences is what they do with their money in the market, and all other methods smack of paternalism.

b. A weak form is that it is impossibly difficult to make such calculations in practice, so judges should stay out of it for reasons of formal realizability.

c. A third, tricky form, is to offer a substantive justification of the choices actually made--arguing either that transaction costs did not in fact impede bargaining, or that bargaining ould have produced exactly the same result as actually occurred.

2. Paternalism: It is important to distinguish four different objections to judicial paternalism.

a. The "philosophical objection:" It is "meaningless" to speak of a person being better off as a result of being forced to choose something they didn't want. The only meaningful criterion of better offness is what people choose freely. Compulsory terms reflect the desires of those who impose them, and have nothing to do with the welfare of those they supposedly "benefit."

b. The "rights objection": People have a right to choose anything they want to, as long as the choice doesn't injure others. It makes sense to invalidate the transactions of infants, the insane, and people under duress because they lack free will. But if a person suffers from no such incapacity, it is a fundamental principle of a free society that a person should be allowed to make wrong choices without state interference (this is what I have been calling the "self-determination" argument.)

c. The formal realizability objection: Although it may be true that poeple sometimes make the wrong choices, it is dangerous and impractical to give judges power to correct them. It is better to take the chance that people will often choose wrong than to take the chance that judges will abuse their power and arbitrarily impose their values on others, as well as embroiling the legal system in a hopelessly uncertain morass of vague arguments about what is "really in the consumers' best interest."

d. The institutional competence objection: It may be be valid to correct peoples' choices by imposing compulsory terms, but judges are the wrong people to do it. They are appointed not elected, their role is to apply law, not to make it, and they lack the information and the enforcement resources that would be necessary to make this kind of decision in a rational way.

3. The Redistribution of Income: There are two different sets of objections to judicial imposition of compulsory terms, depending on whether the opponent is a conservative or a liberal.

a. Conservative objections:

i. "Long term social welfare objection": This is an objection to redistribution from rich to poor "on the merits." The claim is that over the long run the poor will be worse off if they despoil the rich, because the only way to make everyone better off is to accelerate economic development, and economic development is dependent on (1) a high rate of saving and investment, which the rich accomplish and the poor do not, and (2) stimulation of innovation and effort by giving high rewards to those who make the greatest contributions to economic welfare--riches in our society are the reward for high contribution, and if you want the high contributions, which benefit everyone, then you have to put up with the inequalities and the short term low standard of living of those at the bottom.

ii. The rights objection: People come by property in some lawful way (gift, inheritance, creating it through their own labor, paying someone else to create it, or buying it from someone). It is

then legally theirs.[9] Someone approaches them and wants to buy it from them. The owner is not legally obliged to sell. No matter how badly the potential purchaser needs or wants it, the legal system puts no obligation on the owner to help the other person for free (no duty to act). The buyer makes an offer, without the owner exercising any compulsion. The buyer is neither an infant nor a lunatic. The owner would rather have the money offered than the property, and the buyer would rather have the object than the money. Can't we say that the owner has a right to accept the offer, take the money and part with the property? And if the owner has a right to sell for whatever price the buyer offers, how can anyone object to the owner selling on whatever contract terms he and the buyer agree on? It may be that the seller is richer than the buyer, but all that means is that through lawful means the seller has accumulated more property. Trying to equalize them by controlling their contracts violates both their rights: the sellers lose their right to sell on any terms they want to, and the buyers lose their right to buy on any terms they want to. The result for the buyers is that some of them will be forcibly prevented from making the purchase they wanted to, and will have to buy something they wanted less. In the name of redistribution, each has been deprived of his rights.

iii. The formal realizability objection: Both the standard of inequality of bargaining power, and the general goal of redistributing income in a desirable direction, are hopelessly vague. If judges try to apply them, there will be opportunity for every kind of arbitrariness and judicial tyranny masquerading as "law." Moreover, the uncertainty generated by knowing that your transactions may be interfered with arbitrarily will discourage all kinds of individual effort and enterprise, and will reduce the pace of economic activity, making everyone worse off than they would have been had we been willing to tolerate a certain amount of social injustice in exchange for a climate favorable to productive effort.

iv. The institutional competence objection: It may be perfectly legitimate for the legislature, democratically elected, to pass law designed to redistribute income and wealth. That is at least part of the goal of the tax system, the labor laws, the antitrust laws, the welfare system, and a host of programs supposed to "equalize" the regions of the country. But it is a completely different matter for judges to do this. Nothing could be more clearly a "political" as opposed to a "legal" question than the distribution of income. And no task is less suited to being accomplished through individual lawsuits based on facts of particular cases. It's not just that it violates the separation

of powers and the elementary principles of democracy. It's also that the judges will make a hopeless botch of it.

b. Depressed liberal objections:

i. Courtroom victories have little impact on the real world. Consumers are generally unaware of their rights and/or too poor and disorganized to exercise them effectively. Enforcement costs are so great that the rights are merely theoretical.

ii. Insomuch as income is redistributed, it is from the poor to the middle class, who are the only ones for whom the new obligations have any meaning, (pass along, forced out of the market, etc.).

iii. Corporations do not equal "the rich," and corporate power is not in any way dependent on control of contract terms. It is ridiculous to think that the overall distribution of income in this country or the total power of corporations have been even slightly modified by the rise of judicial consumer protection.

iv. The minute judicial activity poses a real threat to corporate interests, those interests simply roll back the court decisions in the state legislatures. The judicial reform movement will be tolerated only so long as it remains practically insignificant.

v. While it remains insignificant, there is every reason for the rich and the corporate powers to tolerate it, since it diverts activist energies into a dead end and gives people a powerful illusion that "the public interest" is winning victories over the "vested interests" when in fact nothing is happening.

vi. The main impact of consumerism has been to create legal complexities and a regulatory morass which large corporations can handle relatively easily, but which make it increasingly difficult for small or new businesses to survive in the market. The overall effect is to shut down opportunities for the lower middle class, reduce the overall level of competition in the economy, increase the power of large economic units, and put consumers even more completely at the mercy of the giants than they were to begin with.

SECOND OUTLINE: THE CHOICE BETWEEN NEGLIGENCE AND STRICT LIABILITY IN COMPULSORY TERMS

There are two issues:

the level of investment in safety

what happens to accident losses that occur in spite of investment in safety

The background question is: what would happen if we imposed no duties at all on sellers to buyers for injuries caused by products or services? That is, what would happen under caveat emptor?

The first step is to imagine a totally unrealistic situation in which buyers and sellers have total knowledge of all risks and all consequences, and in which there are no impediments to bargaining to an individualized transaction in every case.

In such a situation, buyers would offer some increase in the base price of the commodity in exchange for particular investments in safety, and they would also be willing to pay something for insurance through the price against injuries that occur in spite of investment in safety.

Sellers might or might not be willing to provide the services of investment in safety and insurance against accidents at a price consumers were willing to pay. If no bargains about safety and insurance were struck, we could conclude that the services were not worth to consumers that it would have cost sellers to provide them.

The bargains that were struck or not struck about accidents would reflect the buyers' risk preferences. In other words, if buyers were aware of a risk, say a 10% risk of a $100 accident, which could be prevented by a precaution that would cost only $5, they might or might not be willing to pay the $5 to get the seller to take the precaution. They might prefer $5 in hand to a 10% chance of avoiding a $100 loss. If that were the case, then they would be "risk preferers." On the other hand, buyers might be willing to pay $12 in advance to avoid a 10% chance of a $100 injury, in which case they would be "risk averse."

The same analysis applies to bargains about compensation for accidents occurring in spite of the taking of precautions. Some buyers would not want insurance even if the premiums paid in advance were sure to be less than the compensation received for injury to them. Others would buy the insurance even if the premiums were very likely to be more than the cost of the injury.

There is another reason than risk preference why buyers might be unwilling to bribe sellers to take precautions or provide insurance: buyers might feel that they could achieve the same benefits on their own at less cost. For example,

they might calculate that a product was dangerous to most people because most people are ignorant and careless,.but not dangerous to them because they were knowledgeable and careful and knew how to use it safely. Or they might prefer not to buy insurance from the seller because they could get their own personal injury and lost wages insurance for less than it would cost to buy it from the seller. Or they might be confident that if injured they would be compensated from other sources, such as family members or social insurance or charity.

In short, if there were no duties at all on the seller--caveat emptor--and there were a world of perfect information and costless bargaining, the bargains struck would reflect the particular tastes and particular alternatives of buyers. No buyer would have to buy a level of protection higher than he wanted.

There are two reasons why one might favor interference with this free contractual outcome, even maintaining the assumption of perfect information and costless bargaining, these being the general reasons discussed in the first outline: paternalism, and the desire to redistribute income from sellers to buyers, or among buyers.

Paternalism justifies nondisclaimable negligence liability for the seller on the ground that the buyer's risk preference is "not in his best interest." If we think buyers will not voluntarily contract with sellers to have the sellers exercise due care, or that buyers will only pay sellers for obvious or very cheap precautions, then we may feel that buyers would be better off if we forced them to pay for the level of precautions that judges and juries think amount to due care.

Redistribution justifies a nondisclaimable negligence duty on sellers if we think the shape of supply and demand curves is such that sellers will end up taking the precautions and passing on less than their full cost in price increases. But we have to take account of buyers forced out of the market, and of the impact on marginal sellers.

But it is important that a negligence duty will not have any impact on consumer choices about insurance to cover the losses from those accidents that occur even after sellers have been forced to exercise due care. The negligence term leaves consumers free to pay sellers a premium for insurance against these losses, or to choose to buy insurance elsewhere, or not to insure at all and take the chance that they won't be injured, or that their injuries will be compensated from other sources.