



SCHOOL OF LAW
TEXAS A&M UNIVERSITY

Texas A&M University School of Law
Texas A&M Law Scholarship

Faculty Scholarship

11-1999

Regulating Through Information: Disclosure Laws and American Health Care

William M. Sage

Follow this and additional works at: <https://scholarship.law.tamu.edu/facscholar>



Part of the [Administrative Law Commons](#), and the [Health Law and Policy Commons](#)

REGULATING THROUGH INFORMATION: DISCLOSURE LAWS AND AMERICAN HEALTH CARE

*William M. Sage**

Efforts to reform the American health care system through direct government action have failed repeatedly. Nonetheless, an alternative strategy has emerged from these experiences: requiring insurance organizations and health care providers to disclose information to the public. In this Article, Professor Sage assesses the justifications for this type of regulation and its prospects. In particular, he identifies and analyzes four distinct rationales for disclosure. He finds that the most commonly articulated goal of mandatory disclosure laws—improving the efficiency of private purchasing decisions by giving purchasers complete information about price and quality—is the most complicated operationally. The other justifications—which he respectively terms the agency, performance, and democratic rationales—hold greater promise, but make different, sometimes conflicting assumptions about the sources and uses of information. These insights have implications not only for health care, but also for other regulated practices and industries.

TABLE OF CONTENTS

INTRODUCTION	1702
I. THE COMPETITION RATIONALE: BUYING HEALTH CARE	
WISELY THROUGH DISCLOSURE	1713
A. Promise and Reality in Health Care Competition	1713
B. Competitively Motivated Disclosure Laws	1715
C. The Limited Potential of the Competition Rationale ..	1720
1. Feasibility Barriers to Competitive Disclosure	1721
a. Costs of Compliance	1721
b. Diversity	1723
c. Accuracy	1725
2. Effectiveness Barriers to Disclosure	1728
a. Health Literacy	1728
b. Irrationality	1729
c. Limited Choice	1731
d. Anticompetitive Risks	1733
D. Salvaging the Competition Rationale	1736
1. Information Intermediaries	1737
2. Standardization	1741

* Associate Professor of Law, Columbia University. A.B., Harvard College, 1982; M.D., J.D., Stanford University, 1988. The author thanks David Anderson and Rachel Izower for research assistance. Thanks are also due to Anne Alstott, Richard Briffault, John Coffee, Michael Dorf, Daniel Fox, Victor Goldberg, Jeffrey Gordon, Mark Hall, Peter Hammer, Bradley Karkkainen, Rogan Kersh, Jack Knott, Louis Lowenstein, John Manning, Theodore Marmor, Jerry Mashaw, Tracy Miller, Henry Monaghan, Arti Rai, Marc Rodwin, and Charles Sabel, as well as to participants in workshops sponsored by the Milbank Memorial Fund, the University of Michigan, and Yale University.

II. THE AGENCY RATIONALE: MONITORING INTERMEDIARIES THROUGH DISCLOSURE	1743
A. Agency Relationships in Health Care	1743
B. Agency-Related Disclosure Obligations	1746
C. Ambiguities in the Agency Rationale	1752
1. Individual Versus Collective Agency Obligations ..	1752
2. Fiduciary Contracting and Consent	1757
3. Trust	1762
D. Clarifying the Agency Rationale	1764
1. Asserting Legal Rights	1764
2. Therapeutic Disclosure and Professionalism	1767
III. THE PERFORMANCE RATIONALE: IMPROVING HEALTH SYSTEM PRODUCTIVITY THROUGH DISCLOSURE	1771
A. Information Deficits in Health Care	1771
B. Challenges for Performance-Based Disclosure	1780
1. The Role of Government	1781
a. Selectivity and Goal-Setting	1781
b. Effect on Market Structure	1783
c. Privacy	1784
d. Influencing Demand	1786
2. Competition and Performance	1789
a. Business Confidentiality	1790
b. Content and Access	1792
C. Strengthening the Performance Rationale	1796
IV. THE DEMOCRATIC RATIONALE: IMPROVING PUBLIC DELIBERATION THROUGH DISCLOSURE	1801
A. Information, Public Accountability, and the Common Good	1801
B. Contours of the Democratic Rationale	1806
1. Information and Popular Consent	1807
a. Public Spending	1807
b. Rationing	1810
2. Information and Education	1814
C. Circumscribing Democratic Disclosure	1819
1. Honest Broker, Leader, or Propagandist	1819
2. Enforcement and Equal Protection	1821
CONCLUSION	1825

INTRODUCTION

In many ways, the U.S. health care system is a victim of its own success. America has the best medical care in the world, but far from the best health. While the technical accomplishments of American medical science are unparalleled, the United States trails most developed countries in life expectancy, infant mortality, and years of life lost to preventa-

ble causes.¹ Moreover, even the benefits of technology are distributed unevenly. Although the cost of health care in 1997 surpassed \$1 trillion, almost half of it taxpayer money, one-sixth of the American population remained uninsured.²

This situation reflects the fact that health care has become too costly and important an attribute of citizenship to leave to purely private means, yet at the same time is too intimate and complicated to administer publicly. The American electorate has not determined how best to balance the rights and desires of individuals against the needs and constraints of the collective, or whether hard decisions should be made by government, the marketplace, or some combination of the two. History reveals many swings of the political pendulum. The United States flirted with national health insurance first in Theodore Roosevelt's time, again with FDR's New Deal, under Truman after World War II, as part of Johnson's Great Society, and during the Nixon and Carter Administrations. Each time reform faltered for want of political will, leaving the system to decentralized professional control.³ In the early 1990s, following several decades of unconstrained investment in private health care delivery through employment-based health insurance and stop-gap government entitlements, seemingly inexorable cost increases, coupled with economic uncertainty, rekindled interest in a comprehensive restructuring of the health care system.

Once again, however, the coalition supporting radical change proved evanescent, and the Clinton Administration's 1993 health reform plan succumbed to diminishing urgency, ideological division, and distributional in-fighting. In particular, a uniform national entitlement to health insurance came to be perceived as sacrifice rather than security, not only calling for increased financial contributions but threatening unacceptable constraints on individual choice and self-determination.⁴ Ironically, the vehemence with which government-led reform was rejected loosened the reins on the private sector to "manage" care and expense, accelerating the integration of insurance financing with health care delivery and the consolidation of fragmented professionals and facil-

1. See Gerard F. Anderson & Jean-Pierre Poullier, *Health Spending, Access, and Outcomes: Trends in Industrialized Countries*, *Health Aff.*, May-June 1999, at 178, 188-90.

2. See Katharine Levit et al., *National Health Expenditures in 1997: More Slow Growth*, *Health Aff.*, Nov.-Dec. 1998, at 99. Despite piecemeal legislation to improve private insurance portability and increase coverage for children, as well as a booming economy and low unemployment, the number of uninsured has risen from 37 million to 41 million since 1992. See Robert Pear, *Government Lags in Steps to Widen Health Coverage*, *N.Y. Times*, Aug. 9, 1998, at A1.

3. See generally Paul Starr, *The Social Transformation of American Medicine* 243-419 (1982) (discussing these proposals and their historical background).

4. See, e.g., H. Richard Beresford, *The Health Security Act: Coercion and Distrust for the Market*, 79 *Cornell L. Rev.* 1405, 1411, 1423 (1994) (arguing for a less intrusive government role).

ities into large business organizations.⁵ Not surprisingly, corporate intrusion into health care decisions turned out to be as unpalatable as government intervention, prompting the current backlash against managed care and renewing interest in preserving professional ideals through regulation.⁶ Rather than asserting an alternative paradigm, this most recent upheaval is searching for a way to *manage* managed care—to control cost and maintain access without leaving life-and-death decisions to executives and accountants.

Given this tortured history and ambitious agenda, it should come as no surprise that the terms of the current regulatory resurgence are unsettled. Not only are the goals of regulation ill-defined, but public attitudes toward government are ambivalent at best. Nonetheless, one regulatory strategy has emerged as a favored approach of disparate constituencies: expanding the amount of information about the health care system circulating among consumers, providers, and voters. As a Columbia faculty member, I receive, pursuant to federal and New York law, detailed information about the health plan made available to me as an employee benefit, about the hospitals and physicians whose services I might utilize if I become ill, and about the treatments that I might be offered.⁷ Some of these legal mandates fall on private employers, others on insurance companies and health maintenance organizations (HMOs), and still others on health care facilities and professionals. Few existed thirty years ago, and a large percentage have been adopted since 1990.

Today's disclosure laws derive from four historical strands that have shaped the regulatory environment for health care information, albeit not necessarily in identical or consistent ways. First, the size, scope and social importance of the health care system had by the 1970s broadened the notion of medical research from biological science and clinical or epidemiological applications to include analysis of health care financing and delivery using methodologies drawn from economics and the social sciences. This new discipline, called "health services research," is highly

5. For purposes of this Article, it is sufficient to define managed care as any system of health coverage in which the entity responsible for paying for covered services exercises control over the manner in which those services are delivered. Because physicians' clinical decisions generate the majority of health care costs, managed care primarily involves supervising or influencing physicians. Most care management is accomplished using one or more of four basic mechanisms: financial incentives, direct review of service utilization, structural features that affect the availability of services, and the normative environment in which physicians work. See Bruce E. Landon et al., *A Conceptual Model of the Effects of Health Care Organizations on the Quality of Medical Care*, 279 *JAMA* 1377, 1378-79 (1998).

6. There is a growing literature on the managed care backlash, its causes, and solutions. See, e.g., Robert J. Blendon et al., *Understanding the Managed Care Backlash*, *Health Aff.*, July-Aug. 1998, at 80; Alain C. Enthoven & Sara J. Singer, *The Managed Care Backlash and the Task Force in California*, *Health Aff.*, July-Aug. 1998, at 95.

7. See, e.g., 29 U.S.C. §§ 1021-1022 (1994); N.Y. Pub. Health Law § 4408 (McKinney 1985 & Supp. 1999).

sensitive to the need for comprehensive, reliable data to support the pursuit of systemic rather than molecular or organismic knowledge.

Second, the birth of bioethics as a scholarly field in the 1960s reflected a growing commitment to patient autonomy and self-determination as guiding principles for clinical medicine. While the physical sciences were confronting the social dangers of nuclear technology, medicine faced its own technologic imperative and was forced to consider for the first time whether the social value of innovation matched its scientific interest. Participatory decisionmaking requires better communication between doctor and patient, with fuller sharing of clinical information than was the case in earlier, more paternalistic times. The law gave force to this movement by developing a coherent doctrine of "informed consent" out of ancient notions of freedom from unwanted physical contact.⁸ Similarly, patients' wishes regarding end-of-life decisions can be honored only if they are based on accurate information and are conveyed clearly to caregivers.⁹ These developments combined with new sympathy for victims of mental illness and other captive patient groups to widen

8. The doctrine of informed consent remains the paradigmatic example of information-based regulation in health care. An outgrowth of common law battery, which prohibits physical contact without permission, informed consent has evolved into a professional responsibility to apprise patients of the risks, benefits, and alternatives to medical treatment. See Tom L. Beauchamp, *Informed Consent*, in *Medical Ethics* 185, 186-90 (Robert M. Veatch ed., 1989); see also Ruth R. Faden & Tom L. Beauchamp, *A History and Theory of Informed Consent* 114-43 (1986); Stephen Wear, *Informed Consent: Patient Autonomy and Physician Beneficence Within Clinical Medicine* 5-21 (1993); Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients From Their Physicians*, 55 *U. Pitt. L. Rev.* 291, 342-47 (1994). Because of technical complexity, patient vulnerability, and the power of physicians to persuade, it is unclear whether informed consent represents true empowerment or merely the illusion of self-determination. Nonetheless, medical ethics emphasizes information disclosure as a foundational element of the physician-patient relationship. See Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (1998) (discussing the limits of autonomy, including the relationship between information and autonomy).

9. For example, autonomy concerns led to the passage of the Patient Self-Determination Act (PSDA), 42 U.S.C. § 1395cc(f) (1994), which grew out of the Supreme Court's decision in the *Cruzan* case to allow heightened evidentiary requirements for withholding or withdrawing life-sustaining treatment. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 280-84 (1990). The PSDA requires hospitals, skilled nursing facilities and home health agencies to provide written information to patients concerning

an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives . . . and . . . the written policies of the provider or organization respecting the implementation of such rights.

42 U.S.C. § 1395cc(f)(1)(A) (1994). See also Elizabeth H. Bradley & John A. Rizzo, *Public Information and Private Search: Evaluating the Patient Self-Determination Act*, 24 *J. Health Pol., Pol'y & L.* 239, 262-67 (1999) (arguing that the PSDA has improved documentation of patients' wishes by reducing search costs for information).

institutional disclosure requirements as well, resulting in measures such as the now ubiquitous "Patients' Bill of Rights."¹⁰

The third strand is the ascendancy of market processes as a means of controlling health care costs. The stirrings of competition in health care coincided with a more general consumer movement in American society, in which both "caveat emptor" and consumer protection legislation were meaningless without information. To some degree, the rise of health care competition also drew strength from the parallel assertion of patient autonomy. An important corollary to giving patients greater control is taking control away from the medical profession. Buoyed by the anti-establishment movements of the 1960s, new generations of active consumers began to look outside of the medical mainstream for promising therapies.¹¹ For physicians, moreover, having to give patients direct explanations of risks and benefits meant relinquishing exclusive professional dominion over practice.

Even physicians who accepted the notion of patient self-determination continued to resist interference by third parties. Nonetheless, once physicians had become reviewable through data rather than through the confidential opinions of their peers, the genie was out of the bottle. When health care costs continued to rise despite economic recession and ballooning deficits in the late 1970s and early 1980s, other constituencies—such as employers, purchasers, and government—began to hold physicians accountable for their costs and results.¹² Information became a critical need for health care purchasers, financing intermediaries, and

10. Health facilities, such as hospitals, generally have a responsibility to provide accurate information to patients regarding their care, apart from the informed consent process. Prompted by concerns in the 1970s about the vulnerability and potential lack of autonomy of hospitalized patients, federal and state law, as well as private accreditation standards, requires hospitals to post and observe "Patients' Bills of Rights," including the right to be informed about proposed treatments. New York, for example, requires hospitals to post a "statement of rights and responsibilities . . . conspicuously in a public place . . ." N.Y. Pub. Health Law § 2803-c(1) (McKinney 1993). The same provision enumerates the "rights and responsibilities" to which patients are entitled. *Id.* § 2803-c(3). See also N.Y. Pub. Health Law § 206(1)(r) (McKinney Supp. 1999) (mandating that all hospitalized patients receive a booklet upon admission explaining their rights). Nursing homes must meet similar requirements regarding residents' rights. See Omnibus Budget Reconciliation Act of 1987, 42 U.S.C. §§ 1395i-3(c)(1)(B), 1396r(d)(6) (1994).

11. See Kathleen M. Boozang, *Western Medicine Opens the Door to Alternative Medicine*, 24 *Am. J.L. & Med.* 185, 199-200 (1998).

12. Many would argue that this is a good development, noting that physician control has not been an unqualified success. See Barry R. Furrow, *Doctors' Dirty Little Secrets: The Dark Side of Medical Privacy*, 37 *Washburn L.J.* 283 (1998). Some have even suggested that there cannot be autonomy without accountability. See Lee N. Newcomer, *Physician, Measure Thyself*, *Health Aff.*, July-Aug. 1998, at 32, 35. There are tradeoffs, of course. For example, although physicians can no longer cite the sanctity of the consulting room to deny payers information about their proficiency, patients have sacrificed much of their privacy as a consequence.

service providers.¹³ The interweaving of insurance with health care services reinforced the centrality of information, because insurance markets stood or fell based on the absolute and relative knowledge of insurers and insureds with respect to the likelihood and magnitude of loss.

Although it was widely maligned as "big government," the Clinton Administration's attempt to create a national health entitlement similarly was based on a corporatized vision of health care delivery and a philosophical commitment to market competition. In the Clinton proposal, which relied on community-based purchasing cooperatives (called "health alliances") to help individual beneficiaries choose among competing "health plans," mandatory information disclosure had intuitive appeal. As part of my work with the President's Task Force on Health Care Reform in 1993, for example, I convened discussions of the theory and practice of disclosure between health policymakers and senior officials at the Securities and Exchange Commission (SEC), and began to develop a model for disclosure-based federal regulation of managed care.¹⁴

The final thread in the historical fabric of health care disclosure is a resurgent rhetoric of individualism and self-reliance in American politics, reflecting diminished expectations of government and heightened skepticism regarding public programs and public institutions. With the failure of the Clinton health plan, it became clear that rationalizing the health care system conflicted with "reinventing" (i.e., downsizing) government.¹⁵ As noted above, managed care fed on these emotions, and grew. This left average Americans between a rock and a hard place, since their suspicion of government was matched only by their distaste for concentrated corporate power. In an environment of growing distrust of the market but limited willingness to increase government authority, information is one of the few weapons available with which people can further their own interests.

Enthusiasm for mandatory disclosure laws is reaching fever pitch. Virtually every bill under consideration by Congress to regulate managed care devotes major portions to information disclosure and dissemina-

13. As Furrow observes, "[t]he market for medical care is almost as much a market for information as it is a market for specific services." Furrow, *supra* note 12, at 299; see also Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 *Am. Econ. Rev.* 941, 951-52, 965-66 (1963); Mark V. Pauly, *Is Medical Care Different? Old Questions, New Answers*, 13 *J. Health Pol., Pol'y & L.* 227, 228 (1988).

14. See William M. Sage, *Mandatory Public Disclosure in Managed Care: Lessons From the Securities Industry*, in *Achieving Quality in Managed Care: The Role of Law* (John D. Blum ed., 1997) (ABA Monograph); William M. Sage, *Legal Framework for National Quality Management Program* (1993) (unpublished manuscript, on file with the *Columbia Law Review*). Among other things, introducing a federal regulatory presence based on disclosure would have preserved traditional state-based substantive oversight of insurance and health care delivery, resembling the relationship between federal securities law and state corporate law (including merit review).

15. Readers may recall Bob Dole's shining moment before the cameras, in which he used Perotian diagrams to demonstrate the byzantine complexity of the Clinton health plan.

tion.¹⁶ While debate continues over uniform federal protections for health care consumers, moreover, state legislatures and insurance and HMO regulators are enacting comprehensive disclosure rules.¹⁷ In addition, both the Health Care Financing Administration (HCFA), which oversees the Medicare and Medicaid programs, and the National Committee for Quality Assurance (NCQA), which is the principal accrediting body in managed care, have announced extensive data reporting requirements for health plans.¹⁸ In late 1997, President Clinton's "blue-ribbon" Advisory Commission on Consumer Protection and Quality in

16. The patient protection bill recently passed by the House of Representatives includes lengthy disclosure requirements, although with less connection to measurable performance than several contemporary proposals. See Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, 106th Cong. § 121 (1999). The two leading Republican proposals introduced in 1999 emphasized both consumer disclosure by health plans and development of standards for performance reporting. See Patients' Bill of Rights Plus Act, S. 300, 106th Cong. (1999) (Senate leadership proposal); Patients' Bill of Rights Act, S. 326, 106th Cong. (1999). Democratic measures, while containing additional substantive protections for consumers, were equally enthusiastic about disclosure. See, e.g., S. 6, 106th Cong. §§ 121-123 (1999). Disclosure obligations also constituted a major part of nearly all the managed care reform bills considered by the 105th Congress in 1997 and 1998. See Patients' Bill of Rights Act, S. 2330, 105th Cong. (1998); Patient Protection Act of 1998, H.R. 4250, 105th Cong. (1998); Patients' Bill of Rights Act of 1998, H.R. 3605, 105th Cong. (1998); Health Care QUEST Act, S. 1712, 105th Cong. (1998) (Health Care Quality, Education, Security, and Trust Act); Patient Access to Responsible Care Act of 1997 (PARCA), H.R. 1415, 105th Cong. (1997).

17. Approximately half the states have passed omnibus managed care legislation in the last three years, most including consumer information requirements for managed care plans. See William M. Sage & David Anderson, *Health Care Disclosure Requirements*, in *1997 Health Law Handbook* 185, 188 (Alice G. Gosfield ed., 1997); *States Setting Detailed Quality Standards Rather Than "Legislating by Body Part,"* 7 *Health L. Rep.* (BNA) 1059, 1059-60. In 1996 alone, new laws imposed disclosure requirements on health plans in eleven states. Informational requirements regarding health professionals are also on the rise. See Families USA Foundation, *HMO Consumers at Risk: States to the Rescue* 33-36 (1996).

18. In addition to extensive requirements for consumer-oriented disclosure, the 800-page "MegaReg" governing the new Medicare+Choice program builds on HCFA's ongoing development of a Quality Improvement System for Managed Care (QISMC) by requiring health plans both to possess quality assessment capabilities and to establish and meet performance improvement goals. See 63 *Fed. Reg.* 34,968, 34,991-99 (1998). Each organization must measure and report its performance to HCFA, and eventually must achieve performance levels set by HCFA. HCFA anticipates disclosing this information to beneficiaries, either directly or via electronic media. New regulations governing managed care in Medicaid, the joint federal-state program for needy individuals, also contain extensive disclosure requirements. These implement § 1932 of the Social Security Act, which was added by the Balanced Budget Act of 1997. See *Medicaid Program, Medicaid Managed Care*, 63 *Fed. Reg.* 52,022, 52,029-31 (1998) (to be codified at 42 C.F.R. § 438.10) (proposed Sept. 29, 1998).

On the NCQA standards, see NCQA Compliance Audit Program, (visited Nov. 4, 1999) <<http://www.ncqa.org/pages/policy/hedis/audit/auditex.htm>> (on file with the *Columbia Law Review*); see also John K. Iglehart, *The National Committee for Quality Assurance*, 335 *New Eng. J. Med.* 995, 995-96 (1996). NCQA is also increasingly relied on by government in establishing quality metrics for Medicare and Medicaid managed care.

the Health Care Industry made information disclosure the centerpiece of its "Bill of Rights," which the President subsequently mandated for federal health programs.¹⁹ Government is also providing information directly. The Balanced Budget Act of 1997 (BBA) expressly commanded HCFA to mail information to nearly 40 million Medicare beneficiaries, advising them about the complicated choices they will need to make among health plans under the new Medicare+Choice program.²⁰ Even

19. President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Consumer Bill of Rights and Responsibilities: Report to the President of the United States* (1997). "Information disclosure" was listed first among the eight areas in which the Commission urged the adoption of new consumer rights. The report states: "Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities." *Id.*, Executive Summary. The Commission based a right to information on both economic and ethical grounds, including the need for information to stimulate value-based purchasing and to safeguard individual autonomy in choices that affect life and health. The Commission refined these ideas in its Final Report, which was issued in early 1998. See President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Final Report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry* 73, 74-75 (1998) (recommending (i) identification of core sets of quality measures for standardized reporting by each sector of the health care industry, (ii) development of a framework and capacity for quality measurement and reporting, (iii) broad industry participation in quality measurement, including at the individual practitioner level, (iv) establishment of a public-private mechanism to establish reporting requirements and standards, and (v) widespread availability of comparative information on health care quality). For the President's mandate, see Memorandum on Federal Agency Compliance with the Patient Bill of Rights, 34 *Weekly Comp. Pres. Doc.* 298 (Feb. 20, 1998) (Exec. Memorandum).

20. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251, 278 (adding 42 U.S.C. § 395w-21(d) (Supp. III 1997); 42 C.F.R. § 422.64 (1998) (describing enrollment information to be provided to Medicare+Choice eligible individuals); see also Robin Toner, *Extensive Effort Seeks to Clarify Medicare Maze*, N.Y. Times, Sept. 27, 1999, at A1 (describing outreach campaign). Medicare+Choice, which was added by the BBA as a new "Part C" of the Medicare program, allows beneficiaries to choose among several forms of coverage as alternatives to the traditional, government-administered fee-for-service program. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251, 276-337 (codified at 42 U.S.C. § 1395w21 (Supp. III 1997)). These include HMOs, Provider-Sponsored Organizations (PSOs) in which physicians hold ownership stakes, private fee-for-service plans and medical savings accounts. For an overview and analysis, see Sandra Christensen, *Medicare+Choice Provisions in the Balanced Budget Act of 1997*, Health Aff., July-Aug. 1998, at 224 (arguing that the new Medicare+Choice provisions would expand managed care for Medicare enrollees, but not without added complexity); see also Lynn Etheredge, *The Medicare Reforms of 1997: Headlines You Didn't Read*, 23 *J. Health Pol., Pol'y & L.* 573 (1998) (arguing that Medicare+Choice is a historic compromise between advocates of public and private insurance, but that the program grants excessive power to managed care organizations and underestimates the protection needed by beneficiaries).

The proposed outreach effort is a massive undertaking with an initial budget of \$104 million. Because of the scope and complexity of the mailing, HCFA was forced to revise its timetable, limiting its initial national mailing to basic information, while testing "market specific" handbooks in five states. See HCFA Issues Medicare+Choice Rules, *Concerns Voiced Over Provisions*, 7 *Health L. Rep. (BNA)* 1022, 1022-23 (1998). In mid-1999, the Medicare Payment Advisory Commission released a report that included an extensive

the American Medical Association placed "full disclosure of plan details" at the top of its most recent health reform proposal.²¹ Because these efforts come from a variety of directions, however, scholars and policy-makers have been slow to recognize the trend.²²

Is mandatory disclosure the way to manage managed care? I believe that information-based regulation has tremendous potential, but that both its critics and its supporters have overlooked serious operational issues and misunderstood some of the best uses of information. For example, the President's Quality Commission offered few details with respect to its proposals, and left major questions of governance, legal authority and enforcement to future deliberation. Nor did the Commission explicate the feasibility or logical coherence of an informational regime that could support private purchasing decisions, political judgments about social welfare, and industrial improvement simultaneously.

In particular, current political preferences for market solutions to social problems obscure important roles for information outside of the market paradigm. Depending on its orientation, information disclosure in health care can reinforce individual and collective choices, improve lay decisions and expert judgments, and support relationships between patients and both private agents and political representatives. However, disclosure cannot accomplish everything, and it may not do anything effectively unless it is properly designed and implemented. Absent recognition and resolution of these issues, the apparent consensus that prevails as to the desirability of information may devolve into confusion and discord, wasting a precious chance to improve the health care system on politically acceptable terms.

This Article attempts to bring much-needed focus to the debate by identifying and critiquing distinct but interrelated rationales for mandatory disclosure laws in health care. First, disclosure can promote competitive provision of health insurance and medical services given longstanding problems of asymmetric information affecting patients and purchasers. This function of information, which the Article terms the "competition rationale," serves goals of transactional and allocative effi-

discussion of beneficiary choice and information. See Medicare Payment Advisory Commission, Report to the Congress: Selected Medicare Issues 57-76 (1999).

21. See Patients' Bill of Rights: Do It Right, *Am. Med. News*, Aug. 10, 1998, at 15.

22. Several commentators have discussed disclosure in passing when considering the larger landscape of managed care regulation. See, e.g., Mark Hall, Making Medical Spending Decisions: The Law, Ethics, and Economics of Rationing Mechanisms 177-82, 193-227 (1997); Clark C. Havighurst, Health Care Choices: Private Contracts as Instruments of Health Reform 185-90, 208-09, 283-84 (1995); Walter A. Zelman, The Changing Health Care Marketplace: Private Ventures, Public Interests 249-56 (1996); Marc A. Rodwin, Managed Care and Consumer Protection: What Are the Issues?, 26 *Seton Hall L. Rev.* 1007, 1017-18, 1032-35 (1996). For a more detailed discussion, see Sage & Anderson, *supra* note 17. Not until this year did managed care disclosure become the subject of intensive policy debate. See Conference Report, Disclosure in Managed Care (1999) (describing a workshop hosted by the California Medical Foundation).

ciency. Second, disclosure can strengthen agency relationships and enforce fiduciary obligations involving both individual health professionals and collective organizations such as health plans. In this regard, which the Article calls the "agency rationale," information both supports efficient decisionmaking and conveys non-economic values such as respect for persons. Third, disclosure can overcome incomplete information resulting from structural barriers to learning and inadequate incentives to generate public goods, and thereby can improve the dynamic performance of the health care system. This function, which the Article labels the "performance rationale," recognizes the relationship between industrial structure and information, and captures the role of information in productive efficiency. Fourth, disclosure can increase public awareness and political accountability regarding scarce resources and the rights and obligations of citizens. In this respect, the "democratic rationale," information potentially reinforces social solidarity and fosters distributive justice.

This analytic framework is valuable because it reveals complexities within each category and conflicts among them. Most importantly, the presumed beneficial effect on competition that has motivated today's cresting wave of health care disclosure laws turns out to be limited by significant operational barriers. Moreover, informed consumerism is incomplete as a normative model for health care because fiduciary responsibilities of intermediaries such as physicians traditionally have been defined apart from economic considerations or a contractual framework.²³ At the same time, however, sizeable social subsidies for health care reintroduce the need for information to support public financial judgments in addition to private ones. These decisions must be made through political rather than market mechanisms. By distinguishing market freedom from political freedom, and individual responsibility from collective responsibility, the Article's taxonomy also enables readers to tease apart the varied roles of information in furthering personal autonomy, rather than subsuming them within a general "right to know."

The preconditions to achieving particular goals through disclosure are in tension with one another in three major respects. First, effective disclosure to promote competition requires still greater dependence on intermediaries, increasing the burden on disclosure to monitor such transactions and highlighting the uncertain status of agency relationships in health care. Second, the competition rationale and the performance rationale make opposite assumptions about the instrumentalism associated with disclosure-based oversight, the former honoring consumer sovereignty and the latter targeting pre-selected objectives. Third, the democratic rationale for disclosure emphasizes holding government accountable to the public, while the other rationales assume the integrity

23. At the extreme, if medical treatment is determined by objective scientific need, not subjective market preferences, "consumer" becomes an inappropriate label for users of health care services. See Sherry Glied, *Chronic Condition: Why Health Reform Fails* 17-35 (1997) (describing the debate between "marketists" and "medicalists").

of public institutions, and in fact rely on government to serve as an honest broker of information.

Careful analysis of mandatory information disclosure can shed light on several pressing problems confronting the American health care system as it assesses its historical development and searches for an appropriate balance among professional direction, market discipline, and social control. These include the utility of linking health coverage to employment,²⁴ the compatibility of contractual freedom with health care decisions, and the relationship between individual health entitlements and collective resources. Within the fabric of these policy choices runs a common thread of medical professionalism and ethics, for which contemporary health care presents enormous challenges. Abject reliance by patients on physician devotion and expertise has evolved uneasily into self-determination, medical science has burgeoned in cost and complexity, and cash-on-the-barrel payment and provider charity have given way to private insurance pooling and public subsidies. Most significantly, corporate entities and institutional networks are supplanting individual professionals as the dominant unit of production for health care services. Whether information-based regulation can cushion the impact of these dislocations and facilitate the transition to a new equilibrium—and a new professionalism—is a central question for its proponents.

The Article represents the first attempt to untangle these issues, to prioritize goals and suggest tradeoffs, and to transform mandatory disclosure into a coherent regulatory strategy for the health care system. In so doing, it touches on problems whose implications extend beyond health care. Indeed, health care disclosure exemplifies the concept of “government as facilitator” that underlies decentralized alternatives to substantive regulation in many industries. The principal challenge of these approaches is to take advantage of speed and flexibility without sacrificing essential procedural and political safeguards. By addressing these issues in health care, the Article establishes a reference point for future comparative research. Lessons from health care that should be generalizable to other activities include how to implement and enforce mandatory disclosure laws, and how such laws relate to industry structure, the pace of industry change, and the co-existence of other legal and regulatory regimes.

24. In 1997, 64.2% of non-elderly Americans received health insurance from their employers, accounting for nearly 90% of privately insured individuals. See Robert Kuttner, *The American Health Care System: Employer-Sponsored Health Coverage*, 340 *New Eng. J. Med.* 248, 248 (1999). America's employment-based health care system merits much more discussion than is possible in this Article. For a critical view, see Uwe E. Reinhardt, *Employer-Based Health Insurance: R.I.P.*, in *The Future U.S. Health Care System: Who Will Care for the Poor and Uninsured?* 325–52 (Stuart H. Altman et al. eds., 1998).

I. THE COMPETITION RATIONALE: BUYING HEALTH CARE WISELY
THROUGH DISCLOSURE

A. *Promise and Reality in Health Care Competition*

The last two decades have witnessed an extraordinary shift toward reliance on competitive forces to reshape the American health care system, which previously had been characterized by professional decision-making, consumer deference, and price-insensitive insurance payment. As with most radical change that occurs in a generally conservative political system, this shift represents a confluence of forces, some planned and some serendipitous. Chief among them has been a rapid rise in the cost of health care, itself the result of far-flung factors: the emergence of private and public health insurance; technologic advances; government subsidies for insurance purchasing, capital investment, and professional education; changing patient preferences; population growth and aging; and expanded liability. Whatever its cause, health care spending rose from 5.1% to 13.5% of GDP between 1960 and 1997, and currently exceeds one trillion dollars annually.²⁵

Increasing overall national prosperity notwithstanding, cost growth has coincided with the imposition of fiscal constraints on the two largest sources of health care funding: private employers and government. Big business, whose sponsorship of health insurance was the largely fortuitous result of wartime wage freezes and postwar tax policies, by 1980 found itself beset by steeply rising insurance rates resulting from an aging workforce, a growing retiree population, and generous union-negotiated benefits, while increased foreign competition, oil shocks and domestic inflation sapped its economic reserves. In this same environment, government encountered resistance to both taxation and to deficit spending, particularly when economic downturns expanded the numbers of beneficiaries eligible for health care entitlements and reduced the revenue base available to support them.

Concurrently, both of these groups stumbled upon unanticipated avenues for asserting control over expenditures by restructuring insurance and influencing the services provided by physicians and hospitals. For private companies, the passage of ERISA created a federal legal shelter that allowed self-funded employers to escape substantive state regulation of health-related benefits.²⁶ Corporate benefit managers therefore found themselves able to design coverage and organize health care delivery in

25. See Levit et al., *supra* note 2, at 99, 100.

26. See Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1994). ERISA was primarily intended to safeguard worker pensions by imposing fiduciary duties and reporting requirements on plan trustees. The extent to which Congress intended to make major changes to welfare benefits such as health insurance is debatable. Nonetheless, the law includes a broad preemption provision, 29 U.S.C. § 1144(a) (1994), that has limited state regulation of ERISA plans without substituting a clear federal scheme. See Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 *Am. J.L. & Med.* 251 (1997); Catherine L.

ways that, essentially for the first time, forced health care insurers and providers to compete based on cost. At the same time, HCFA and state Medicaid programs gradually modified the incentives governing hospital and physician reimbursement, and shifted financial risk to prepaid health plans such as HMOs.

Reinforcing a competitive model of health care purchasing in recent years is a prevailing sentiment that government efforts to design a cost-effective national health care program have failed. In part because American society was unable to resolve the distributional issues implicit in universal coverage, it instead identified a common though vaguely defined enemy—"waste, fraud and abuse"—to blame for the shortcomings of the existing system. Competition among prepaid managed care plans became widely touted as a way for purchasers to police these perceived excesses. In theory, managed care would sharpen competitive incentives and stimulate innovation. For example, preauthorization requirements for hospitalization and surgery would force physicians to justify expensive treatment, as would concurrent utilization review of hospital length of stay. Selective provider contracting, primary care gatekeeping, and organized systems of care such as HMOs would induce coordination of services and focus attention on disease prevention and early treatment. In addition, proponents of managed care hoped that purchasers would move beyond the narrow quest for lower insurance premiums to a broader concept of "value," implying optimization of both price and quality.

Although private bargaining indeed reduced health insurance costs, the evolving health care marketplace has yet to fulfill these high expectations. None of the principal mechanisms by which managed care has lowered insurance premiums necessarily increases the overall efficiency of the health care system. Instead, the change from cost-unconscious to cost-conscious health care buying has served primarily to redistribute resources from health care providers and high-utilizing beneficiaries to employers, other group purchasers, and care managers. Using a competitive model of insurance purchasing to achieve competition in the underlying market for health care services (such as physician care, hospitalization, or prescription drugs) also introduced a host of agency problems and other distortions.

For example, initial premium reductions were generally achieved by increasing consumer cost-sharing through higher deductibles and co-insurance, which reduced moral hazard but failed to discriminate between necessary and unnecessary services and often left large uninsured costs on patients. Similarly, managed care organizations succeeded in negotiating lower per-service prices from health care providers who were in oversupply as the result of earlier, overly generous payment policies. This

Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 *Harv. J. on Legis.* 35 (1996).

strategy diminished rents but did little to promote innovation or ensure long-term performance. In addition, financially successful managed care organizations often focused more on avoiding high-risk enrollees than providing cost-effective services. Moreover, both provider price concessions and insurer risk-selection reduced funds available to cross-subsidize care for the indigent.

Despite these shortcomings, free market advocates continue to believe that the competitive model shows promise. For one, they argue that managed care has rationalized provider capacity, reducing redundancy in the system and diminishing supply-induced demand. They point as well to the population-based orientation of some managed care organizations as improving disease prevention and benefiting overall public health. They also contend that the structural reorganization of health care delivery occasioned by managed care has positioned the system for further improvements promising greater social utility.

The validity of these claims has yet to be established. Additionally, it is not clear that savings from managed care are sustainable. Long-term cost control implies both an efficient baseline for spending and a reasonable rate of growth. Recent evidence suggests that health insurance premiums are once again rising, though at single-digit rather than double-digit annual rates.²⁷ Moreover, even real gains in efficiency may not yield long-term cost control because of future increases in technologic capability and demographic trends yielding larger cohorts of elderly, medically needy beneficiaries.²⁸

Finally, as the current movement to impose comprehensive regulatory restrictions demonstrates, managed care has proved daunting to many of the consumers it was intended to benefit. Explicit attention to cost, seemingly achieved through limitations on access to specialist physicians and cutting-edge technology, strikes much of the public as jeopardizing quality, particularly when care management is delegated to shareholder-owned, profit-making corporations. Consequently, the demands on today's marketplace are doubly great: not only must it work to dislodge entrenched interests and resist inflationary pressures, it must also generate non-price benefits such as performance, choice, service, and innovation.

B. *Competitively Motivated Disclosure Laws*

Can information remedy these competitive failings and restore the promise of managed care? It is not surprising that many people think so. Certainly, theoretical support exists for enhancing competition through

27. See Levit et al., *supra* note 2, at 106.

28. See Glied, *supra* note 13, at 90-93 (suggesting that without external cost constraints, attempts to improve efficiency will have no more than a short-term effect on the rate of cost growth); Joseph P. Newhouse, *An Iconoclastic View of Health Care Cost Containment*, *Health Aff., Supp.* 1993, at 162-65 (arguing that the "enhanced capabilities of medicine" account for the bulk of the rise in health-care spending).

information disclosure.²⁹ A market is allocatively efficient if prices of goods and services approximate the marginal costs of producing them, ensuring that economic resources are put to their most highly valued uses. A prerequisite to accurate pricing is that consumers understand exactly what they are buying. If information is asymmetric, with the asymmetry favoring sellers over buyers, disclosure laws can restore the balance of knowledge and allow consumers to make efficient choices among market offerings.³⁰ Indeed, imbalances of information and the authority it confers have long been identified as the principal reason health care markets might fail.³¹

Moreover, purchasers' lack of information stands out as the biggest obstacle to competitive care management. Information deficits in health care relate to each of the three dimensions along which American health care is typically measured: cost, access to services, and quality of care.³² Of these, quality has proved to be a particularly elusive concept. Conventional views of quality are grounded in overall impressions of American medical science and tied loosely to provider reputation, with little discriminatory power at the margin. Although managed care creates an opportunity to measure quality systematically, and to apply population-based, epidemiologic data to individual as well as public health, quality-centered purchasing is hard to find. Most employers still base their decisions overwhelmingly on price, often interpreting the breadth of physi-

29. See, e.g., John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. Kan. L. Rev. 705 (1997) (recognizing complexities in the competition rationale and reserving a place for regulation).

30. For an excellent summary of the law and economics view of mandatory disclosure laws, see Michael J. Fishman & Kathleen M. Hagerty, *Mandatory Disclosure*, in 2 *The New Palgrave Dictionary of Economics and the Law* 605 (Peter Newman ed., 1998) (setting forth assumptions under which private information is disclosed voluntarily, and discussing the result of varying those assumptions).

31. See Arrow, *supra* note 13, at 964-67.

32. With respect to private insurance, cost includes enrollees' premium and out-of-pocket payments, as well as contributions made by employers or other plan sponsors. Access refers to the availability of health professionals, facilities and treatments, and in managed care it encompasses both overall provider participation and authorization or gatekeeping requirements for specialized care. Quality, which will subsume access considerations in this Article, is the hardest of the three to define. Measures of quality tend to focus on three areas: the structure of care delivery, the process of care, and treatment outcomes. Although outcomes, meaning demonstrable benefits from medical therapy, are the gold standard of quality measurement, it is often necessary to rely on structural features, such as hospital staffing, and process factors, such as thoroughness of examination, because of time lags and statistical considerations. See Harold S. Luft, *Health Maintenance Organizations: Dimensions of Performance* (1981); Avedis Donabedian, *Quality, Cost and Clinical Decisions*, 468 *Annals Am. Acad. Pol. & Soc. Sci.* 196 (1983).

cian and hospital participation in managed care networks as an imperfect proxy for quality.³³

Nonetheless, managed care regulation is frequently predicated on a vision of consumer choice among competing offerings, and usually attempts to increase informed decisionmaking through disclosure.³⁴ At the state level, disclosure requirements have been recalibrated to match the needs of a competitive managed care marketplace. Whereas traditional state insurance regulation limited disclosure to basic elements of plan design, new mandates target a wide range of information concerning access to and quality of treatment. Competition-oriented disclosure falls into three principal categories: details of managed care insurance,³⁵

33. See Jack Meyer et al., *Theory and Reality of Value-Based Purchasing: Lessons From the Pioneers 2* (1998) (Agency for Health Care Policy and Research Pub. No. 98-0004, 1997).

34. Consumer fraud laws, which are among the oldest informational interventions in health care, offer a bridge between traditional protective regulation and current disclosure requirements. These laws, generally enforced by states rather than the federal government, police advertising and marketing claims and a variety of contractual conduct, including accuracy of representations and compliance with contractual covenants. See, e.g., *Engalla v. Permanente Med. Group*, 938 P.2d 903, 908 (Cal. 1997) (holding that fraudulent non-compliance with the stated terms of a mandatory arbitration provision for medical malpractice would be sufficient to remove the dispute from arbitration); *Napoletano v. CIGNA Healthcare of Conn., Inc.*, 680 A.2d 127, 146 (Conn. 1996) (holding that health plans may be held liable for misstating the stability of their physician networks in violation of state consumer protection law).

Using general state antifraud authority to monitor managed care appears to be on the upswing, in part because such measures are less likely to be preempted by ERISA. See, e.g., *Napoletano*, 680 A.2d at 136-45; see also *Karlin v. IVF Am., Inc.*, 712 N.E.2d 662, 663-64 (N.Y. 1999) (permitting suit against infertility treatment company for deceptive business practices and false advertising under New York's general business law rather than the state's more restrictive informed consent statute).

States have also regulated health-plan disclosure by monitoring marketing activities under specific antifraud authority relating to health care. For example, Arizona requires prior review of marketing material, Minnesota sets standards for both verbal and written information, and Nevada defines "untrue" and "misleading" broadly to require near absolute accuracy and detailed contextual disclosure. See Alice G. Gosfield, *Guide to Key Legal Issues in Managed Care Quality 208-09* (1996) [hereinafter *Gosfield, Guide*]. Improper marketing activities can also constitute fraud and abuse under federal law. See 18 U.S.C. § 1035 (Supp. III 1997). In addition, promotional claims, whether or not true, can generate vicarious liability for the actions of physicians under theories of apparent agency, see, e.g., *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1235 (Pa. Super. Ct. 1988) (allowing question of whether participating physicians were ostensible agents of HMO to go to trial), and can influence coverage litigation if they contradict the formal plan document, see, e.g., *Warne v. Lincoln Nat'l Corp.*, No. 96932 (Idaho Dist. Ct., July 23, 1994) (upholding multimillion dollar jury verdict). Finally, unfair competition claims can be brought by one plan against another. See, e.g., *U.S. Healthcare, Inc. v. Blue Cross of Greater Philadelphia*, 898 F.2d 914, 926-27 (3d Cir. 1990) (upholding Lanham Act claim by HMO that it had been falsely impugned in its competitor's advertisements).

35. These include information about cost-sharing, benefits, providers, and managerial restrictions on utilization. See Sage & Anderson, *supra* note 17, at 187-93. Cost-sharing includes annual deductibles and annual or lifetime limits on reimbursement, as well as per-service co-payments and co-insurance. Cost-sharing in managed care generally varies

objective assessments of provider and health plan performance,³⁶ and subjective, survey-based information regarding perceptions of quality in health care.³⁷ The first group is largely descriptive, while the others require the development and dissemination of quantitative indicators to measure processes of care, clinical outcomes, or customer satisfaction.

Not only are these disclosure laws more complex than previous ones, their intent is also different. The primary purpose of disclosure in traditional insurance regulation was to educate consumers about their substantive rights with respect to claims, rather than to facilitate choice and enhance competition.³⁸ A few states even continue to subject insurance

according to type of service, such as physical and mental health, and depends on which provider networks are used and whether providers are accessed directly or through approved referrals. Benefits are often extremely complicated: Each insurance product offers several groups of specifically included services, such as hospitalization, professional services, and medical equipment; lists specifically excluded services, such as infertility treatment or organ transplantation; enforces rules limiting coverage within approved categories, such as maximum lengths of stay or numbers of consultations; and establishes standards for determining coverage at the margin, such as requirements that services be "medically necessary" or "non-experimental." For an overview of these issues, and a comprehensive discussion of medical necessity, see Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. Pa. L. Rev. 1637 (1992).

36. Efforts to assess the quality of health plans according to statistically valid, quantitative, objective data have been underway for several years. See generally 1997 *Comparative Performance Data Sourcebook* (John Reichard ed., 1996). Large employers and other group purchasers conduct quality reviews mainly through NCQA, which began accrediting health plans in 1991 to help health care purchasers make informed decisions. See Iglehart, *supra* note 18, at 995. In addition to accreditation per se, NCQA is the motive force behind the Health Plan Employer Data and Information Set (HEDIS), which is the leading survey instrument for assessing quality in managed care. HEDIS evaluates health plans in five major areas: quality, access and patient satisfaction, membership and utilization, finance, and health plan management. Information on the HEDIS database is available on NCQA's website (visited Aug. 18, 1999) <<http://www.ncqa.org/pages/policy/hedis/intro.htm>> (on file with the *Columbia Law Review*).

37. Information about customer satisfaction is intuitively comprehensible to consumers, and replicates to some degree the conventional process of searching for doctors and hospitals through personal recommendations. Subjective information regarding health plan quality also gives freer rein to consumers' idiosyncratic preferences than does process or outcome data, and is often less expensive to generate. Although many satisfaction surveys are in use, the leading instrument is the Consumer Assessment of Health Plans (CAHPS). CAHPS is designed to apply to a variety of care delivery systems, focusing on information that consumers want when choosing a health plan and presenting it in an easily understood format, including data of interest to important subpopulations, such as persons with chronic conditions or disabilities, children, and beneficiaries of public programs. CAHPS is being phased into use for Medicare and Medicaid managed care, and NCQA is in the process of expanding its reporting of patient satisfaction by incorporating elements of CAHPS into its HEDIS framework. For background information on CAHPS and a copy of the survey itself, see CAHPS 2.0 Questionnaires (visited Oct. 7, 1999) <<http://www.ahcpr.gov/qual/cahps/cahpques.htm>> (on file with the *Columbia Law Review*).

38. Because insurance relationships typically involve transactions between vulnerable individuals and large corporations in which advance payment is made in reliance on the later availability of benefits, state regulators have been granted broad authority to protect

companies (though not typically health insurers) to rate regulation, on the theory that price discounting is actuarially imprudent and a threat to solvency. By contrast, new disclosure requirements contemplate active competition accompanied by broader consumer choice.³⁹ For example, Maryland has adopted a detailed "report card" format comparing health plans according to parameters such as availability of preventive care and outcomes of common health conditions.⁴⁰

At the federal level, consumer information was a key component of the theory of managed competition as it was discussed in connection with national health reform in 1993-94.⁴¹ More recently, regulations governing the new Medicare+Choice initiative rely heavily on consumer information to assist beneficiaries selecting health plans in a competitive

policyholders. Insurance regulations generally include reporting and disclosure rules as well as substantive limitations on the policy relationship, such as mandated benefits, marketing and enrollment restrictions, reserve requirements, and claims administration standards. The largest body of law governing disclosure of information by managed care organizations consists of state statutes and regulations requiring the details of HMO coverage to be shared with current and prospective policyholders. See, e.g., Health Maintenance Organization Model Act § 8(A)(3) (Nat'l Ass'n Ins. Comm'rs 1995) (listing twenty-four areas of required disclosure in the contract of insurance). An important limitation of state law is that, at least as applied to self-funded employee benefit plans, it may be preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144(a) (1994). See generally Fisk, *supra* note 27, at 38-39; Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 *New Eng. J. Med.* 1986, 1986 (1996) (discussing how ERISA has precluded states from enacting health care reform).

39. A statement issued by the Governor of Pennsylvania in conjunction with signing that state's comprehensive health care consumer protection bill into law is representative: "This new law will help Pennsylvanians enrolled in managed care plans, such as HMOs, get the information they need to make important choices, and the medical treatment they need to stay healthy." See *Governor Signs Managed Care Reforms, Children's Health Insurance Expansion*, 7 *Health L. Rep.* (BNA) 1015, 1015 (1998).

40. See *Health Care Consumer Information and Education Act*, 1997 Md. Laws 145. Maryland uses a layered approach, providing different information to individual consumers, to corporate purchasers, and to the public as a whole. Consumer information focuses on satisfaction data, presented graphically to allow plan-to-plan comparisons, while employer information consists of detailed statistical measures of quality, and is audited for accuracy. California, the state with perhaps the greatest managed care experience, recently committed to a similar informational approach, mandating a user-friendly "health benefits matrix" for individual and small group health plans to aid comparison shopping. See 1998 Cal. Legis. Serv. 23 (West) (signed Apr. 16, 1998) (codified at Cal. Health & Safety Code § 1363 (West 1999)).

41. See *Health Security Act*, H.R. 3600, 103d Cong. § 1404(b)(1) (1993) (requiring health plans to disclose information about plan cost, participating providers, utilization control procedures, rights and responsibilities, and plan disenrollment); see also Alain C. Enthoven, *The History and Principles of Managed Competition*, *Health Aff.*, Supp. 1993, at 24, 29-33. Enthoven's conception of competition provides for choice of health plan at the individual subscriber level, a standardized coverage contract to facilitate value-for-money comparisons, and quality-related information regarding outcomes and satisfaction. See *id.* at 32-33.

marketplace.⁴² While awaiting Congressional action on national disclosure standards for managed care, moreover, President Clinton issued an executive memorandum directing administrative agencies to implement the disclosure recommendations of the Health Care Quality Commission in all federal programs, including Medicare, Medicaid and the Federal Employees Health Benefits Program (FEHBP).⁴³ Drawing these developments into a coherent regulatory approach, the former chief economic advisor to President Clinton has even suggested that "participants in the health-care marketplace could benefit from a Securities & Exchange Commission-type organization requiring compulsory registration and public disclosure of certain kinds of information on a timely basis by all accredited health plans."⁴⁴

C. *The Limited Potential of the Competition Rationale*

Despite the theoretical appeal of using disclosure to improve transactional efficiency, several ways in which health care differs from other purchases belie the apparent simplicity of this regulatory mission. These include the structural complexity of health care delivery, the technical nature of medical science, the diversity of health-related preferences, and the collateral uses to which information may be put in insurance relationships. In addition, irrationality and lack of opportunity to make decisions in response to information constitute barriers to translating private preferences into efficient choices.⁴⁵ Some of these problems challenge the feasibility of the competition rationale for disclosure, while others compromise the effectiveness of disclosed information as a market facilitation tool.

As will become evident, moreover, most of these problems disproportionately affect insurance consumption decisions by *individuals*. Uncertainty over whom to regard as the true consumer of health insurance clouds many aspects of health law, ranging from coverage interpretation to antitrust. As a factual matter, seventy-six percent of non-elderly Americans with health insurance received it through employment in 1996, sixteen percent were covered by government (mainly through Medicaid), and less than eight percent purchased coverage individually.⁴⁶ Yet it is the rhetoric of protecting individuals and fostering personal

42. Information generated by participating health plans is collected in the Medicare Compare database, which is available via Internet. See Health Care Financing Administration's Medicare Compare Homepage (visited Nov. 3, 1999) <www.medicare.gov/comparison> (on file with the *Columbia Law Review*).

43. See Memorandum on Federal Agency Compliance with the Patient Bill of Rights, *supra* note 20.

44. Laura D'Andrea Tyson, HMOs: A Good Idea That Could Get a Lot Better, *Bus. Wk.*, Aug. 9, 1999, at 20.

45. See, e.g., Thomas Rice, *The Economics of Health Reconsidered* 64-80 (1998).

46. Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book* 19 (1998). Essentially everyone over age sixty five is insured through the federal Medicare program.

choice in a competitive market that dominates debate over disclosure, creating a substantial gap between regulatory effort and likelihood of success.

Individuals have been relatively passive participants in the competitive resurgence described above, which has concentrated on employers, government, and other sponsors of insured groups. Among other things, individual consumers are poorly positioned to understand health care costs. The bulk of insurance premiums are paid on a pre-tax basis by employers, and a generous but even less visible tax subsidy is added by the federal treasury. Few consumers are wealthy enough to pay cash for medical treatment; the rest often conflate their out-of-pocket expenditures with the total cost of coverage.⁴⁷ Moreover, the small subset of people who purchase individual rather than group coverage often find their costs and choices dictated by their health status. Individual perceptions of quality are similarly underdeveloped, with most people relying on employers or government to arrange coverage and on physician expertise to select specific treatments.⁴⁸

1. *Feasibility Barriers to Competitive Disclosure.* —

a. *Costs of Compliance.* — The complexity and scope of information required to accommodate the apparent needs of health care consumers imply high compliance costs if disclosure laws are enacted, and argue for regulatory restraint. In other areas of disclosure regulation, such as the federal securities laws, critics often complain that legal requirements are either duplicative of, or not as useful as, less costly voluntary forms of information sharing.⁴⁹ High compliance costs for health care disclosure

47. The diminishing percentage paid directly by individuals is a striking feature of health care spending over the past fifty years. This is attributable primarily to the development of expensive therapies that are unaffordable by individuals without insurance, and to the subsequent rise of employer-sponsored and government insurance programs. See Glied, *supra* note 13, at 86–121.

48. This means that information disclosed to individuals must serve two purposes: it must help consumers manage their own care, and enable them to monitor the insurance sponsors and health professionals they utilize. Discussion in this section of the Article focuses on individual consumers' direct role in obtaining services from health plans and providers. Although this process necessarily implicates the skills and loyalties of these organizations and professionals when acting on behalf of patients seeking referral and treatment, information specifically intended to facilitate monitoring of agents and intermediaries is considered separately below. See *infra* Part II.

49. See, e.g., Gregg A. Jarrell, *The Economic Effects of Federal Regulation of the Market for New Securities Issues*, 24 *J.L. & Econ.* 613 (1981); see also Jonathan R. Macey, *Yes: The Mission is Over, But the Agency Lingers On*, *A.B.A. J.*, Nov. 1995, at 52 (arguing that the SEC is an unnecessary institution and that capital markets should be deregulated); George Stigler, *Public Regulation of the Securities Markets*, 37 *J. Bus.* 117 (1964) (refuting a special SEC study that concluded strict regulation of securities markets is necessary). The federal securities laws represent the best example of using mandatory disclosure, antifraud enforcement, and strict liability to improve market processes. See, e.g., Securities Act of 1933, §§ 11(a), 12(2), 15 U.S.C. §§ 77k(a), 77l(a)(2) (1994); Rule 10b-5 under the Securities Exchange Act of 1934, 17 C.F.R. § 240.10b-5 (1998). Like state consumer protection laws, federal securities law prohibits material misstatements in connection with

requirements are particularly troubling from a health policy perspective given a voluntary, employment-based health insurance system because they will be passed along to consumers as higher premiums, and therefore may discourage employer sponsorship or individual purchase of coverage.

The torrent of legislative proposals to mandate information availability is generating a parallel plume of cost estimates prepared by or for the proponents and opponents of each bill. Most of these commissioned studies reach extreme results, and are suspect on those grounds alone.⁵⁰ The most authoritative cost estimate to date was prepared by the Congressional Budget Office (CBO) regarding the Patients' Bill of Rights Act of 1998.⁵¹ The CBO concluded that the proposed legislation would increase private health insurance premiums by four percent, one-eighth of which represents quality assurance activities and the collection of standardized data, including HEDIS measures and consumer health and satisfaction surveys.⁵²

Compliance costs depend on who is required to collect data, process it, and make it available to the public. Possibilities include individual physicians, institutional health care providers such as hospitals, home health agencies and nursing facilities, insurance organizations such as managed care plans, and intermediary organizations such as employers, group purchasers, and other plan sponsors. Unfortunately, the most convenient parties from whom to require disclosure are not necessarily those who are truly accountable for care, and the most accountable parties may not be able to disclose accurately or economically. For example, many new laws assign primary responsibility for disclosure to health plans, often using quality measures such as HEDIS and CAHPS to synthesize data from individual patient encounters into plan-level scores that can be used for comparison shopping.⁵³ In addition to subjecting the party about which the public is most suspicious to direct scrutiny, plan-based disclosure duties are attractive because they can be implemented through established insurance and HMO regulation. In addition, they affect a dis-

curities transactions. However, securities law imposes affirmative disclosure obligations by condemning material omissions as well. The latter obligations are twentieth-century innovations. See Stuart Banner, *Anglo-American Securities Regulation: Cultural and Political Roots, 1690-1860*, at 243-44 (1998).

50. See Geri Aston, *Studies Split Over Cost Impact of Patient Protection Bills*, *Am. Med. News*, May 11, 1998, at 1, 27 (describing low estimates from the Kaiser Family Foundation and high estimates from American Association of Health Plans).

51. H.R. 3605, S. 1890, 105th Cong. (1998).

52. Congressional Budget Office, *Cost Estimate: H.R. 3605, S. 1890* (1998). Even 0.5% of national health care spending is still \$5 billion annually.

53. See, e.g., Ron Paterson et al., *Implementation of Managed Care Consumer Protections in Missouri, New Jersey, Texas and Vermont* (1999) (Kaiser Family Foundation report describing new information disclosure requirements and other consumer protections).

crete number of larger, wealthier organizations, which limits both the enforcement burden on regulators and the financial onus of compliance.

However, focusing on the choice among competing health plans by providing comparative information regarding performance at the plan level assumes that health plans, not physicians or hospitals, have the greatest influence over cost and quality of care. This is a radical change from the traditional view of medicine as a learned art practiced by individual professionals. Although evidence is mounting that institutional processes determine many aspects of safety and quality, consumers have been slow to embrace an industrial model of health care delivery.⁵⁴ Moreover, health plans are not monolithic, despite efforts by critics of managed care to portray them that way. Recent studies have demonstrated substantial variability of practice within health plans.⁵⁵ Furthermore, current trends in managed care are away from tightly organized entities such as staff-model HMOs toward looser contractual networks of providers that are favored by consumers who value breadth of choice among physicians.⁵⁶ Quality may vary considerably within these large insurance organizations, making conclusions drawn from averages problematic, particularly as guides for individual consumers.

Disclosure at the provider level, while potentially more useful, suffers from feasibility problems. The universe of potentially regulated parties below the level of the health plan is daunting. JCAHO accredits approximately 18,000 hospitals nationally, and practicing physicians exceed half a million. Furthermore, if the voluntary quality reporting initiative on physicians administered by the AMA's American Medical Assessment Program (AMAP) is any guide, necessary information would be quite detailed.⁵⁷ Given the logistical difficulties of a broader scope, state disclosure mandates involving providers have focused primarily on hospitals, and have been limited to a few conditions or treatments.

b. *Diversity*. — In most parts of the economy, a relatively small number of expert comparison shoppers disciplines the entire market.

54. One might argue that disclosure obligations will force health plans to assume control of clinical processes. Again, this ends-forcing use of disclosure is part of the performance rationale, not the competition rationale. See *infra* text accompanying notes 254–259. Furthermore, the extent to which various organizations and individuals should control health care delivery is a central debate in health care that has yet to achieve consensus among policymakers or the public. See William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 *Law & Contemp. Probs.* 159 (1997) (describing the relationship between liability for patient injury and control over care) [hereinafter Sage, *Enterprise Liability*].

55. See Sheldon M. Retchin, *Variations in Medicare Health Maintenance Organizations*, 281 *JAMA* 755 (1999).

56. See Sage, *Enterprise Liability*, *supra* note 54, at 191–95.

57. AMAP's "gold standard" encompasses five areas—credentials, personal qualifications, environment of care, clinical performance, and patient care results—and includes a variety of structural, process, and outcome elements. See Andrew A. Skolnick, JCAHO, NCQA, and AMAP Establish Council to Coordinate Health Care Performance Measurement, 279 *JAMA* 1769 (1998).

One difference in health care is the diversity of decision points and preferences involved. Which information is "material" is therefore a difficult question, as is how and when that information should be conveyed. For health care disclosure to be useful to individuals, it must accommodate a variety of transactions affecting people who are differently situated in terms of factors such as age, gender, family status and medical history. These include choice of health plan, choice of access points for care (typically a primary care physician but potentially a health facility or medical specialist), and choice among particular treatments.⁵⁸ Because situations and concerns vary from consumer to consumer, comprehensive or open-ended disclosure is impractical, particularly concerning the quality of specific health conditions and medical interventions. Furthermore, consumers of insurance as opposed to specific services must attempt to anticipate their *future* needs and match them to disclosed characteristics of available health plans, which is an even harder task. Unfortunately, disclosure laws that have been enacted or are now under consideration often ignore these limitations in favor of a "more is better" approach, assuming incorrectly that all information is useful, and relying on the political process to restrain overly costly regulatory requirements.⁵⁹

Heterogeneity of preferences sets health care apart from other industries governed by disclosure laws.⁶⁰ The most seasoned example of disclosure-based regulation, the federal securities laws, imposes an affirmative disclosure obligation regarding material information, which the Supreme Court has held to mean "a substantial likelihood that the disclosure of the omitted fact would have been viewed by the reasonable investor as having significantly altered the 'total mix' of information made available."⁶¹ Certainly, what constitutes material information to an investor in corporate securities varies greatly by industry and financial product. However, a narrow category of financial information regarding se-

58. Moreover, many decisions are made by employers and other group purchasers rather than by individuals. For example, an accelerating trend is for purchasers to contract directly with providers for services, instead of depending on a commercial insurer or plan administrator, which involves purchasers in decisions about structuring and delivering services at a more detailed level. See Debra J. Lipson & Jeanne M. De Sa, *Impact of Purchasing Strategies on Local Health Care Systems*, *Health Aff.*, Summer 1996, at 62, 70-72.

59. Reliance on HEDIS in legislation is a good example. HEDIS was originally developed by large employers for their own use rather than as an aid to individual beneficiaries not linked to employer-sponsored health plans. See *supra* note 36. Because of this, a major focus of ongoing quality assessment activities is to construct a broad-based process to design and select measures with more general relevance and utility. See, e.g., *Foundation for Accountability* (visited Aug. 17, 1998) <<http://www.facct.org>> (describing efforts to find universally applicable quality measures).

60. At the same time, of course, heterogeneity of preferences reinforces the importance of allowing consumer choice, and therefore makes disclosure laws preferable to substantive regulation that limits the range of available options.

61. *Basic, Inc. v. Levinson*, 485 U.S. 224, 231-32 (1988) (quoting *TSC Industries, Inc. v. Northway, Inc.*, 426 U.S. 438, 449 (1976)).

curities, notably earnings per share, is largely determinative of investor interest. Moreover, even the most complex investment information distills to a single factor—risk—and hence the financial return required to assume it.

The obstacles presented by the heterogeneity of relevant health care information are heightened by the fact that health insurance and health care services—unlike securities—are consumed by their purchasers rather than being traded in a secondary market. In the general economy, price substitutes for extensive dissemination of detailed information about conditions of supply and demand.⁶² The price at which a security trades in the secondary market reflects its aggregate valuation and is ultimately the measure of greatest importance to investors, even if individuals might react differently to specific information disclosed in a prospectus.⁶³ The absence of a pricing mechanism in health care is a major obstacle to addressing information market failure through disclosure. As yet, no financial product has been devised to capture the underlying value of health insurance.⁶⁴ The only rough correlate is the attempt by a few large employers to adjust the corporate contribution to a given health plan based on the employer's estimate of the plan's quality, thereby altering the price to enrollees.⁶⁵ In addition, the absence of secondary market trading in health care eliminates the "first-mover advantage" that incentivizes private parties to expend resources uncovering and analyzing information about securities. This arguably increases the importance of mandatory disclosure laws in generating information as a public good,⁶⁶ but complicates the task of supplying market participants with the specific facts they would consider pertinent.

c. *Accuracy.* — A related feasibility concern for disclosure in health care is data integrity, especially when disclosure laws are enacted in the heat of politics. Hastily assembled under real-world conditions, managed

62. See F.A. Hayek, *The Use of Knowledge in Society*, 35 *Am. Econ. Rev.* 519, 525–26 (1945).

63. Arguments can be made that the effectiveness of disclosure in the securities industry depends on the level of secondary market trading. For example, information regarding seasoned issuers is quickly factored into a market price, while initial public offerings are priced by underwriters and only upon issuance is available information captured in secondary trading. Mutual funds may be the hardest case for disclosure because they are not traded.

64. Although a health insurance futures market is being developed for companies seeking to hedge unpredictable health care costs, it will not provide signals for individual insurance enrollment decisions. See Michael T. Bond & Brenda S. Marshall, *Managing Financial Risk with Options on Futures*, 49 *Healthcare Fin. Mgmt.* 50 (1995) (describing plans by Chicago Board of Trade to offer futures contracts).

65. For example, General Motors and GTE offer employees a discount for enrolling in high-quality plans, as measured by HEDIS results, accreditation status, and consumer satisfaction. See *Growing Reliance on Self-Reported HEDIS Data Underscores Need for Auditing*, *Med. & Health Persp.*, May 18, 1998, at 1 [hereinafter *Growing Reliance*].

66. See Part III *infra* (exploring the potential for disclosure laws to enhance industry performance).

care "report cards" and other supposedly standardized, reliable information may prove to be neither standardized nor reliable. Problems include erratic data collection and coding, inadequate risk adjustment, and questionable connections between process measures of quality and bottom-line effects on health.⁶⁷ For example, HCFA recently revealed that most HEDIS data submitted by Medicare managed care plans were inaccurate, but nonetheless elected to disseminate the results of several measures to beneficiaries.⁶⁸ Although politicians sometimes prefer to construe such failures as fraud or deceit, technical problems are likely to plague consumer-oriented mandatory disclosure laws for the foreseeable future, even without intentional or negligent misconduct.⁶⁹

Centralized disclosure by health plans has certain advantages over decentralized disclosure by physicians or hospitals with respect to accuracy, because many plans invest in sophisticated information systems as part of their managerial role, and can standardize and process information received from affiliated physicians and hospitals.⁷⁰ Data aggregated

67. These connections must be established between processes and outcomes, and between "intermediate outcomes" and "ultimate outcomes." See David M. Eddy, *Anatomy of a Decision*, 263 JAMA 441 (1990). For example, process-based performance factors such as cholesterol testing may not prove that high cholesterol was treated if detected, and cholesterol reduction may or may not correlate with prolonged life or improved well-being.

68. See *Medicare+Choice May Be Compromised by HEDIS Data HMOs Have Submitted . . .*, *Med. & Health*, Mar. 2, 1998, at 1. Furthermore, according to former HCFA official Bruce Fried, "where there were problems, the information erred consistently in plans' favor." *Id.* Even descriptive disclosure can be error-laden. See General Accounting Office, *Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature 2-3* (1999) (finding erroneous or misleading information in marketing brochures from 16 Medicare MCOs).

69. Most problems have been attributed to data systems failure, but instances of deliberate manipulation have also occurred. See *Growing Reliance*, *supra* note 65, at 1. Some concerns over both accidental and intentional misreporting can be addressed through external auditing. Where auditing has been performed to date, it has revealed significant lapses in self-reporting. A recent audit of HEDIS submissions used to generate Maryland's HMO report card concluded that 15-25% of health plans failed to report, or reported data that was not verifiable. An audit of New Jersey's report card data showed similar results. See *Doubts About Quality Data Submitted by HMOs Raise Questions About Other HEDIS Report Cards*, *Med. & Health*, Mar. 2, 1998, at 1-2. The President's Advisory Commission recommended auditing in its final report on consumer protection, and, beginning in 2000, HCFA will require all managed care plans to contract with independent, certified auditors to review the quality and satisfaction information submitted to Medicare. However, auditing adds to the expense of disclosure rules, and can identify problems with, but cannot substitute for, sound data collection at the level of patient encounters. Auditing also does little to assure that disclosed information is meaningful.

70. See Arnold M. Epstein, *Rolling Down the Runway: The Challenges Ahead for Quality Report Cards*, 279 JAMA 1691, 1694-95 (1998). Epstein also makes the points that data collection by individual physicians is harder to mandate politically, as is public reporting of physician rankings, and that the smaller the unit for reporting and disclosure, the more likely it is that confidential information traceable to individual patients will be revealed. See *id.*

across many transactions carry greater statistical weight, and are less prone to skewing based on underlying health risk.⁷¹ On the other hand, profit-making insurance organizations that are remote from care delivery may be less reliable sources of clinical information than health care providers, and may have greater incentives to distort results.⁷²

Similarly, the markedly unequal distribution of illness within any enrolled population can affect quality measurement and communication of quality-related information as well as consumer response. Because only a small percentage of enrollees are likely to be affected by any single managed care practice, moreover, aggregate data can be misleading. For example, broad surveys of beneficiaries regarding their satisfaction with coverage may conceal major failings in serving the seriously ill if most people never utilize services. In other cases, health care consumers may not recognize quality unless they have an immediate need for care, leading to lower than deserved ratings. In addition, rapid turnover of participating physicians and hospitals, as well as of enrollees whose views form the basis of many scores, casts doubt on the predictive value of plan-level performance measures from year to year.

Finally, lack of information is the ultimate feasibility barrier to disclosure. The growth of managed care has in many ways outstripped its managerial capabilities. Contrary to predictions by managed competition theorists, most managed care organizations are not tightly integrated entities with the infrastructure to measure and improve care delivery, but loosely constituted networks of physicians and facilities that have agreed to serve insurance companies at low prices.⁷³ These entities are poorly equipped to collect and process information. Consequently, it may be that *nobody* possesses the information that is supposed to be disclosed. Governmentally-imposed disclosure requirements are based on the premise that information is asymmetric but not incomplete. In other words, they presuppose that matters such as quality of care are understood by the health plans, hospitals, and physicians who deliver services, and simply must be made equally available to individual consumers for competition to flour-

71. According to a recent study, for example, individual physicians' practice styles account for only four percent of observable variation in care for diabetic patients, making "report cards" poor indicators of physician performance unless physicians care for a large number of diabetic patients. See Timothy P. Hofer et al., *The Unreliability of Individual Physician "Report Cards" for Assessing the Costs and Quality of Care of a Chronic Disease*, 281 JAMA 2098, 2098 (1999).

72. Of course, large corporate organizations whose shares are publicly traded are also subject to higher effective penalties for fraud, which may be exacted through adverse publicity or through the operation of federal securities laws.

73. Compare Robert A. Berenson, *Beyond Competition*, Health Aff., Mar.-Apr. 1997, at 171, 175-77 (describing broad, overlapping provider networks), with Alain C. Enthoven, *The History and Principles of Managed Competition*, Health Aff., Supp. 1993, at 24, 29-40 (postulating discrete, integrated organizations).

ish. If that assumption is false, competitively motivated disclosure may be a house of cards.⁷⁴

2. *Effectiveness Barriers to Disclosure.* —

a. *Health Literacy.* — Disclosure must be comprehensible to be effective as a competitive tool, but comprehension is limited by the technical nature of health care information and by consumers' underlying characteristics.⁷⁵ Individuals vary widely in their knowledge and experience, as well as in their capacity to understand disclosed information. Recent studies paint a bleak picture of "health literacy," with a large percentage of English-speaking patients unable to read and understand basic health-related materials.⁷⁶ Consequently, individuals' responses to detailed information about the organization and availability of health care services are unpredictable, especially when that information concerns matters removed from their personal circumstances. For example, it is increasingly clear that the general public does not understand even elementary aspects of health plan and health system design, which is a prerequisite for more detailed disclosure.⁷⁷

This problem is particularly acute in the case of vulnerable subpopulations. A recent survey found that only eleven percent of Medicare beneficiaries have sufficient knowledge to make an informed choice between new Medicare+Choice options and the traditional fee-for-service program.⁷⁸ Many beneficiaries of health insurance are elderly, infirm,

74. Nonetheless, mandatory disclosure laws have the potential to overcome institutional inertia and industrial failure by requiring regulated parties to produce it. This is an intrusive process, however—more market restructuring than market facilitation. We will return to ends-forcing justifications for disclosure laws, under the rubric of the performance rationale, later in this Article. See *infra* Part III.

75. Similar considerations limit patients' autonomous choices among treatment alternatives in response to clinical information provided by physicians to secure "informed consent." See Carl E. Schneider, *supra* note 8, at 109–35 (explaining why some patients prefer not to make "medical" decisions).

76. See Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, *Health Literacy: Report of the Council on Scientific Affairs*, 281 JAMA 552, 552–53 (1999).

77. In the last few years, researchers have begun to investigate consumer information needs and modes of supplying them. See generally Community Service Society, *What Medicaid Beneficiaries Understand—and What They Don't About Managed Care* (1996); Susan Edgman-Levitan & Paul D. Cleary, *What Information Do Consumers Want and Need?*, *Health Aff.*, Winter 1996, at 42 (discussing consumer definitions of high-quality care and types of information sought by consumers); Judith H. Hibbard & Jacquelyn J. Jewett, *Will Quality Report Cards Help Consumers?*, *Health Aff.*, May–June 1997, at 218 (discussing consumers' misunderstanding of the current health care context); Stephen L. Isaacs, *Consumer Information Needs: Results of a National Survey*, *Health Aff.*, Winter 1996, at 31 (discussing high percentage of Americans who do not understand the basic elements of health plans).

78. See Judith H. Hibbard et al., *Can Medicare Beneficiaries Make Informed Choices?*, *Health Aff.*, Nov.–Dec. 1998, at 181, 186.

poorly educated or unfamiliar with American language and culture.⁷⁹ In another study, focus groups conducted with elderly Medicare beneficiaries revealed that many people mistakenly praised a health plan with high rates of hospitalization for pneumonia, reasoning incorrectly that the health plan was lenient about providing access to hospital care, and failing to grasp that the plan had not administered pneumococcal vaccine to its members.⁸⁰

b. *Irrationality.* — More generally, irrationality of response can limit the ability of health care disclosure to affect consumer behavior.⁸¹ Although universal rationality is not necessary for market efficiency, even relatively sophisticated individuals approach health issues with a variety of cognitive biases which may lead them to evaluate health care information inaccurately and reach incorrect decisions. At bottom, information to facilitate competition in health care is information about probabilities, not certainties. Specifically, consumers of health insurance must estimate the likelihood that they will require particular care, and the chance that treatment received will be effective.

As demonstrated by Tversky and Kahneman, people misinterpret information, particularly probabilistic information, in striking and consistent manners.⁸² For example, people overestimate risks that are available or salient, construct faulty generalizations based on the degree to which individual events seem representative of familiar patterns, and ignore prior probabilities when judging the likelihood of future occurrence. Where health care is concerned, these tendencies may lead people to

79. Consumer education is a serious problem in Medicaid managed care, many of whose beneficiaries are poorly equipped to choose a health plan, and is being approached through a variety of regulatory efforts. Importantly for mandatory disclosure, many state programs prohibit rather than encourage direct contact between health plans and beneficiaries because of concerns over fraudulent marketing. See Irene Fraser et al., *Promoting Choice: Lessons From Managed Medicaid*, *Health Aff.*, Sept.–Oct. 1998, at 165, 172–73.

80. See Barbara S. Cooper, *From Bill-Payer to Purchaser: Medicare in Transition*, *Health System Rev.*, July–Aug. 1997, at 16, 17.

81. This is true as well for other informational regulatory schemes, such as hazard warnings. See W. Kip Viscusi, *Individual Rationality, Hazard Warnings, and the Foundations of Tort Law*, 48 *Rutgers L. Rev.* 625 (1996) (arguing for a balance of direct regulation and reliance on informed behavior by individuals).

82. See Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 *Econometrica* 263 (1979). Kahneman and Tversky term the study of these influences “prospect theory.” A new field of behavioral economics has arisen from this work. See Christine Jolls et al., *A Behavioral Approach to Law and Economics*, 50 *Stan. L. Rev.* 1471 (1998). An important limitation of behavioral economics is that prospect theory has been tested under strictly controlled circumstances and has yet to articulate a cohesive vision that would allow information to be re-framed on a systematic rather than an ad hoc basis. See Jennifer Arlen, *Comment: The Future of Behavioral Economic Analysis of Law*, 51 *Vand. L. Rev.* 1765, 1768 (1998).

discount information when they are healthy, overrate information conveyed during illness, and otherwise mis-estimate risks and uncertainties.⁸³

It is theoretically possible to overcome these tendencies using mandatory disclosure laws, but operationally challenging. Tversky and Kahneman divide cognitive biases into framing errors and valuation errors.⁸⁴ Framing errors occur when individuals draw erroneous conclusions from the manner in which information is presented to them, while valuation errors occur when individuals display preferences that diverge from those expected.⁸⁵ If one could present data so as to compensate for framing errors, but respect differences in subjective valuation, one might be able to convey complex information without encroaching on individual autonomy. In practice, however, correcting individuals' cognitive biases without introducing other distortions is difficult. Although economic analysis generally regards preferences as fixed, persons conveying information about managed care may have reasons, both principled and pecuniary, for attempting to influence preferences. The former category subsumes public-spirited educational campaigns, perhaps to discourage smoking or other health-impairing lifestyle choices. The latter category encompasses advertising by providers, facilities, and manufacturers of medical products, which aims to increase perceived value (and hence utilization), as well as opposite efforts by insurers and other payers to reduce demand and hence reimbursable expense.

A central insight from the behavioral economics literature is that effective communication to individuals of complex quality-related information necessitates walking a fine line separating facilitation and manipulation.⁸⁶ There is considerable gray area between framing and valuation; for example, information that a physician had been sued for medical malpractice might be given "excessive" importance by a prospective patient because she is unaware of the frequency of claims against doctors (framing) or because she did not feel comfortable entrusting herself to a doctor who had alienated a patient (valuation).⁸⁷ In addition, although pat-

83. For example, research suggests that information about managed care is more salient for chronically or severely ill individuals than for healthy enrollees. See Judith H. Hibbard & Jacquelyn J. Jewett, *What Type of Quality Information Do Consumers Want in a Health Care Report Card?*, 53 *Med. Care Res. & Rev.* 28, 46 (1996).

84. Amos Tversky & Daniel Kahneman, *The Framing of Decisions and the Psychology of Choice*, 211 *Science* 453 (1981).

85. Research shows that individuals systematically approach voluntarily incurred risks with less anxiety, while regarding certain forms of potential injury or death, such as cancer, as especially dreaded. See Cass R. Sunstein, *Health-Health Tradeoffs*, 63 *U. Chi. L. Rev.* 1533, 1541 (1996). The former seems more a framing error, based on the unwarranted assumption that control changes the underlying probabilities, while the latter seems more a matter of valuation.

86. See *infra* text accompanying notes 315-327 (discussing demand modification and health care performance); *infra* text accompanying notes 286-295 (discussing conflicts in government's role as information broker).

87. Cognitive dissonance is another link between framing and valuation. People may articulate preferences that are not their own when the alternative is to consider

terns of bias are generally consistent across individuals, substantial variation exists, making it hard to adjust the presentation of information prospectively for a diverse audience.

c. *Limited Choice*. — Limitations on consumer response to information should also temper optimism about the usefulness of disclosure to health care competition, especially disclosure aimed at individuals. Because information-based regulation is useless unless informed parties can improve their positions,⁸⁸ even comprehensive, accurate disclosure in managed care will be pro-efficient only if it influences actual consumer decisionmaking.⁸⁹ For example, requiring disclosure to consumers of their grievance and appeals rights in health plans enhances the value of other disclosure by alerting consumers to their avenues of recourse if plan performance fails to meet their informed expectations.⁹⁰

However, health care consumers are often constrained in the choices they can make, no matter how much information they possess. For example, exit options in private health insurance are frequently restricted. Most employers who sponsor health insurance for their workers do not offer a choice among competing plans. According to one recent study, seventy-eight percent of employers offer only one health plan, although employees may have a choice among insurance products within that plan.⁹¹ As a result, many workers change health insurance only when they change employment. Neither is health insurance fully portable, despite the best efforts of state and federal legislators.⁹² Consequently,

information that they find upsetting. For example, smokers may overstate the pleasure they derive from smoking rather than confront its dangers. See Rice, *supra* note 22, at 76–77. Consequently, presentation of information to overcome framing errors may not be gratefully received. Moreover, the response to improved framing may be distorted valuation, with no easy way to determine the “truth.”

88. Scholars of disclosure and corporate governance have long recognized the need for shareholders to convey dissatisfaction with management, usually by exit (selling their shares). See Alhert Hirschman, *Exit, Voice and Loyalty* (1988).

89. On the other hand, neither public opinion nor the legal system invariably forces individuals to bear the consequences of poor decisions regarding the existence or scope of health insurance. For example, some commentators believe that courts often uphold patients’ challenges to coverage denials regardless of contractual language. See Havighurst, *supra* note 22, at 180–85; Hall & Anderson, *supra* note 35, at 1647–49. Allocating health care resources based on “informed consumer choice” may be wishful thinking if individuals’ *ex ante* decisions are revisited by judges and juries.

90. See *infra* text accompanying notes 223–236.

91. See Karen Davis & Catherine Schoen, *Managed Care, Choice and Patient Satisfaction* (1997); see also Louis B. Harris & Assoc., *Most People With Employer-Provided Health Insurance Plans Have No Real Choice of Plans*, *Bus. Wire*, Mar. 12, 1999, at 1, available in LEXIS, News Group File (reporting the results of a survey finding that only 34% of respondents with employer-sponsored health coverage reported having a “real choice of plans”).

92. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996), (codified at 29 U.S.C. §§ 1181–1182 (Supp. III 1997)), prohibits outright denials of coverage and assures insurability from one covered workplace to another, but does nothing to guarantee that individually purchased insurance is affordable.

health plan enrollees with serious health problems are especially limited in their ability to switch, even though they are generally the best informed about their plan's quality.⁹³

Similar problems exist in public programs. Medicaid recipients have few choices in states that sign exclusive contracts with single managed care organizations in particular geographic areas. Even in Medicare managed care, which allows beneficiaries the option of returning to fee-for-service coverage at any time, disenrollment from a health plan can adversely affect eligibility for supplemental (Medigap) coverage.⁹⁴ Furthermore, the right to disenroll from managed Medicare into traditional coverage will probably be curtailed in the near future because of concerns about encouraging risk-selection and therefore generating excessive payments to HMOs.⁹⁵

Pressures on patients to remain passive consumers may be exerted at the point of service—the doctor's office—as well as the point of enrollment. Emotional vulnerability and urgent medical need limit free choice in response to information. As may also be true of medical malpractice litigation, patients may be reluctant to jeopardize existing therapeutic relationships even when legitimate quality of care issues arise. These problems may be compounded by financial incentives in physicians' contracts with managed care organizations. For example, doctors who are affiliated with health plans that pay them on different bases may subtly influence patients' enrollment decisions or may fail to alert them to particular treatment options.⁹⁶

The need to coordinate disclosure with decision points creates its own challenges. Even where choices exist, variability of information use by individuals suggests that timing and manner of disclosure is important to effectiveness. Written disclosure in connection with annual open enrollment periods may make sense for information about choice of health plan, but decisions regarding selection of primary care or specialist physician, and certainly of specific treatment when ill, will require a different informational framework offering greater availability. Some communications will be more effective if delivered orally. Furthermore, studies conducted of consumers' information preferences suggest that the public fa-

93. See Mark Schlesinger et al., *No Exit? The Effect of Health Status on Dissatisfaction and Disenrollment from Health Plans*, 34 *Health Servs. Research* 547 (1999).

94. See Elsa Brenner, *As H.M.O.'s Flee the Elderly Wonder, Who Pays Now?*, N.Y. Times, Feb. 28, 1999, § 14 (Westchester), at 4–5.

95. See Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* 30–31 (1998).

96. Physician behavior is potentially a significant problem in the Medicare+Choice program, where special provider-sponsored organizations will compete for patients with HMOs and fee-for-service Medicare. See *infra* text accompanying notes 209–210.

vors subjective, relational information over abstract, statistical data.⁹⁷ A potential problem is that these types of disclosure practices increase the strain on oversight and enforcement resources.⁹⁸ Because they offer inexpensive access to large amounts of data, and can vary the content and presentation of information while still leaving a trail of evidence, electronic communications technologies hold out some promise to address diverse informational needs.⁹⁹ However, customization using interactive software on home computers or dedicated kiosks creates risks as well. In the absence of effective laws protecting privacy, the process of accessing this information can reveal confidential information about the recipient, which can be misused for insurance, employment, governmental, and commercial purposes.¹⁰⁰

d. *Anticompetitive Risks.* — Another issue worth exploring is the potential for disclosure laws to retard rather than advance competition. Anticompetitive risks come from two directions. First, disclosure may worsen other market failures in the market for health insurance, as opposed to the market for health care services. Second, disclosure may facilitate collusion.

The unequal distribution of illness is a central fact of health care, and a core challenge for sound policy. Competition makes sense in managed care only if it improves the efficiency of health care delivery. Because health status predicts insurance expense to a greater extent than does cost-effectiveness of care, however, health plans can profit most easily by selectively enrolling healthier individuals.¹⁰¹ At present, this problem is greatest for Medicare's managed care program, because five percent of beneficiaries account for half of total expenditures, and managed care plans are paid based on average program cost rather than market prices, competitive bids, or the predicted expenses of their actual enroll-

97. See Edgman-Levitan & Cleary, *supra* note 77, at 51–53 (recommending types of information, such as peers' experiences, that consumers need and want in order to make a choice).

98. This is true generally for mandatory disclosure laws. Mutual fund regulation, for example, is struggling to balance user-friendly disclosure with competent oversight. See Tamar Frankel, *Trends in the Regulation of Investment Companies and Investment Advisers*, 1 Vill. J.L. Invest. Mgmt. 3, 6–9 (1999) (describing the trend towards more varied disclosure) [hereinafter Frankel, *Trends*].

99. See Arti Rai, *Reflective Choice in Health Care: Using Information Technology to Present Allocation Options*, 25 Am. J.L. & Med. 387 (1999) (discussing electronic technologies and consent to rationing); Arnold J. Rosoff, *Informed Consent in the Electronic Age*, 25 Am. J.L. & Med. 367 (1999) (discussing electronic exchange of information regarding clinical alternatives).

100. See *infra* text accompanying notes 308–313.

101. See generally Harold S. Luft & Robert H. Miller, *Patient Selection in a Competitive Health Care System*, Health Aff., Summer 1988, at 97. These practices run counter to the requirements under Medicare and Medicaid that all eligible individuals be given the opportunity to enroll, as well as to risk-pooling laws, such as state community rating statutes and HIPAA, which restrict insurers' ability to deny coverage based on health status.

ees. However, it also plagues private employers and pension funds that offer a choice of health plans to their members, because it redirects plan efforts from improving aggregate service into "cream skimming."¹⁰² In addition to diverting competition away from clinical care, risk selection demonstrates how individual and social welfare considerations may diverge in health insurance markets.¹⁰³ Competition based on risk may be economically advantageous to the healthy people who are the most desirable customers, but renders sicker individuals uninsurable or insurable only at much higher premiums.

Under these circumstances, a potentially adverse effect of disclosure is that information about services can be structured so as to attract healthier subscribers and discourage sicker ones.¹⁰⁴ In particular, concerns have been raised about selective marketing by Medicare HMOs to healthy seniors.¹⁰⁵ Similar problems exist for Medicaid managed care, where health plans are often paid less and therefore have more temptation to risk-select.¹⁰⁶ These hazards are even greater if information is presented orally, as opposed to in writing, which is one reason why in-person solicitation is strictly regulated by Medicaid. In addition, to the extent that patients reveal confidential information about their own health status through their choices (or their information search strategies), they may expose themselves to risk-selection and other forms of discrimination.

102. Furthermore, the actuarial technologies that would allow purchasers to compensate for risk selection by paying risk-adjusted amounts to health plans do not yet exist. See Sandra Shewry et al., *Risk Adjustment: The Missing Piece of Market Competition*, Health Aff., Spring 1996, at 171.

103. The dual role of health insurance in diversifying private risk and pooling social costs is a continuing subject of debate. See Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, in *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future* 26 (James A. Morone & Gary S. Belkin eds., 1994) (focusing on the difference between "actuarial fairness" and the more redistributive "solidarity principle").

104. Furthermore, disclosure can destabilize socially beneficial risk pools. If many managed care options exist, health plans can use consumers' preferences for certain characteristics to glean information about those consumers' likely utilization of services, and can price their products accordingly. This generates separating equilibria and reduces the risk of adverse selection, a potential benefit in a voluntary insurance market. However, it also increases the likelihood that high-risk individuals will find themselves uninsurable, which may not lead to optimal risk-bearing on a societal level. See Sherry Glied, *Managed Care 16-17* (National Bureau of Economic Research Working Paper No. 7205, 1999) (visited Oct. 9, 1999) <<http://www.nber.org/papers/w7205>> (on file with the *Columbia Law Review*) (discussing how asymmetric information about health risks leads to adverse selection and segmentation of the health care market).

105. See, e.g., Patricia Neuman et al., *Marketing HMOs to Medicare Beneficiaries: Do Medicare HMOs Target Healthy Seniors?*, Health Aff., July-Aug. 1998, at 132 (study of advertising answering the question posed in the affirmative).

106. On the other hand, even a genuine reputation for excellence can be disadvantageous if it attracts the sickest patients. For this reason, health plans (and providers paid on a fixed fee basis) have sometimes been reluctant to advertise their skill at treating AIDS or other expensive diseases. Mandatory disclosure might help overcome this tendency.

Another set of issues regarding disclosure relates to competitive conditions. First, maximum choice does not necessarily imply maximum efficiency in the health care system. Competition can and should occur along both price and non-price dimensions. However, high levels of quality differentiation can deter price competition by making consumers consider the differentiated products poor substitutes for one another. For example, health plans differentiate their products by varying benefit design in subtle ways, partly to avoid competing on price. Facing a trade-off between choice and competition, managed competition theory opted for the latter by imposing a standard benefit package, in the hope that consumers would recognize and respond to differences in price or measurable quality.

To the extent that abundant information about health plans and providers increases product differentiation more than it aids quality comparison, it may reduce price competition even as it increases nominal choice, ultimately disadvantaging consumers. For example, there is a rich literature debating the effects of advertising on competition. Some commentators hold that the informational value of advertising improves allocative efficiency by reducing search costs and better matching available products to prevailing preferences, while others maintain that advertising creates artificial distinctions among similar products and facilitates the acquisition of market power.¹⁰⁷

Mandatory information disclosure also has the potential to facilitate collusion in concentrated markets. In some parts of the country, a small number of health plans have garnered a large market share, and new entry is difficult.¹⁰⁸ Requiring frequent publication of cost and quality information in these settings could allow erstwhile competitors to coordinate prices or availability of services, leading to oligopoly.¹⁰⁹ Because information-sharing can also increase efficiency and benefit consumers, however, restrictions motivated by competitive concerns should be approached cautiously. For example, the Department of Justice and the Federal Trade Commission have announced an antitrust safety zone for quality-related information-sharing, but require that price information be

107. Compare E. Thomas Sullivan, *On Nonprice Competition: An Economic and Marketing Analysis*, 45 *U. Pitt. L. Rev.* 771, 788-92 (1984) (arguing that advertising benefits consumers), with H. Michael Mann, *Advertising, Concentration, and Profitability: The State of Knowledge and Directions for Public Policy*, in *Industrial Concentration: The New Learning* 138-56 (Harvey J. Goldschmid et al. eds., 1974) (arguing that advertising raises barriers to entry).

108. In the Minneapolis-St. Paul area, for example, three health plans service about 80% of the market. See Jan Greene, *The Minneapolis Myth, Hosp. & Health Networks*, Feb. 5, 1997, at 56.

109. Parallel concerns exist in other industries. For example, it has been suggested that rules requiring corporate insiders to disclose their securities trades may facilitate collusion among insiders in a given firm by allowing them to monitor each other's trading. See Steven Huddart et al., *Public Disclosure of Trades by Corporate Insiders in Financial Markets and Tacit Collusion* (manuscript on file with the author).

released only on a delayed basis and not be identified with specific competitors.¹¹⁰

Finally, there is a more direct conflict between competition and regulation, which is particularly problematic given the high expectations currently being placed on the competitive paradigm for health care financing and delivery. Like substantive quality standards, costly and complex disclosure regulations by their very nature favor large, experienced competitors over new entrants.¹¹¹ One objection to the new Medicare+Choice MegaReg, for example, is that it would deter smaller, more innovative parties from competing for Medicare business.¹¹² This problem is difficult for regulators to solve, because "small issuer" exemptions or other exclusions for selected parties may increase the politicization of any regulatory program, and ultimately may reduce its effectiveness by excusing from disclosure the very parties about whom the least is known to the market.¹¹³

D. *Salvaging the Competition Rationale*

Where does this leave competition as a justification for disclosure? Despite the primacy of the competition rationale in the political rhetoric of mandatory disclosure laws, the constraints discussed above suggest that the benefits of information are more modest than at first they might appear. Although medical practice is not as unitary nor medical "need" as absolute as critics of the market model often contend, the assumptions of feasibility and rational response that undergird predictions of efficiency through individual informed choice are contestable. That is not to say that information is useless to the competitive marketplace, only that comprehensive disclosure aimed at individual consumers is a poor candidate for regulatory intervention. Where individual consumers are concerned, disclosure is unlikely to be a practical substitute for minimum quality standards, private accreditation, and expert intermediaries. Nonetheless, disclosure laws can be beneficial when directed at group purchasers and other information intermediaries, and when geared to standardization and benchmarking rather than detail. By acknowledging the complexity of health care purchasing, however, this approach rejects the instinctive

110. See Department of Justice & F.T.C., *Statements of Antitrust Enforcement Policy in Health Care*, Statements 4–5 (1996).

111. See generally Robert M. Goldberg, *Why HMOs Now Love Regulation*, *Wall St. J.*, July 17, 1998, at A15 (arguing that regulations deter entry of higher quality competitors).

112. See HCFA *Issues Medicare+Choice Rules, Concerns Voiced Over Provisions*, *supra* note 21, at 1024–25 (1998) (quoting health care attorney William G. Schiffbauer as saying that the regulations pose "a daunting challenge to new entrants" into the Medicare market).

113. See Stephen J. Choi, *Company Registration: Toward a Status-Based Antifraud Regime*, 64 *U. Chi. L. Rev.* 567, 577–80 (1997) (describing the higher risks of securities fraud for smaller companies). The savings and loan crisis is a good example of political favoritism for local businesses leading to relaxation of regulatory standards.

political tendency to make consumer protection, no matter its form, available chiefly to unsophisticated buyers.

1. *Information Intermediaries.* — The competition rationale reaffirms the centrality of expert intermediation in today's health care system. A possible solution to the problems raised earlier is to find or create intermediaries who can locate information relevant to the parties they represent, analyze and distill it, and communicate it fairly and accessibly to individual consumers. Information intermediaries can be merely expert conduits for data,¹¹⁴ or can be directly involved in health care purchasing decisions. In fact, early conceptions of managed competition contemplated that plan sponsors (such as the Clinton plan's "health alliances") would digest and make available comparative information to individuals, who would use it to select desired combinations of price and quality.¹¹⁵

Employers, pension funds, and other group purchasers of health coverage therefore constitute valid audiences for disclosure,¹¹⁶ and perhaps should be subject to legal obligations with respect to information intermediation.¹¹⁷ Unlike most individuals, these parties have expertise,

114. Demand for health care information of all sorts is burgeoning, bringing forth a plethora of organizations ready to serve as intermediaries. See, e.g., *America's Best Hospitals: 1999 Hospital Guide*, U.S. News & World Rep., July 19, 1999, at 58–102; Ann Carrns, *Today's Cybercraze Is Any Website Devoted to Health or Maladies*, Wall St. J., June 10, 1999, at B1; Alex Kuczynski, *Rating of Doctors Now a Business Unto Itself*, N.Y. Times, Mar. 25, 1999, at B1 (describing publication of the "Manhattan Doctor Guide"). Although the quality of these publications vary, one recent study concluded that "America's Best Hospitals," as identified by U.S. News & World Report, indeed offered better short-term survival after myocardial infarction, largely because of more consistent use of established therapies such as aspirin and beta-blockers. See Jersey Chen et al., *Do "America's Best Hospitals" Perform Better for Acute Myocardial Infarction?*, 340 *New Eng. J. Med.* 286, 290–92 (1999).

115. See Enthoven, *supra* note 41, at 32. These sponsors had clear legal charters and defined responsibilities within a comprehensive regulatory framework. See, e.g., Health Security Act, H.R. 3600, 103d Cong. §§ 1300–1397 et seq. (1993) (outlining standards for "health alliances," whose task was to structure competition among health plans in designated geographic markets).

116. This is one respect in which health care has much in common with the securities markets. A longstanding challenge for the SEC—one it has not necessarily handled successfully—has been to craft disclosure regulations that are useful both to individuals and to large institutional investors. Consequently, subsets of securities regulation emphasize different goals. Required corporate disclosure, both registration statements for new issues and periodic reporting by traded companies, emphasizes detail needed by sophisticated purchasers at the expense of clarity for less knowledgeable ones. Mutual fund disclosure, on the other hand, has become shorter and more straightforward in an attempt to be intelligible to small investors. In 1983, the SEC introduced split disclosure for mutual funds, putting only the basics into the mailed prospectus and leaving the rest for a "statement of additional information" that is filed with the Commission but not distributed to investors. See Rules 495–497 under the Securities Act of 1933, 17 C.F.R. §§ 230.495–230.497 (1999); Adoption of Registration Form for Securities and Exchange Commission, 48 Fed. Reg. 37,928 (1983) (to be codified at 17 C.F.R. pts. 230, 239, 270 and 274); Frankel, *Trends*, *supra* note 98, 5–9.

117. One suggestion is to use potential revocation of the tax deductibility of health insurance premiums to persuade employers and their insurers and administrators to

defined goals, clear choices, and bargaining power. Indeed, private employers and employer-organized purchasing cooperatives have taken the lead in obtaining detailed disclosure from health plans and providers, even without legal mandates, and conveying it to beneficiaries.¹¹⁸ Many employers use disclosed information to select health plans for their workforce. Some corporations give employees formal explanations of the reasons for their choices; others make extensive information available to beneficiaries in addition to processing it internally. For example, Xerox allows its workers to choose among competing health plans based on standardized, comparative information provided by the plans and synthesized by the employer.¹¹⁹

Similarly, public employers have focused on disclosure as they expand the managed care options available to workers.¹²⁰ FEHBP requires health plans to submit detailed information which it compiles into a booklet containing comparative charts for federal government employees.¹²¹ Detailed disclosure formats have also been developed by state

collect and report standardized information. See Gwen Moulton, *Public/Private Quality Model for Health Care Revisited with Mixed Reviews*, 7 *Health L. Rep. (BNA)* 275, 276 (1998) (quoting Lynn Etheredge). Like other regulatory mandates in a voluntary, employer-based health system, the benefit of such a requirement must be balanced against the incentive its cost creates at the margin for employers to reduce coverage. See David M. Studdert et al., *Expanded Managed Care Liability: What Effect on Employer Coverage?*, *Health Aff.*, Nov.-Dec. 1999, at 7, 12-16.

118. See *Creating Consumer Choice in Healthcare: Measuring and Communicating Health Plan Performance Information* (Richard E. Curtis et al. eds., 1998) (describing the efforts of employer purchasing groups); Michael L. Millenson, *Demanding Medical Excellence: Doctors and Accountability in the Information Age 204-81* (1997) (describing how large companies use business strategies such as competitive bidding to negotiate more favorable rates and to improve quality); James Maxwell et al., *Managed Competition in Practice: 'Value Purchasing' by Fourteen Employers*, *Health Aff.*, May-June 1998, at 216. But see Ezekiel J. Einanuel, *Choice and Representation in Health Care*, 56 *Med. Care Res. & Rev.* 113, 131-36 (Supp. 1, 1999) (describing barriers to effective employer representation and proposing reforms).

119. See Millenson, *supra* note 118, at 342-43; Maxwell, *supra* note 118, at 221-22.

120. Although these programs do not make law per se, it is conceivable that government's purchasing leverage for its employees will be used to require health plans to disclose information to all their enrollees even in the absence of a formal legal mandate. For example, the Clinton Administration has announced that it will use the threat of being barred from FEHBP to force health plans to meet the "letter and spirit" of federal consumer protection law in their non-FEHBP enrollment. Robert Pear, *Clinton to Punish Insurers Who Deny Health Coverage*, *N.Y. Times*, July 7, 1998, at A1.

121. See 5 U.S.C. § 8907 (1994) ("(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans . . ."); see also Federal Employees Health Benefits Program, *Enrollment Information and Plan Comparison Chart* (1998) (visited Jan. 10, 1999) <<http://www.opm.gov/insure/html/openseas/htm/>> (on file with the *Columbia Law Review*). FEHBP also reviews brochures published by health plans to make sure they are complete, reasonable, and in the required format, and posts those brochures on the Office of Personnel Management website. See Office of Personnel Management, "The Federal

pension funds. For example, the California Public Employees Retirement System (CalPERS) gives beneficiaries a variety of information about how to select a health plan, how plans work, eligibility, and enrollment.¹²² CalPERS also publishes and distributes charts comparing features, rates, and benefits.¹²³ As noted previously, moreover, Medicare and Medicaid have expanded disclosure requirements markedly in recent months in compliance with new statutory mandates to promote health plan competition, and have committed themselves to roles as information intermediaries that resemble employer sponsorship.¹²⁴ For example, if Medicare moves toward a competitive bidding model, disclosed information may help government evaluate bids and monitor contractors.¹²⁵

However, group purchasers could become better at both obtaining data and communicating it.¹²⁶ A recent GAO study concluded that few organizations were meeting the high standards for disclosure suggested by the President's Quality Commission.¹²⁷ The GAO surveyed only large firms that offered a choice of health plans to employees; it is unlikely that even this much information is available in other settings. Furthermore, voluntary disclosure by health plans is likely only if absence of disclosure provokes a negative inference among purchasers.¹²⁸ Yet few consumers

Employees Health Program 1998 Plan Information" (visited Oct. 9, 1999) <<http://aps.opm.gov/insure/98/html/index.htm>> (on file with the *Columbia Law Review*).

122. See California Public Employees' Retirement System, Basic Health Plans (1993).

123. See *id.* CalPERS also publishes an annual health plan report card, which contains plan quality and performance data, including selected HEDIS indicators; a member satisfaction survey with specific information about members who changed plans; and a worksheet that allows members to determine health issues relevant to them. See 1997 Comparative Performance Data Sourcebook, *supra* note 36, at 291-93.

124. See *supra* text accompanying notes 16-20.

125. See generally Robert Pear, Clinton Proposes a Discount System on Medicare Costs, *N.Y. Times*, Oct. 19, 1999, at A1 (detailing President Clinton's latest proposals, including introduction of price competition among HMOs).

126. See Judith H. Hibbard et al., Choosing a Health Plan: Do Large Employers Use the Data?, *Health Aff.*, Nov.-Dec. 1997, at 178-79 (finding limited use of quality information); Jon R. Gabel et al., When Employers Choose Health Plans: Do NCQA Accreditation and HEDIS Data Count? (1998) (Commonwealth Fund report) (only five percent of employers reported that HEDIS data was "very important" in plan selection).

127. See U.S. General Accounting Office, Consumer Health Care Information: Many Quality Commission Disclosure Recommendations Are Not Current Practice (GAO/HEHS-98-137) (1998). According to the GAO, conventional insurance information explaining covered benefits and cost-sharing is typically provided, and clinical quality and satisfaction measures are sometimes available. Less often disclosed are the business arrangements and financial incentives used by managed care organizations, and assessments of the customer service aspects of performance.

128. In transactions involving asymmetric information, voluntary disclosure ("unraveling") will occur if an inference can be drawn from silence. See Douglas G. Baird et al., *Game Theory and the Law* 89-91 (1994). Unraveling is most likely under the following conditions: (i) a remedy exists for false (as opposed to no) disclosure, (ii) the information is verifiable after the fact by the other party or a court, (iii) the uninformed party is aware that the relevant information exists, (iv) the uninformed party is certain that the other party possesses the information, and (v) the informed party knows the

of health care are sophisticated enough to realize that a health plan's or provider's failure to offer detailed evidence of quality might indicate lack thereof.¹²⁹ In fact, several organizations that voluntarily disclosed HEDIS scores and other information to employers in the past have recently withdrawn their cooperation.¹³⁰ By setting and enforcing mandatory disclosure standards, the law could condition the market to receive information and thereby benefit both group purchasers and the individuals they represent.¹³¹

A critical issue going forward is whether employers will continue to mediate between health plans and employees. For various reasons, employment-based health coverage declined from 69.2% of the non-elderly population in 1987 to 63.5% in 1993.¹³² In 1998, moreover, 25% of employers offering a choice among health plans contributed a preset dollar amount (a "defined contribution") regardless of the plan selected, twice the percentage making a defined contribution in 1994.¹³³ Unlike a defined benefit, which requires the employer to choose a source of coverage, a defined contribution is merely cash. If this shift from defined benefit plans to defined contribution plans accelerates, as may occur if

uninformed party's preferences with respect to the information. See *id.* At a minimum, stimulating voluntary disclosure through unraveling therefore requires government enforcement of anti-fraud laws to deter participants from reporting false information rather than merely remaining silent.

129. A related problem is that, in the absence of context and comparability, an organization that discloses statistics such as clinical outcomes, or even the rate of malpractice claims against it, may discover that what it considers superior performance is not viewed as such by the market. Without benchmarks, consumers may focus on the negative aspects of disclosure, while the larger number of parties that decline to disclose remain inconspicuous. Given the cost of disclosure, a first-mover problem may result, in that no individual organization has sufficient incentive to offer information to customers who do not expect to receive it and may not understand it. In situations like this, mandatory disclosure can provide a much needed jump-start. Cf. Gillian K. Hadfield & David Thomson, *An Information-Based Approach to Labeling Biotechnology Consumer Products*, 21 *J. Consumer Pol'y* 551, 551 (1998) (discussing biotechnologically altered food products and recommending mandatory disclosure in the form of "simple alert label[s] . . . that will prompt consumers to assess their information needs and producers or others to supply those needs.").

130. See Thomas M. Burton, *Examining Table: Operation that Rated Hospitals Was Success, But the Patience Died*, *Wall St. J.*, Aug. 23, 1999, at A1.

131. In the securities law context, Rock speculates that the primary value of mandatory disclosure is that once firms become subject to SEC regulation, exit from the system is difficult, so that initial disclosure is seen by the market as making a credible commitment to continue high-quality, comprehensive disclosure indefinitely. See Edward Rock, *Securities Regulation as Lobster Trap: A Credible Commitment Theory of Mandatory Disclosure* 44 (Mar. 1999) (unpublished draft on file with the *Columbia Law Review*).

132. See Employee Benefits Research Institute, *The Future of Medical Benefits* 9 (Dallas L. Salisbury ed., 1998); see also Richard Kronick & Todd Gilmer, *Explaining the Decline in Health Insurance Coverage, 1979-1995*, *Health Aff.*, Mar.-Apr. 1999, at 30, 31-33.

133. See Paul Fronstein, *Insurance, Risk, and Responsibility: Toward a New Paradigm?*, Presentation to the University of Connecticut Law School (Apr. 1999).

rampant medical inflation resumes or if employers are threatened with liability relating to health plan malfeasance, group purchasers may adopt a much more passive role, foreclosing an important opportunity to improve market processes using information disclosure.¹³⁴

2. *Standardization.* — The benefits to competition of standardized data reporting over piecemeal information provide another argument in favor of regulatory action. Design and manufacturing standards are used in industry for two basic purposes: to generate economies of scale by limiting variety in production, and to lower transaction costs by facilitating coordination of use and reducing the need for quality monitoring by users.¹³⁵ Similar considerations apply to markets for information. Health care regulation has experimented with both standardized services and standardized information. For example, Medicare supplemental insurance (Medigap) regulation is based on limiting consumer choice to a few standardized benefits, while food labeling oversight requires standardized descriptions of nutritional content.¹³⁶

Standardization of health care disclosure has potentially fruitful effects on both the supply of and the demand for data. On the supply side, standardizing information required of health plans and providers, and the coordination among monitoring bodies it implies, can reduce data collection and processing costs. On the demand side, standardization of reporting methods, quality measures, and modes of presentation to consumers can help to assure data integrity and maximize comparability across providers, organizations, and geographic areas.¹³⁷

For example, standard protocols should be devised for risk- and severity-adjustment of performance information for both health care providers and insurers. Public and teaching hospitals have often complained that their mortality rates for surgical procedures and other treatments appear artificially high because their patients are sicker than average.¹³⁸

134. See Studdert et al., *supra* note 117, at 22.

135. See Charles P. Kindleberger, *Standards as Public, Collective and Private Goods*, 36 *Kyklos* 377, 378, 384 (1983).

136. See Medicare Payment Advisory Commission, *supra* note 21, at 151–56 (analyzing these programs as potential models for Medicare+Choice regulation).

137. Health policy experts seem to have reached consensus on the desirability of standardized measures for required reporting. See, e.g., Rosanna M. Coffey et al., *The Case For National Health Data Standards*, *Health Aff.*, Sept.–Oct. 1997, at 58, 59 (recommending methods for improving nationwide standardization of health data); David M. Eddy, *Performance Measurement: Problems and Solutions*, *Health Aff.*, July–Aug. 1998, at 7, 23 (noting utility of standardization). Standardization is useful even for descriptive information. See, e.g., Md. Regs. Code tit. 31, § 10.17.04(B)(1) (1998) (creating and requiring disclosure by health plans of standardized descriptions of physician compensation).

138. For example, private community hospitals typically perform routine heart valve replacement and coronary artery bypass graft surgery, but leave repeat operations (which are more technically demanding) and patients with serious coexisting illnesses to the large academic centers. Surprising regional variations exist as well. For example, the fact that hospitals in California generally fare better than hospitals in New York in terms of in-

Not only are unadjusted statistics misleading to consumers, but they create incentives at the margin to avoid caring for patients who might have bad outcomes, even though they are also those most in need of services.¹³⁹

Although trade associations or other private groups can achieve standardization voluntarily,¹⁴⁰ economic arguments exist for a government disclosure mandate. To the extent that purchasers use information disclosed by one organization to value competing organizations, the disclosing organization cannot capture the social benefits from disclosure.¹⁴¹ This externality, created by the potential for competitors to free ride on any single firm's disclosure, may be sufficient to justify regulatory intervention.¹⁴² Governmental action to standardize data reporting can be taken directly or in partnership with self-regulatory organizations. For example, several commentators have suggested creating a health care panel analogous to the Financial Accounting Standards Board, which establishes rules for financial reporting under SEC authority. Paul Ellwood, for example, envisions a body "which would specify the types of information that health care organizations would have to collect about their performance, how they would collect the information, analyze it and make it available to the public."¹⁴³

hospital mortality as reported by consumer publications is explainable to a large degree by the fact that California has developed non-hospital settings for terminal illness, while most people who die in New York die in hospitals. See Sherry Glied, Are "America's Best Hospitals" America's Best?, 278 JAMA 473 (1997) (letter to the editor).

139. This fear was voiced when New York State began publishing "report cards" for cardiac surgeons. Initial studies suggested that some surgeons in western New York were declining to treat high-risk individuals, sending them to Ohio or Pennsylvania for care. Fortunately, subsequent research has not revealed evidence of restricted access or increased out-of-state transfers. See Eric D. Peterson et al., The Effects of New York's Bypass Surgery Provider Profiling on Access to Care and Patient Outcomes in the Elderly, 32 J. Am. Cardiology 993, 993 (1998).

140. One step in this direction is a recently announced effort by the three largest health care accrediting organizations—NCQA, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and the American Medical Accreditation Program (AMAP)—to coordinate their quality and performance measurement activities. See Andrew A. Skolnick, JCAHO, NCQA, and AMAP Establish Council to Coordinate Health Care Performance Measurement, 279 JAMA 1769, 1769 (1998).

141. In other words, standardized information about competitors is partly a public good. See Anat R. Admati & Paul Pfleiderer, Forcing Firms to Talk: Financial Disclosure Regulation and Externalities (Apr. 1998) (unpublished working paper, on file with the *Columbia Law Review*). If all firms benefit from standardization in the way they communicate with customers, they may have sufficient incentive to join together and set standards voluntarily. Of course, any anticompetitive potential of foreclosing product differentiation by standard setting may prompt review under the antitrust laws.

142. The Forum on Health Care Quality is a public-private partnership created to promulgate standards for data reporting in accordance with the recommendations of the President's Advisory Commission. See *infra* text accompanying note 300.

143. Health Care System, on Verge of Collapse, Must Heal Itself, Reformer Says, *Fedgazette: Fed. Reserve Bank of Minneapolis Regional Bus. & Econ. Newsletter*, April 1991, at 4; see also Lynn Etheredge, Promarket Regulation: An SEC-FASB Model, *Health*

In summary, the competition rationale for disclosure-based regulation should not be abandoned, but neither should it be overstated. Arguably, it should be redirected to meet the needs primarily of group purchasers instead of individuals. This, however, magnifies the importance of assuring that group purchasers truly serve the needs of the health care consumers or other constituencies they purport to represent. Not only do insured individuals and group purchasers have disparate degrees of sophistication; they have different objectives. The former seeks to maximize personal benefit from health insurance, based often on idiosyncratic concerns and ex post perceptions, while the latter strives to minimize aggregate cost and residual risk.¹⁴⁴ This leads us to the second rationale for disclosure laws. If individual interests are to be protected through disclosure, the protection required is most likely from group purchasers themselves, and from other intermediaries that translate individual needs and resources into the financing and delivery of health care services.

II. THE AGENCY RATIONALE: MONITORING INTERMEDIARIES THROUGH DISCLOSURE

A. *Agency Relationships in Health Care*

Agents and intermediaries dominate modern health care.¹⁴⁵ Employers, government, and other health plan sponsors act as purchasing agents for defined classes of beneficiaries. Insurance organizations pool risk and arrange services for policyholders. Physicians and other health professionals not only choose among treatments they themselves deliver but also help select other providers with specialized expertise or resources. The risks of relying on these agents went largely unnoticed as long as consumers, employers, and taxpayers were willing to fund unlimited amounts of care, except perhaps insofar as their presence manifested

Aff., Nov.–Dec. 1997, at 22, 23 (“If we want a market that is driven by quality-based competition, we need a common set of reporting requirements and publicly available data about each health plan.”).

144. See Mark V. Pauly, *The Public Policy Implications of Using Outcome Statistics*, 58 *Brook. L. Rev.* 35, 47–48 (1992) (noting divergent incentives of employers and insured workers).

145. See Emanuel, *supra* note 118, at 117–22. This Article uses the term “agent” in its general economic sense to mean anyone who makes a decision on behalf of another, whether or not the agent bears any special responsibility to the principal, whether or not the principal can control the agent, and whether or not the agent deals with third parties in carrying out her assignment, although those considerations may be addressed in specific situations. By contrast, the law of agency takes a narrower view, defining an agent as a fiduciary subject to the principal’s right of control. See *Restatement (Second) of Agency* § 1 (1958); see also Deborah A. DeMott, *A Revised Prospectus for a Third Restatement of Agency*, 31 *U.C. Davis L. Rev.* 1035, 1053 (1998). Health care relationships can be formal agencies—especially in modern medicine where insurance companies, health care institutions, and physicians frequently must deal with third parties on behalf of patients, and where the law treats patients (if not always insurance enrollees) as autonomous actors—but need not be.

itself in excessive services and high prices. In traditional fee-for-service medicine, physicians' financial incentives were relatively straightforward: greater utilization meant more income. Although this did not always result in optimal treatment, neither was it unexpected. Subtler conflicts of interest arose when physicians had ownership interests in, or contractual affiliations with, health service providers, such as medical laboratories, hospitals, and radiology facilities, and frequently and preferentially referred patients to them for services.¹⁴⁶ Nonetheless, such arrangements usually took financial advantage of third-party payers without clearly compromising patient care.

The rapid conversion of the American health system to managed care has magnified the need to safeguard agency relationships. The most significant threat created by managed care is its explicit cost constraint. In a system whose priority is curtailing aggregate spending, the potential danger to patient welfare of divergent interests between principal parties and their agents is much starker. If costs can be "managed," plan sponsors such as employers and government can benefit financially at the expense of the constituencies they are supposed to represent. In contrast to the individual patient focus of traditional medical ethics, these intermediaries exist to serve collectives. For example, trustees administering ERISA plans owe their loyalty to the plan, not to individual beneficiaries.¹⁴⁷ Their responsibilities are complex: unlike directors of corporations, who represent shareholders that are for the most part similarly situated, plan trustees are constantly confronted with situations where the interests of a single participant are in conflict with the interests of the plan as a whole.¹⁴⁸ Further, self-dealing by purchasers may be subtle, in that it often benefits other pooled interests, such as those of share-

146. Research on these arrangements reveals that physician-owned facilities charge higher prices and perform more services than independent facilities. See Jean M. Mitchell & Jonathan H. Sunshine, *Consequences of Physicians' Ownership of Health Care Facilities—Joint Ventures in Radiation Therapy*, 327 *New Eng. J. Med.* 1497, 1499–1500 (1992); Alex Swedlow et al., *Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians*, 327 *New Eng. J. Med.* 1502, 1502 (1992).

147. See *infra* text accompanying notes 185–190. Although ERISA plans are not permitted to discriminate against individual beneficiaries, see 29 U.S.C. § 1140 (1994), non-discrimination is a far cry from representation.

148. Corporate law offers an analogy. It is often assumed that large, sophisticated parties—institutional investors—are better able to monitor corporate officers and directors than small shareholders. At the same time, however, institutional investors do not perfectly represent general shareholder interests, and have their own agency obligations to constituents. The parallels to group health care purchasers and insurers are imperfect, but potentially instructive. See generally Bernard S. Black, *Agents Watching Agents: The Promise of Institutional Investor Voice*, 39 *UCLA L. Rev.* 811, 812–20, 826–27 (1992) (discussing institutional investors' role in corporate oversight); Elliott J. Weiss & John S. Beckerman, *Let the Money Do the Monitoring: How Institutional Investors Can Reduce Agency Costs in Securities Class Actions*, 104 *Yale L.J.* 2053, 2105–27 (1995) (arguing for institutional investor oversight of both opportunistic and collusive class action suits).

holders or taxpayers, rather than the agents themselves. The fact that care management activities increasingly are conducted by profit-oriented, non-professional parties such as managed care organizations adds another layer of agency risk.

Managed care is also challenging and perhaps redefining the agency obligations of physicians in fundamental ways. Managed care commits physicians to the care of groups of patients and may yield dividends in disease prevention, screening, and early treatment. At the same time, however, a population-based approach necessarily asks physicians to consider collective needs when allocating scarce resources and therefore is at variance with the ethical traditions of medicine. As the editor-in-chief of the *New England Journal of Medicine* recently observed: "If we capitulate to an ethic of the group rather than the individual, and if we allow market forces to distort our ethical standards, we risk becoming economic agents instead of health care professionals."¹⁴⁹

Managed care organizations enforce a group orientation using financial incentives that induce physicians to recognize the collective cost consequences of their treatment recommendations.¹⁵⁰ However, these methods of payment potentially weaken physicians' commitment to individual patients' best interests and may lead them to limit necessary as well as wasteful care.¹⁵¹ Because many arrangements in essence require physicians to assume insurance risk, they also create incentives to avoid treating sicker patients. Moreover, physicians who participate in many different payment schemes may be tempted to steer particular patients into the health plan with the most favorable reimbursement, whether or not it is in the patient's medical interest.¹⁵²

149. Jerome P. Kassirer, *Managing Care—Should We Adopt a New Ethic?*, 339 *New Eng. J. Med.* 397, 398 (1998).

150. See Barry R. Furrow, *Incentivizing Medical Practice: What (If Anything) Happens to Professionalism?*, 1 *Widener L. Symp. J.* 1, 27 (1996); David Blumenthal, *Effects of Market Reforms on Doctors and Their Patients*, *Health Aff.*, Spring 1996, at 170, 175–76.

151. Managed care has developed an extraordinary diversity of provider compensation mechanisms. Thus far, however, financial incentives have not been based on demonstrated improvement of individual or population health, but tend to reward crude reductions in service. "Withhold pools" set aside a portion of fees owed to physicians, in effect penalizing them for ordering high levels of specialist, hospital, or ancillary care. Fixed-fee capitation consists of a preset monthly payment based on the number of enrollees for whom a physician is responsible, whether or not they seek treatment, and benefits physicians who minimize patient contacts. Capitation may be limited to the services of primary care or specialist physicians, or may cover all services, including hospitalization. Case rates such as diagnosis-related group (DRG) payments to hospitals, and "contact capitation" or similar methods for paying physicians, encourage initiation of care but create incentives to limit services within each treatment episode.

152. Although HCFA has expressed discomfort with the possibility of steerage in the Medicare+Choice program, and the AMA has cautioned its members about potential fraud and abuse liability, all parties agree that physicians will be asked for their advice and are well qualified to respond. See *American Med. Ass'n, Medicare+Choice: What You Should Say or Not Say to Your Patients* 5 (1999), (visited Sept. 23, 1999) <<http://www.ama->

Recent structural changes in health care financing and delivery obscure the position in the marketplace of many of these intermediaries. Some agents, such as employers who make available a choice of health plans to their employees, are concerned with procurement alone. Others combine procurement with delivery of services: these include "direct-contracting" employers, insurers and HMOs who assemble and manage networks of providers,¹⁵³ and even primary care "gatekeeper" physicians who control specialist referrals as much as they render services.¹⁵⁴ Given the prepaid character of managed care, the funds that support these functions are integrated, rather than fees being paid for discrete activities. Consequently, particular organizations may act at different times as buyers, buyers' agents, sellers' agents, or sellers. All of these parties may also play informational roles vis-à-vis individual consumers, recommending health plans, physicians, or particular therapies. Pure "information intermediaries," such as accrediting bodies and quality rating organizations, are increasingly common as well.

B. *Agency-Related Disclosure Obligations*

Because of the risk that intermediaries will not perform effectively in transactions they undertake, principal parties must expend resources, termed "agency costs," to select and monitor them. Mandatory disclosure laws can reduce agency costs.¹⁵⁵ Focusing legal intervention on information to support agency relationships avoids some of the criticisms leveled at the competition rationale for mandatory disclosure. Bureaucratically determined disclosure requirements are often lambasted as costly, cumbersome, and misdirected—reflecting the flawed assumption that government knows better than the market what the market needs, and can ob-

assn.org/advocacy/healthpolicy/medicare/medicare.htm> (on file with the *Columbia Law Review*). See *infra* notes 209–210.

153. Some view the primary agency role of managed care organizations as assuring physician competency by measuring and rewarding successful outcomes. See, e.g., Lee N. Newcomer, *Measures of Trust in Health Care*, *Health Aff.*, Winter 1997, at 50. For this reason, many states require plans to disclose to beneficiaries the manner in which physicians are selected and quality is assured. See, e.g., N.Y. Pub. Health Law § 4408(2)(g), (k) (McKinney Supp. 1999).

154. Surprisingly, information about physician quality produced in response to current disclosure mandates fails to discriminate between their skills as agents and their skills as direct providers. This is especially important in managed care because most health plans require enrollees to select a primary care ("gatekeeper") physician to coordinate referrals to specialists. In particular, although HEDIS and other performance scales evaluate health plans based on ease of access to specialists, no tools currently exist to measure individual physicians' referral skills. Information is also sadly lacking with respect to physicians' communications abilities and educational practices, even though it is a fair surmise that physicians who spend time learning about patients' objectives and concerns will be more likely to carry out their agency duties well.

155. This rationale for disclosure has been explored primarily in the context of securities regulation. See, e.g., Paul G. Mahoney, *Mandatory Disclosure as a Solution to Agency Problems*, 62 *U. Chi. L. Rev.* 1047 (1995).

tain it less expensively.¹⁵⁶ These arguments apply with much less force to the subset of information that concerns agency. Information suggesting that an agent's loyalty or competence is compromised is extremely useful to a principal party, and is unlikely to be revealed voluntarily by the agent.¹⁵⁷ In addition, the cost of disclosing conflicts of interest and similar matters is usually modest. Unlike disclosure that entails extensive data gathering, analysis, adjustment, and auditing, such as report cards derived from HEDIS measures, information about agency issues in health care is generally descriptive, and is therefore relatively inexpensive to produce and disseminate.

Although agency is less commonly invoked than competition as an explicit justification for disclosure laws in health care, many statutes and regulations emphasize agency obligations. In particular, a growing body of law mandates disclosure in written enrollment material circulated to current and potential subscribers of the financial incentives that managed care plans offer physicians to induce them to conserve treatment expense.¹⁵⁸ Since 1996, for example, the federal government has re-

156. The federal securities laws frequently have been attacked on those grounds. See, e.g., Macey, *supra* note 49, at 52; Stigler, *supra* note 49. The most powerful theoretical argument against mandatory disclosure is the efficient capital market hypothesis, which in its strong form postulates that securities prices already reflect all information, including that known only to insiders. See Eugene F. Fama, *Efficient Capital Markets: II*, 46 *J. Fin.* 1575, 1575-77 (1991); Eugene F. Fama, *Efficient Capital Markets: A Review of Theory and Empirical Work*, 25 *J. Fin.* 383, 383 (1970). More recently, behavioral economics and "noise theory" have cast doubt on both the strength and rationality of market efficiency. See Donald C. Langevoort, *Theories, Assumptions, and Securities Regulation: Market Efficiency Revisited*, 140 *U. Pa. L. Rev.* 851 (1992).

157. Evidence suggests that voluntary disclosure of conflicts of interest in health care is indeed uncommon. In a recent survey of leading purchasers and their associated health plans regarding disclosure practices, the U.S. General Accounting Office failed to find a single instance in which beneficiaries received disclosure of financial incentives paid to physicians. See U.S. General Accounting Office, *supra* note 127, at 11.

158. Physician financial incentives are regulated through a combination of substantive prohibitions and disclosure requirements. Under federal law applicable to HMOs and competitive medical plans contracting with Medicare or Medicaid, payments may not be made "as an inducement to reduce or limit medically necessary services provided with respect to a specific individual." 42 U.S.C. § 1395mm(i)(8)(A)(i) (1994). State substantive regulation of financial conflicts of interest are also being extended to managed care incentives. See Tracy E. Miller, *Managed Care Regulation: In the Laboratory of the States*, 278 *JAMA* 1102, 1103-04 (1997). As of September 1998, 21 states had banned incentives that encourage physicians to skimp on "medically necessary" treatment. See Health Policy Tracking Service (1998); see also Fred J. Hellinger, *Regulating the Financial Incentives Facing Physicians in Managed Care Plans*, 4 *Am. J. Managed Care* 663 (1998) (surveying state legislation mandating disclosure of managed care plan financial relationships with physicians and/or prohibiting the use of financial inducements to physicians to reduce services); Wendy L. Krasner & Thomas J. Walsh, *The Regulation of Physician Incentives in Health Law Handbook* 179 (Alice G. Gosfield ed., 1995) (reviewing federal statutes and regulations addressing limitation or reduction of services by providers); Beth Schermer & Lawrence Foust, *Assumption of Risk: Federal Regulation of Physician Incentive Plans*, 30 *J. Health & Hosp. L.* 1 (1997) (outlining various physician incentives and regulatory responses to them).

quired health plans that serve Medicare or Medicaid beneficiaries to report financial incentives to the Health Care Financing Administration and to enrollees upon request.¹⁵⁹ More recently, President Clinton ordered all federal health programs to implement the recommendations of the President's Advisory Commission, including that health plans disclose provider payment methods in their enrollment materials.¹⁶⁰ Nearly twenty state governments also require health plans to explain provider compensation to enrollees.¹⁶¹ Some states mandate disclosure of all types of incentives, including fee-for-service payment, while other states focus narrowly on incentives to limit treatment.

In addition to imposing affirmative disclosure obligations, legislative efforts to promote agency through information have prohibited private restrictions on information exchange.¹⁶² After a well-known Boston physician who had been vocal in his opposition to managed care was "deselected" from an insurer's provider network, rumors quickly circulated that health plans were infringing professional relationships and forbidding doctors from discussing treatments not covered by the plan.¹⁶³ Although little evidence exists that so-called "gag clauses" in managed care contracts are impairing physician-patient communications,¹⁶⁴ nearly every state has enacted legislation outlawing contractual restrictions on

159. See Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans, 42 C.F.R. § 417 (1998).

160. See *supra* note 43 and accompanying text.

161. See Tracy E. Miller & William M. Sage, *Disclosing Physician Financial Incentives*, 281 JAMA 1424, 1427 (1999).

162. Relatedly, several states have enacted laws prohibiting health plans or providers from retaliating against physicians who advocate for their patients. See William M. Sage, *Physicians as Advocates*, 35 Hous. L. Rev. 1529, 1548-50 (1999) [hereinafter Sage, *Advocates*]. California's legislation, for example, was adopted to allow physicians to comply with a judicially imposed duty of advocacy in pursuing coverage of medically necessary services. See Cal. Bus. & Prof. Code § 2056(c) (West 1999) (prohibiting termination of or retaliation against physicians as a result of patient advocacy); *Wickline v. State*, 228 Cal. Rptr. 661, 671 (Cal. Dist. Ct. App. 2d 1986) (imposing advocacy duty on physicians in dictum). In the first successful suit brought under the advocacy statute, a jury awarded \$1.75 million in compensatory damages to a physician who had been terminated by his medical group. See *Self v. Children's Associated Medical Group*, No. 695870 (Cal. Super. Ct. 1998). The case settled prior to the punitive damage phase. See Julie Marquis, *Doctor Gets \$2.5-Million Settlement*, L.A. Times, Apr. 28, 1998, at A3.

163. See Alison Pass, *Focusing on Managed Care*, Boston Globe, Dec. 21, 1995, at 32. Effective communication has always been an important component of the fiduciary relationship between physicians and patients. For example, longstanding confidentiality requirements and testimonial privileges associated with physician-patient communications are intended to foster openness and honesty. See Barry R. Furrow et al., 1 *Health Law* §§ 6-19, at 445-57 (1995). Even without specific legal prohibitions on gag clauses, provisions that impede discussion of the risks, benefits and alternatives to proposed treatment would generally conflict with informed consent obligations.

164. See General Accounting Office, *Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, But Physician Concerns Remain* 2-3 (1997).

disclosure.¹⁶⁵ Similarly, Medicare immediately issued an advisory notice to participating managed care plans warning them that gag clauses violated their coverage agreements.¹⁶⁶ Congress has also included gag clause prohibitions in its most recent reform proposals.¹⁶⁷

Still more agency-related disclosure obligations have been imposed by courts, which have concentrated their attention on two areas: informed consent by physicians and the informational responsibilities of trustees and administrators of ERISA plans.¹⁶⁸ With respect to informed consent, managed care has raised new questions about the extent to which physicians' existing disclosure responsibilities should be modified to reflect the changed economic environment of clinical practice and the

165. See, e.g., Cal. Bus. & Prof. Code § 2056.1 (West Supp. 1999); Ga. Code Ann. § 33-20A-7 (Supp. 1998); Ind. Code Ann. § 27-13-15-1(a) (2) (Michie Supp. 1998); Me. Rev. Stat. Ann. tit. 24-A, § 4303(3) (West Supp. 1998); R.I. Gen. Laws § 23-17.13-3(8) (1996); Wash. Rev. Code Ann. § 48.43.075 (West 1999); see also Robert Pear, *Laws Won't Let HMOs Tell Doctors What to Say*, N.Y. Times, Sept. 17, 1996, at A12.

166. See Office of Managed Care, Operational Policy Letter # 44 (Nov. 25, 1996) (interpreting 42 U.S.C. § 1395mm(c)(2)(A) (1994) to mean that "[c]ontractual provisions that limit a physician's ability to . . . counsel or advise a Medicare beneficiary are a violation of the law" insofar as they limit discussion of "medically necessary treatment options that may be appropriate for the individual's condition or disease"). See also Robert Pear, *U.S. Bans Limits on H.M.O. Advice Within Medicare*, N.Y. Times, Dec. 7, 1996, at A1.

167. See, e.g., Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, 106th Cong. § 131 (1999) (bill passed by House of Representatives). Although most proposals focus on discussion of treatment alternatives, some are much broader. For example, one bill defines "medical communication" to include information about provider compensation, utilization review procedures, drug formularies, and experimental coverage determinations, in addition to the patient's medical condition and treatment options. See H.R. 3547, 105th Cong. § 3(a) (1998).

168. In addition to its preemption provision, ERISA contains explicit disclosure requirements, and imposes fiduciary duties on employers and managed care organizations to whom responsibility to administer employee benefit plans is often delegated. See 29 U.S.C. §§ 1105, 1109, 1132 (1994 & Supp. III 1997). ERISA expressly requires plan trustees to provide beneficiaries with a "Summary Plan Description" (SPD), "written in a manner calculated to be understood by the average plan participant," describing rights and obligations under the plan, including benefits, procedures for claiming benefits, and methods for appealing denials of claims. 29 U.S.C. §§ 1021-1022 (1994 & Supp. III 1997); 29 C.F.R. §§ 2520.102-5, 2560.503-1 (1999). These provisions, like most of ERISA's specific requirements, were designed primarily for pension benefits. However, SPDs are also required for welfare benefits, including health coverage. The fiduciary obligations imposed by ERISA include conveying accurate information about the plan. In *Varity Corp. v. Howe*, 516 U.S. 489, 506-07 (1996), the Supreme Court held that ERISA's fiduciary duty provisions prohibit plan administrators from making intentional misrepresentations about the plan. In addition, the Court gave a huge boost to existing disclosure duties by permitting plan beneficiaries to sue in their own right for breaches of fiduciary duties, rather than being limited to bringing actions in the name of the plan. However, the Court expressly left open the question whether ERISA imposes affirmative disclosure obligations on plan fiduciaries, beyond those contained in the statute and regulations. See *id.* Lower courts are beginning to address this issue, generally holding in favor of plaintiffs. See, e.g., *Krohn v. Huron Mein'l Hosp.*, 173 F.3d 542 (6th Cir. 1999) (holding that ERISA imposes an affirmative duty on the employer to disclose the availability of coverage).

resultant threat to the integrity of agency relationships.¹⁶⁹ Specifically, courts must determine whether the scope of required disclosure should extend beyond the physical risks of treatment to other matters that shape patients' access to treatment, course of care, and clinical outcomes. Candidates for disclosure include information about physicians' individual biases, skills, expertise, and incentives, as well as external constraints on their ability to pursue their patients' medical interests.¹⁷⁰ For example, informed consent law is beginning to consider the relevance to patients of physician compensation arrangements and other financial interests.¹⁷¹ To date, most courts have resisted requiring so-called "physician-specific" disclosure.¹⁷² This may change as managed care encourages primary

169. Notably, the risks of non-treatment that managed care has brought to the forefront are not easy to redress through informed consent law, which deals mainly with acts rather than omissions. Compare N.Y. Pub. Health Law § 2805-d (McKinney 1997) (limiting informed consent to treatments and invasive diagnostic procedures), with *Truman v. Thomas*, 611 P.2d 902 (Cal. 1980) (requiring disclosure of risks of not consenting to a pap smear).

170. Because informed consent has traditionally focused on the administration of medication or the performance of invasive procedures, most disclosable information relates to the patient's intrinsic medical condition and the objective characteristics of the available treatments, not to extrinsic factors affecting the patient's caregivers. One bridge between the two categories is information about the HIV status of the physician, disclosure of which remains unsettled in both law and legal scholarship. See, e.g., *Doe v. Noe*, 690 N.E.2d 1012 (Ill. App. Ct. 1997) (imposing an absolute duty on physicians to disclose HIV status when seeking a patient's consent to perform an invasive medical procedure which exposes the patient to the risk of HIV transmission); see also Bobinski, *supra* note 8.

171. Nearly a decade ago, the California Supreme Court allowed informed consent and breach of fiduciary duty claims to proceed against a physician for failing to disclose financial interests. See *Moore v. Regents of the University of California*, 793 P.2d 479 (Cal. 1990). In *Moore*, the physician had allegedly removed tumor cells from a patient to create a patentable cell line without disclosing his financial interest in the results of the procedure. According to the court, "a physician who is seeking a patient's consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient's informed consent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment." *Id.* at 485. More recently, a Minnesota court ruled that payments received from a pharmaceutical manufacturer to prescribe particular medication were within the scope of a physician's informed consent obligations. See *D.A.B. v. Brown*, 570 N.W.2d 168 (Minn. Ct. App. 1997). However, both cases involved treatment actually rendered; no court has yet considered disclosure of incentives in a situation where treatment was withheld. In neither of these decisions, moreover, was informed consent the central issue in the case. The *D.A.B.* ruling ultimately went against the plaintiff, and the *Moore* decision has not had a discernable effect on other litigation, even in California. An intermediate situation is most likely to bring the issue to litigation. If a less expensive but arguably less effective treatment is delivered in a situation involving managed care, a court might address the existence of financial incentives in connection with the explanation of risks, benefits, and alternatives that was given by the physician.

172. See, e.g., *Ditto v. McCurdy*, 947 P.2d 952, 958 (Haw. 1997) ("we decline to hold that a physician has a duty to affirmatively disclose his or her qualifications or the lack thereof to a patient"); *Abram v. Children's Hosp. of Buffalo*, 542 N.Y.S.2d 418, 419 (N.Y. App. Div. 1989) (rejecting argument that informed consent required disclosure of qualifications of staff participating in plaintiff's surgery); *Whiteside v. Lukson*, 947 P.2d

care physicians to perform procedures with which they have little experience, and restricts referrals to better trained but more costly specialists.¹⁷³

As regards ERISA, some but not all courts have interpreted the statute as imposing an affirmative duty on employers and health plans to disclose physician financial incentives under federal law.¹⁷⁴ Because insurers who are not administrators of employee benefit plans do not have formal fiduciary duties to policyholders, these cases are more difficult to bring outside of the ERISA context. For example, the first case to challenge financial incentives in managed care unsuccessfully argued that HMOs' concealment of payments made to physicians constituted a pattern of fraudulent non-disclosure prohibited by the federal Racketeer

1263, 1265 (Wash. Ct. App. 1997) ("a surgeon's lack of experience in performing a particular surgical procedure is not a material fact for purposes of . . . informed consent"); *Thomas v. Wilfac, Inc.*, 828 P.2d 597, 601 (Wash. Ct. App. 1992) ("[informed consent] requires disclosure of material facts relating to treatment, not disclosure of a physician's qualifications"); see also *Furrow*, supra note 12, at 289-90 (stating that the law has consistently avoided a rule of informed consent that requires disclosure of physician risk); Rebecca Walker, Note, *Governing Physician-Associated Risk Disclosure by Adopting the ADA "Direct Threat" Approach: Doctors, Pack Up Your Stethoscopes and Get Out Your Checkbooks*, U. Ill. L. Rev. 1199, 1207-10 (1997) (discussing problems with informed consent and common-law fiduciary principles).

173. In one recent case, the Wisconsin Supreme Court approved a jury verdict holding a physician liable for not disclosing his inexperience in operating on a particular type of cerebral aneurysm, because "[a] reasonable person in the [patient's] position would have considered such information material in making an intelligent and informed decision about the surgery." *Johnson v. Kokemoor*, 545 N.W. 2d 495, 505 (Wis. 1996).

174. In *Shea v. Esenstein*, 107 F.3d 625 (8th Cir. 1997), cert. denied, 118 S. Ct. 297 (1997), a primary care physician who was penalized by the plaintiff's health plan for the cost of specialist referrals failed to refer the plaintiff to a cardiologist, even though he was at high risk for coronary artery disease. The plaintiff, who was unaware of the physician's financial interest in reducing referrals, subsequently died of a heart attack. The Eighth Circuit reversed the district court's dismissal of a claim against the defendant HMO, which had served as the administrator of the decedent's employee benefit plan, for breach of fiduciary duty under Section 502 of ERISA. The court reasoned that "the duty of loyalty requires an ERISA fiduciary to communicate any material facts which could adversely affect a plan member's interests," and ruled that financial incentives were material. *Id.* at 628. In *Drolet v. Healthsource, Inc.*, 968 F. Supp. 757 (D. N.H. 1997), a federal district court in New Hampshire followed *Shea* and denied a motion to dismiss brought by an HMO serving ERISA plan beneficiaries, holding that it was a fiduciary whose duty of loyalty required it to disclose material facts, potentially including financial incentives. Unlike the individual plaintiff in *Shea*, the plaintiffs in *Drolet* were the class of beneficiaries subjected to the incentives, none of whom had as yet suffered injury. In *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748 (S.D.N.Y. 1997), however, a New York district court declined to require insurance administrators to disclose physician financial incentives, at least in the absence of actual injury to a beneficiary. The court reasoned that the administrator, although a plan fiduciary, was not subject to the specific disclosure obligations that ERISA places upon employers. *Id.* at 754-55; accord *Ehlmann v. Kaiser Found. Health Plan*, 20 F. Supp. 2d 1008, 1012 (N.D. Tex. 1998) (refusing to imply disclosure requirements in addition to those specified in ERISA).

Influenced and Corrupt Organizations (RICO) statute.¹⁷⁵ However, interest in bringing disclosure-related claims under RICO may increase in the wake of a recent U.S. Supreme Court decision holding that the McCarran-Ferguson Act does not bar application of RICO to state insurance fraud.¹⁷⁶ In addition, one court considering lack of disclosure of physician financial incentives recently upheld a suit for breach of fiduciary duty under state law, independent of informed consent requirements or ERISA.¹⁷⁷

C. *Ambiguities in the Agency Rationale*

These trends notwithstanding, significant complexities underlie agency-related disclosure requirements. In many ways, the nuances of agency-related disclosure are the opposite of those discussed in the competition section of this Article. As noted above, for example, objections to competitive disclosure based on feasibility apply less forcefully to agency issues. On the other hand, the theoretical underpinnings of the agency rationale are shaky compared to the competition rationale, creating potentially fatal ambiguities in intent and effect. One cannot use information to support agency obligations unless one understands what those obligations are. Two competing notions exist regarding the nature and purpose of health care agency. The first is an economic construct, in which agency obligations, including insurance arrangements, are freely contracted for and hopefully efficient. The second is a professional paradigm, in which individual benefit is paramount and costs are secondary. Although disclosure is useful in each situation, neither health care regulators nor the courts have come to terms with the hard fact that there is, ultimately, a tradeoff between them.

1. *Individual Versus Collective Agency Obligations.* — At every level—philosophical, political, professional, and pragmatic—the distribution of resources between individual patients and society at large is *the* critical problem in American health policy. It is also one we have yet to solve—although our health care system is both costly and compassionate, it is far from universal. The absence of consensus on this larger question presents a dilemma for agency-enhancing disclosure, which suffers from a parallel uncertainty with respect to whom health care agents properly represent, individuals or collectives. All insurance markets present the classic “moral hazard” problem of divergent incentives between insurers

175. See *Teti v. U.S. Healthcare, Inc.*, Nos. 88-9808, 88-9822, 1989 U.S. Dist. LEXIS 14041 (E.D. Pa. Nov. 20, 1989), *aff'd*, 904 F.2d 694 (3d. Cir. 1990) (addressing withhold pools for physician referrals).

176. See *Humana Inc. v. Forsyth*, 119 S. Ct. 710 (1999). For example, a class action suit was recently filed against Aetna/U.S. Healthcare by health plan members alleging that the plan's advertising constituted a nationwide fraudulent scheme to mislead the public. See Robert B. Lowry & Lawrence J. Rose, *Aetna RICO Lawsuit Uses New Theory to Challenge Health Delivery, Financing*, 8 Health L. Rep. (BNA) 879 (1999).

177. See *Neade v. Portes*, 710 N.E.2d 418 (Ill. App. Ct. 1999).

and insured individuals. However, health insurance heightens this tension, in part because the poignancy of disease as an *ex post* predicament leads both legislatures and courts to revisit the *ex ante* bargain articulated in the insurance contract, and in part because employers and other champions of the collective viewpoint have become active proponents of "population health" as a proper objective for the private as well as the public health care system. Increasingly, "role uncertainty" plagues both health plans and physicians because the traditional functions of insurers and health professionals are to a considerable degree merged in managed care.

Physicians and other health professionals have traditionally viewed themselves as agents of individual patients, and have generally resisted countervailing pressures created by managed care. For example, the AMA's Council on Ethical and Judicial Affairs takes the position that physicians should act as advocates for individual patients regardless of the organizational structure within which they practice.¹⁷⁸ However, arguments can be made that physicians should factor collective costs and benefits into their treatment decisions. In a world of free contracting, consumers purchasing insurance may elect to sacrifice expensive treatments with marginal benefits in exchange for lower premiums and access to basic services, and may prefer that physicians enforce these obligations rather than corporations or bureaucrats.¹⁷⁹ Physicians may also have social responsibilities to avoid high-cost, low-benefit care, since health care is cross-subsidized not only within risk pools but from general funds, and society's resources are limited. For example, the president of the Institute of Medicine of the National Academy of Sciences recently argued that cost-effectiveness and other "considerations of public health and public well-being were indeed legitimate considerations in [the] individual encounter," because physicians are stewards for social in addition to individual resources.¹⁸⁰

On the other hand, circumstances may exist under which individual patients' interests should become paramount for managed care organizations. Insurance companies by definition accommodate pooled interests. Although certain aspects of health system design equally benefit all plan members and can be seen as fulfilling agency obligations to the group,

178. See Council on Ethical and Judicial Affairs, *Ethical Issues in Managed Care*, 273 JAMA 330 (1995) [hereinafter AMA Council, *Ethical Issues*].

179. See Mark A. Hall & Robert A. Berenson, *Ethical Practice in Managed Care: A Dose of Realism*, 128 Ann. Internal Med. 395 (1998) (examining the ethics of medical practice and its implications for both patients and physicians). See generally Steven H. Miles & Robert Koepp, *Comments on the AMA Report "Ethical Issues in Managed Care,"* 6 J. Clin. Ethics 306, 307-09 (1995).

180. Kenneth I. Shine, *The Health Sciences, Health Services Research, and the Role of the Health Professions*, 33 Health Services Res. 439, 444 (1998). Shine also points out the illogic of "the notion that we could provide healthcare to the medically indigent without having some social responsibility for healthcare expenditures, which would ultimately be reflected in the individual patient-doctor interaction." *Id.*

others inevitably affect care options and service quality for individual patients. Because managed care organizations have taken on physicians' traditional responsibilities for organizing and delivering care in addition to financing it, a strictly collective orientation no longer matches public expectations.

In modern health plans, moreover, it is naive to assume that any single physician is fully in control of patient care. Physicians still command many resources by virtue of their ability to prescribe and refer, but the health plan often determines the character and extent of those resources, as well as coordination among them. Furthermore, institutional rather than professional processes may have the greatest effect on overall quality. Physicians serving as individuals' agents may have little ability to influence these matters, while organizations acting as collective agents may not be attentive to idiosyncratic needs. A complicating factor is that agency obligations in health care relate to both financial and physical integrity. Corporate organizations accustomed to dealing in money terms and observing standards of fiscal prudence may not know how to apply those standards to situations where the stakes are measured in human lives.

Efforts to quantify whether health plans are enriching shareholders at the expense of patients exemplify the difficulties facing disclosure laws when health care agents serve multiple principals.¹⁸¹ A failed 1996 California ballot measure would have required health insurers to disclose their "medical loss ratios" to purchasers and the state.¹⁸² Proponents maintained that high levels of administrative spending correlate with poor clinical quality; however, low levels could equally indicate financial waste or the provision of unnecessary services.¹⁸³ Other attempts to police the loyalties of managed care organizations through disclosure have scrutinized profits and senior executive compensation. But these measures are prone to error and manipulation, and tend to be invoked primarily by lobbying groups seeking greater substantive regulation of man-

181. Whether non-profit status is associated with improved quality is a continuing subject of debate. Compare David U. Himmelstein et al., *Quality of Care in Investor-Owned vs Not-for-Profit HMOs*, 282 JAMA 159 (1999) (asserting higher quality of non-profit health plans), with David A. Hyman, *Hospital Conversions: Fact, Fantasy, and Regulatory Follies*, 23 J. Corp. L. 741 (1998) (disputing superiority of non-profit form).

182. See 1996 Cal. Legis. Serv. Prop. 214 (West). The "medical loss ratio" is the percentage of premium dollars that are spent on medical services, as opposed to administrative costs. The ballot initiative defined administrative costs as "expenses not related to the provision of direct health care services." *Id.*

183. In addition, rapidly growing health plans have lower medical-loss ratios because they must reinvest revenue to support capital expansion. See James C. Robinson, *Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*, *Health Aff.*, July-Aug. 1997, at 176. Administrative costs are also highly dependent on organizational structure and accounting convention. Administrative tasks performed in physicians' offices, for example, may appear as treatment costs because they are included in physician fees, while coordination of care may seem administrative despite its clinical value simply because it occurs at the health plan level.

aged care. For example, the California Medical Association compiles annual rankings of health plans according to medical-loss ratio and CEO earnings, and publicizes its findings aggressively to both consumers and legislators.¹⁸⁴

It is particularly difficult for ERISA plans to reconcile their various agency obligations. Unlike corporate insurers who simply must minimize payouts from prepaid premiums while honoring contractual commitments, ERISA plans are formally trustees of employees' funds.¹⁸⁵ Fulfilling these financial responsibilities while ensuring adequate care is a daunting challenge. Moreover, ERISA plans and their insurer or HMO administrators typically enter into contractual relationships with physicians, who themselves have fiduciary obligations to beneficiaries once those individuals become patients in need of care. These overlapping duties render arguments favoring disclosure of financial incentives under ERISA analytically strained.

For example, the question may arise whether an insurer acting as administrator of an ERISA plan must disclose to beneficiaries that it withholds fees from physicians in its network who refer patients to specialists more frequently than the insurer thinks appropriate. This is different from the question of whether the *physicians* must disclose their fee structures to patients under informed consent or general state fiduciary law. Whereas physicians act as fiduciaries for individual patients, employers and insurers represent the interests of beneficiaries only as a group. Therefore, financial incentives to withhold care are potentially self-dealing transactions for physicians vis-à-vis individual patients, but they are not conflicts of interest for the plan itself. If anything, financial incentives represent attempts by the plan to use resources prudently, while waste of those resources indeed would violate the trustees' fiduciary obligations.¹⁸⁶ And it is the plan, not the physician, upon which ERISA imposes a fiduciary duty.¹⁸⁷

184. See David R. Olmos, Study Says California HMOs Spend up to 31% on Overhead, L.A. Times, Apr. 7, 1994, at D1.

185. See 29 U.S.C. §§ 1001-1461 (1994). Nevertheless, employer-sponsored health plans suffer from an inevitable conflict of interest simply by virtue of their commitment to offering health coverage as a defined benefit. Because these plans are self-funded or experience-rated, the employer whose resources are diverted to health care from other uses desires to spend as little as possible, and the plan trustees want the greatest value from the available funds. If employee health coverage becomes funded as a defined dollar contribution, as is increasingly the case for pension plans, the employer's financial self-interest recedes; however, so does the employer's incentive to serve as an information intermediary, or otherwise to participate actively in employees' insurance decisions.

186. By contrast, failure to disclose discounts from physicians received by the plan administrator but not passed along to beneficiaries as lower co-insurance payments would violate fiduciary restrictions against concealed self-dealing. See, e.g., *McConocha v. Blue Cross & Blue Shield*, 898 F. Supp. 545 (N.D. Ohio 1995).

187. Under ERISA, a person is a "fiduciary" to the extent that he exercises any discretionary authority or discretionary control in the management of the plan, the management or disposition of plan assets, or the administration of the plan. See 29 U.S.C.

What might justify requiring ERISA plan fiduciaries to disclose physician financial incentives if not an obligation to reveal self-dealing? The answer is that an agent must apprise principals of information relevant to their own decisions.¹⁸⁸ For example, the *Weiss* court observed that the use of "gag clauses" to hinder physician communication might breach ERISA plans' fiduciary duties, on the grounds that participants were entitled to "unfettered access to all relevant information relating to their physical or mental condition and treatment options."¹⁸⁹

However, this formal analysis is remote from the gut sense of professional betrayal that motivates most criticism of financial incentives in managed care. As a result, even federal circuit courts can seem unsure of the agency obligations that they are attempting to enforce. In *Herdrich v. Pegram*,¹⁹⁰ a panel of the U.S. Court of Appeals for the Seventh Circuit held that, regardless of disclosure, paying cost-saving financial incentives to physicians violated the *health plan's* fiduciary duty under ERISA. The court justified this odd finding by reference to the fact that the plan was owned and operated by physicians, not by an independent insurer. The court apparently reasoned that physicians who impose financial constraints on their own referral practices breach their obligations to the plan as a whole by tempting themselves to limit services to a greater degree than is compatible with "objective" medical judgment. Even if this is a sensible interpretation of ERISA, which is doubtful, its practical effect is to discourage physician control of health plans in favor of non-professional investor ownership, which is generally considered to present greater conflicts of interest and to maintain fewer professional safeguards against misbehavior.

These ambiguities in principal-agent relationships may be transitional, in that managed care as yet follows no paradigmatic structure, and consumer expectations are likely to change over time. Mandatory disclosure of information relating to the skills and loyalties of agents may therefore be preferable to a *Herdrich*-like prohibition because it allows practices and preferences to mature and coalesce before limiting the range of available alternatives. Disclosure is also potentially helpful to guide principal parties through this period of uncertainty, so that they have more realistic expectations about the relationship between the overall integrity of the health plan in which they have enrolled and the fulfillment of their individual medical needs. However, deciding who should disclose what to whom, and legally enforcing those obligations, probably requires

§ 1002(21)(A) (1994). Arguably, the managed care organizations to whom fiduciary duties are delegated by ERISA plan trustees must disclose their fees and profits, which might be influenced by the remuneration paid to physicians.

188. Although the legal obligation of a trustee to furnish information is generally limited to requests made by beneficiaries, a trustee has an affirmative duty to disclose all facts that he knows or should know are material in connection with transactions between the trustee and the beneficiaries. See Restatement (Second) of Trusts § 173 cmt. d (1959).

189. *Weiss v. Cigna Health Care, Inc.*, 972 F. Supp. 748, 751 (S.D.N.Y. 1997).

190. 154 F.3d 362 (7th Cir. 1998), cert. granted, 144 L. Ed. 2d 841 (1999).

greater consensus regarding the primacy of individual or collective concerns than currently exists.

2. *Fiduciary Contracting and Consent.* — Agents who are considered fiduciaries have special obligations. As Frankel observes, “[a] fiduciary society attempts to maximize both the satisfaction of needs and the protection of freedom.”¹⁹¹ Fiduciary relationships therefore imply a degree of vulnerability and reliance beyond that of buyers and sellers in arms-length business arrangements. Contractual protections are insufficient to assure the integrity of fiduciary relationships. Unlike contractually undertaken agency responsibilities, fiduciary duties are grounded at least in part on the status of the parties involved. Consequently, although parties to fiduciary relationships often assume their relative positions by virtue of a written document or other consensual behavior, their continuing responsibilities to one another are generally defined apart from that agreement, frequently by the law of trusts or statutes derived from trust law, such as ERISA.

Disclosure as a strategy to reduce agency costs can be viewed in two ways. First, disclosure can be seen in purely economic terms as a subset of competitively relevant information, allowing efficient outcomes to be reached by enabling principal parties to reassert direct control when agents stray, or to exit unsatisfactory agency relationships and replace them with better ones—in each case deterring agency failures *ex ante*.¹⁹² For example, the simplest approach to monitoring an agent is to specify contractually the agent’s qualifications, scope of authority, restrictions, and responsibility to report performance. Improving information flow through disclosure laws facilitates both contract formation and ongoing oversight for breach. However, these functions require a degree of robustness on the part of the principal that is not universal. Second, disclosure can be recognized as limited by its fiduciary context. Physicians and other health professionals are generally considered fiduciaries to patients.¹⁹³ Frankel’s “satisfaction of needs” parallels the bioethical concept

191. Tamar Frankel, *Fiduciary Law*, 71 Cal. L. Rev. 795, 802 (1983) [hereinafter Frankel, *Fiduciary Law*].

192. As noted above, rights of control and termination are hallmarks of legal agency. See DeMott, *supra* note 145, at 1037–43. However, other forms of agency may be vulnerable to one or the other response. For example, the separation of ownership from control in public companies means that officers and directors who shirk their duties are vulnerable primarily to shareholder exit. See Louis Lowenstein, *Financial Transparency and Corporate Governance: You Manage What You Measure*, 96 Colum. L. Rev. 1335, 1342–45 (1996) [hereinafter Lowenstein, *Transparency*]; see also Robert Charles Clark, *The Four Stages of Capitalism: Reflections on Investment Management Treatises*, 94 Harv. L. Rev. 561, 570–71 (1981) (explaining both fiduciary duties for corporate managers and the mandatory disclosure provisions of the federal securities laws as necessary regulatory responses to the separation of ownership from control in maturing capitalist economies).

193. See Frankel, *Fiduciary Law*, *supra* note 191, at 796 n.6 and accompanying text; American Medical Association, *Code of Medical Ethics*, Rep. 37, at 6 (1992). But see Restatement (Second) of Trusts § 2 cmt. b (1959) (characterizing medical care as a “confidential relationship,” meaning that transactions between physician and patient are

of physician beneficence, while "protection of freedom" parallels the notion of patient autonomy.¹⁹⁴ Health care relationships therefore combine an economic construct of agency, in which principal parties make informed choices among agents and define their scope and obligations in contract, with a fiduciary notion based more on status, imbalance of power, and tort. The former group generates monitoring problems that are familiar from the corporate governance context, and that are generally amenable to default rules combined with mandatory disclosure as an agency cost reduction strategy. By contrast, the latter group presents principal-agent issues that resemble trust law, and that favor non-waivable duties of care and loyalty, although disclosure can still be an important aid to oversight.¹⁹⁵

Many agency relationships in health care lack meaningful opportunities for control or exit.¹⁹⁶ This is not a natural milieu for the economic interpretation of disclosure-based regulation.¹⁹⁷ The physician's traditional role substitutes patient dependence for consumer sovereignty and collegiality for competition, and therefore strays far from the market model. Patients confronting illness have historically been considered emotionally vulnerable and, given the technical nature of medicine, intellectually incapable of representing their own interests—a status very different from that of an informed consumer. Instead, it falls to the physician to diagnose illness, explain prognosis, recommend treatment, and provide or arrange for services.¹⁹⁸

not voidable absent reliance and fraud or undue influence, and that the physician does not have an absolute legal duty to act for the benefit of the patient).

194. Frankel also associates the growing importance of fiduciary law with two changes in the nature of power in post-industrial society: specialization and pooling. See Frankel, *Fiduciary Law*, *supra* note 191, at 802–04. Pooling of interests reduces individuals' incentives to monitor their agents, while specialization reduces their ability to do so. This analysis has obvious applicability to the insurance-dominated, technologically sophisticated health care industry.

195. See Frankel, *Fiduciary Law*, *supra* note 191, at 826–27 (describing aids to monitoring of fiduciaries).

196. For example, many patients may be reluctant to challenge their physician for fear of weakening the physician's commitment to them, and may be equally afraid—especially when they are ill—to leave an established relationship and search out another doctor.

197. As Paul Starr observes: "There are no relations of dependency in the ideal market Nor are there supposed to be any relations of authority in the market, except those necessary to provide rules of exchange and the enforcement of contracts The absence of power is, paradoxically, the basis of order in a competitive market." Starr, *supra* note 3, at 23.

198. According to the AMA's Council on Ethical and Judicial Affairs, "physicians are not simply businesspeople with high standards. Physicians are engaged in the special calling of healing, and, in that calling, they are the fiduciaries of their patients. They have different and higher duties than even the most ethical businessperson." Council on Ethical and Judicial Affairs, *Conflicts of Interest: Physician Ownership of Medical Facilities*, 267 *JAMA* 2366, 2367 (1992) [hereinafter *AMA Council, Conflicts of Interest*].

Because of the imbalance of authority between physician and patient, physicians who have entered into therapeutic relationships bear affirmative obligations to act in patients' best interests.¹⁹⁹ In other words, the acceptability of particular threats to health care agents' loyalty is not simply a matter of consumer choice. By contrast, most disclosure requirements implicitly assume that actual contracting between principal and agent is preferable to any default rule, and that the principal party, once informed, can voluntarily waive the right to the agent's fidelity.²⁰⁰ For example, corporation law allows shareholders to ratify financial transactions in which directors profit at the corporation's expense, even though such transactions would otherwise violate directors' duty of loyalty.²⁰¹ Some commentators espouse a similar view of medicine, arguing that disclosure by health care agents of conflicts of interest such as physician financial incentives should allow for informed waiver of those conflicts.²⁰²

Regulating fiduciary obligations through disclosure therefore presents a logical fallacy. To the extent that the fiduciary obligation between physician and patient arises from a relationship of dependence, not from an express contractual agreement, physicians' duty of loyalty arguably should not be waivable upon disclosure.²⁰³ It is paradoxical to

199. For physicians, the fiduciary duty of care is represented by professional practice standards, and is enforced through medical malpractice law. By contrast, the duty of loyalty—which compels physicians to refrain from self-dealing—has generally been the province of ethical codes, and has largely been taken for granted by the law (with occasional exceptions, such as restrictions on fee-splitting and self-referral). See Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 *Am. J.L. & Med.* 241 (1995).

200. See Hall, *supra* note 22, at 182–84; see generally Havighurst, *supra* note 22, at 157–76 (making the case for private contracting as the guiding principle for the health care system).

201. See, e.g., Cal. Corp. Code § 310 (1998) (allowing shareholder approval of contracts in which directors have material financial interests). This approach is shared by the Restatement of Agency: “[u]nless otherwise agreed, an agent is subject to a duty to his principal to act solely for the benefit of the principal in all matters connected with his agency.” Restatement (Second) of Agency § 387 (1958).

202. See Martin Gunderson, *Eliminating Conflicts of Interest in Managed Care Organizations Through Disclosure and Consent*, 25 *J.L. Med. & Ethics* 192 (1997) (arguing for disclosure as the sole limitation on conflicts of interest).

203. See Restatement (Second) of Agency § 389 cmt. b, § 390 cmt. e (1958) (in situations involving a “peculiar trust and confidence,” an agent is under a duty to deal fairly with the principal in arranging the terms of employment); DeMott, *supra* note 145, at 1054 (“Acting to engender the trust and confidence of people to whom one provides advice is a basis for the relationship-specific imposition of fiduciary obligation.”); Frankel, *Fiduciary Law*, *supra* note 191, at 821 (stating that courts have supervisory authority to determine whether waiver should be allowed); *id.* at 822 n.90 (stating that “the fact that a trustor knows that the trustee has a conflict of interest is not an excuse for breach of fiduciary duty”). The same is true of the attorney-client relationship, where some but not all conflicts are waivable. See Model Rules of Professional Conduct Rule 1.7 cmt. 5 (1996) (“when a disinterested lawyer would conclude that the client should not agree to the representation under the circumstances, the lawyer involved cannot properly ask for such agreement or provide representation on the basis of the client’s consent”).

create fiduciary duties on the assumption that patients are incapable of protecting their interests without professional guidance, but then to efface those safeguards following disclosure of contemplated breaches on the assumption that patients can make such decisions if given adequate information. In effect, a physician disclosing a significant conflict of interest is saying to her patients: "I know you need to rely on me, but is it OK with you that I may be unreliable?"

As discussed at length by Mehlman, "fiduciary contracting" requires a delicate balance between consumer autonomy and consumer protection.²⁰⁴ Rodwin notes that the complexity of medical science dictates that "[p]atients need an opinion from a physician who is not compromised."²⁰⁵ He and other commentators therefore assert that patients may not waive physician loyalty, and conclude that mere disclosure of financial incentives or other conflicts of interest should not allow a physician to profit at a patient's expense.²⁰⁶ The way out of this dilemma is to establish clear categories of waivable and non-waivable skills and loyalties for health care agents. Prohibiting egregious conflicts of interest while mandating disclosure at the margin is a different model for disclosure than would be predicted by either consumer sovereignty or patient autonomy. Medical ethics has side-stepped this problem. In 1992, for example, the AMA's Council on Ethical and Judicial Affairs, for the first time, discouraged physicians from referring patients to health care entities in which they have a financial interest, but did not prohibit the practice, relying instead on a duty to disclose such arrangements to patients.²⁰⁷ These positions may be explained by the medical profession's equation of discussion with autonomy, or simply by the difficulty of reaching a professional consensus on prohibition, leaving disclosure as a convenient fallback.

This problem is likely to become a major challenge for Medicare. As noted previously, information dissemination to beneficiaries, including disclosure of physician financial incentives, is a principal regulatory strategy in the new Medicare+Choice program.²⁰⁸ Elderly patients, who rely heavily on their physicians' expertise, will undoubtedly ask them for help

204. See Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 *U. Pitt. L. Rev.* 365 (1990).

205. Marc A. Rodwin, *Medicine, Money & Morals: Physicians' Conflicts of Interest* 215 (1993).

206. See *id.* at 215-17; see also Kate T. Christensen, *Commentary: A Physician's Perspective on Conflicts of Interest*, 25 *J.L. Med. & Ethics* 199 (1997).

207. See AMA Council, *Conflicts of Interest*, *supra* note 198, at 2368-69 (mooted by Congressional prohibitions on self-referral of Medicare and Medicaid patients, see *Ethics In Patient Referral Act*, 42 U.S.C. § 1395nn (1994)). Similarly, the AMA Council has concluded that financial incentives to limit care must be disclosed, although "[p]hysicians should avoid reimbursement systems that cannot be disclosed to patients without negatively affecting the patient-physician relationship." *Code of Medical Ethics* § 8.051 (AMA Council on Ethical and Judicial Affairs 1998-1999).

208. See *supra* text accompanying note 117.

selecting a health plan under the new law. Physicians may be tempted to “steer” patients toward the enrollment choice that is most profitable for them: PSO or HMO for the younger, healthier individual, and fee-for-service for the older beneficiary with higher medical expenses.²⁰⁹ Particularly problematic is the fact that physicians can rationalize this behavior by articulating a quality-related rationale for encouraging the chronically ill elderly to continue their established therapeutic relationships, while urging more vigorous elderly to avail themselves of enhanced preventive care and health promotion activities by enrolling in HMOs. Although the disclosure of financial interests by physicians may be preferable to silence, fiduciary issues ultimately render the notion of “informed choice” illusory.²¹⁰

This discussion of the limits of disclosure in fiduciary contexts summons a deeper debate over the permissible scope of contracts in the modern health care system. In particular, scholars and jurists have struggled with the propriety of allowing explicit agreements to determine the quality of care, even if lower quality care is associated with a lower price to the patient or policyholder.²¹¹ Under medical malpractice law, for example, a physician’s obligation to provide treatment in accordance with the standard of care is generally considered unalterable, however well-informed the patient may be.²¹² Common law allows physicians to accept or reject patients at will, but not to vary their fiduciary obligations by agreement,²¹³ and courts have looked askance on waivers of physician negli-

209. Steering is a potential problem because some physicians will have a choice of treating patients under traditional Medicare (in which separate payment is received for each service rendered), an HMO contract (in which they receive a fixed capitation payment for each enrolled patient whether or not they provide services), and/or a PSO (where enrolling healthier patients may increase profits to physician-owners). See American Medical Association, *Medicare+Choice: What You Need to Know About Providing Services to Your Patients* (1999).

210. In its June 1998 report, the Medical Payment Advisory Commission observed that “physicians may find conflict between wanting to give advice about plans to beneficiaries and acting as a good business partner to all the plans with which they contract.” Medical Payment Advisory Commission, *Report to the Congress: Context for a Changing Medicare Program* (1998).

211. See, e.g., Havighurst, *supra* note 22, at 193–94; Max W. Fine & Jonathan H. Sunshine, *Malpractice Reform Through Consumer Choice and Consumer Education: Are New Concepts Marketable?*, 49 *Law & Contemp. Probs.*, Spring 1986, at 213; Richard A. Epstein, *Contracting Out of the Medical Malpractice Crisis*, 20 *Persp. Biology & Med.* 228, 236–45 (1977). Others have argued that the standard of care should not be changed based on cost-containment priorities in managed care. See Edward B. Hirshfeld, *Should Ethical and Legal Standards For Physicians Be Changed to Accommodate New Models for Rationing Health Care?*, 140 *U. Pa. L. Rev.* 1809, 1842–46 (1992). For a general discussion of price and quality in health care, see Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 *Nw. U. L. Rev.* 6, 9–38 (1975).

212. See Richard A. Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, 49 *Law & Contemp. Probs.*, Spring 1986, at 201, 203–07 (arguing for some degree of contractual freedom).

213. See Hirshfeld, *supra* note 211, at 1839–42.

gence.²¹⁴ Whether this will change as managed care matures is an important question.²¹⁵

3. *Trust.* — The special nature of the physician-patient relationship also puts the issue of trust front and center in the decision whether to mandate disclosure of agency issues. The combination of physicians' legal monopoly on medical care and patients' preferences for caring physicians suggests that reinforcing trust is a legitimate goal of health care regulation.²¹⁶ Trust may be particularly important given the complexity of modern health care delivery. As Atul Gawande writes: "In the increasingly tangled web of experts and expert systems, the primary-care doctor has the obligation and the opportunity to take on the role of the patient's knowledgeable guide, contractor, and confidant. Maybe machines can decide, but only doctors can heal."²¹⁷

Considered in this context, statements raising doubts about physicians' loyalty to patients can be incendiary if improperly presented. Physicians do not typically discuss billing practices with their patients, and many physicians would find it even more awkward to reveal compensa-

214. See, e.g., *Tunkl v. Regents of Univ. of California*, 383 P.2d 441 (Cal. 1963) (declaring invalid a release from liability imposed as a condition for hospital admission); *Hirschfield*, *supra* note 211, at 1839-42. Procedural restrictions, such as binding arbitration, have found greater favor. See, e.g., *Engalla v. Permanente Med. Group*, 938 P.2d 903 (Cal. 1997) (affirming the basic policy in favor of enforcement of arbitration agreements); *Madden v. Kaiser Found Hosps.* 552 P.2d 1178 (Cal. 1976) (upholding binding arbitration in group medical agreement). See also Maxwell J. Mehlman & Susan R. Massey, *The Patient-Physician Relationship and the Allocation of Scarce Resources: A Law and Economics Approach*, 4 *Kennedy Inst. of Ethics J.* 291 (1994). Mehlman & Massey assert that the preservation of trust between physician and patient was a motivating force behind the imposition of fiduciary duties, and that modifications to such duties should be made cautiously. See *id.* at 296-99. See *infra* text accompanying notes 216-222.

215. The only attempt explicitly to reflect cost-quality tradeoffs in the standard of care to date has been Oregon's controversial Medicaid program, which prioritizes covered benefits according to effectiveness, and immunizes physicians from liability for failing to offer treatments not covered by the state. See Or. Rev. Stat. § 414.745 (1998). Oregon's Medicaid plan represents a governmentally imposed tradeoff between access and quality within a defined budget, and therefore does not exactly parallel private contractual modifications to the standard of care. Government's role, however, reinforces the need for public disclosure of limits on coverage and on physician's fiduciary obligations in order to assure open democratic deliberation. See *infra* Part IV (discussing a "democratic rationale" for disclosure).

216. A direct relationship between trust and quality of care is by no means proven. Certainly, blind faith in physicians perpetuates established forms of treatment and reinforces physicians' professional and economic power. In addition, patients' and physicians' almost willful denial of the cost implications of clinical decisions is arguably a major cause of the health care system's current problems. On balance, however, trust in one's physicians seems beneficial. Trust may improve the outcome of treatment by supporting free and open communication between physicians and patients, focusing patients on healing and giving them emotional strength to withstand suffering. See David Mechanic, *Changing Medical Organization and the Erosion of Trust*, 74 *Milbank Q.* 171, 177 (1996).

217. Atul Gawande, *No Mistake*, *The New Yorker*, Mar. 30, 1998, at 74, 81.

tion methods under managed care.²¹⁸ An effective disclosure requirement therefore must strike a balance between educating patients and alarming them. Furthermore, patients vary considerably in their backgrounds, and hence in their ability to weigh specific details regarding conflicts of interest. To some, that managed care uses financial incentives to influence professional behavior will be obvious, while to others it will be surprising and unnerving. Moreover, sick individuals may attach unwarranted value to such information if it reinforces cognitive dissonance or other biases toward or against particular treatments. Finally, it may be difficult to craft a statement that is complete, balanced and accurate without being either uselessly vague or incomprehensibly dense.

The way in which even properly presented information regarding financial incentives affects trust may determine whether disclosure should be required. Although the effect of disclosing financial incentives on the therapeutic bond between patients and physicians has yet to be demonstrated empirically, theoretical arguments exist on both sides of the question.²¹⁹ On one hand, disclosure in health care can demystify and hence reassure, especially if patients are already sensitized to the possibility that managed care may deny them needed treatment. As a result, candor by physicians, or even a mere willingness to acknowledge the existence of incentives, might reinforce trust for some patients.²²⁰ On the other hand, if explaining the details of managed care contracting and benefit design breeds unwarranted suspicion, the patient may be ill-served by disclosure.²²¹ Rodwin, for example, believes that disclosure of financial in-

218. In part for this reason, existing laws generally impose the disclosure obligation on the health plan at the point of enrollment, rather than on the physician at the point of service. If disclosure in the physician's office is required, it could be made by a nurse or other support staff rather than by the physician. Although this might reduce adverse effects on trust, it equally might deteriorate into a mere paper requirement, and in any event would lack the deterrent effect of actual physician disclosure. See *infra* text accompanying notes 250–253.

219. Several researchers are beginning to study the interplay of financial incentives, disclosure, and trust. See, e.g., Audiey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 JAMA 1708, 1708 (1998) (finding greater trust associated with fee-for-service payment, and noting that patients who did not know how their doctors were paid had higher levels of trust).

220. Similarly, the low risk of physician-to-patient transmission suggests that reassurance and trust-building may be more important justifications for requiring disclosure of physician HIV status than informed decisionmaking. See *supra* note 170. HIV disclosure also exemplifies a common problem in disclosure regulation, because it requires balancing the benefit of providing the information against its cost in forgone privacy, although here the physician's rather than the patient's. See *infra* text accompanying notes 308–313.

221. An analogy can be made to the "therapeutic privilege" that allows physicians leeway to limit disclosure in traditional informed consent situations if the information would harm the patient. See Fran Carnerie, *Crisis and Informed Consent: Analysis of a Law-Medicine Malocclusion*, 12 Am. J.L. & Med. 55, 62 (1986). Of course, whether withholding information for therapeutic purposes represents genuine concern or self-serving paternalism is an open question.

centives may place physician and patient in an adversary relationship, which will reduce rather than increase communication and participatory decisionmaking.²²² Certainly, if disclosure were required each time the patient faced a medical decision, it could threaten the patient's confidence in both the physician and the proposed therapy, even in cases where the indications for treatment are clear cut. These possibilities highlight the complex interaction in medicine between data, which generally reflect the past, and trust, which ultimately anticipates the future. Perhaps the best that can be said is that the normative implications of coloring expectations with experience through disclosure are less obvious in fiduciary than in non-fiduciary relationships.

D. *Clarifying the Agency Rationale*

Although the ubiquity of agency relationships in contemporary health care makes the agency rationale for disclosure intuitively attractive, irremediable imbalances in authority between agent and principal render direct, definitive responses to disclosed information unlikely. Nonetheless, mandatory disclosure can play a vital role in preserving agency through indirect mechanisms that protect as well as inform the public. One such mechanism is government itself, which can confer substantive rights on consumers and patients. Another is the medical profession which, in both its institutional and individual personae, can articulate and defend ethical norms. At the same time, however, questions as to the scope of those rights and norms, and how they balance individual and collective needs, cannot be answered within the disclosure paradigm.

1. *Asserting Legal Rights.* — As we have seen, information disclosed to reduce agency costs falls generally into two categories that match the duties with which the law typically charges agents: the skill and care with which they are performing their services, and their loyalty. Laws requiring disclosure of physician qualifications typify the former, while information about financial incentives and similar self-dealing transactions exemplifies the latter. There is, however, a third category, which encompasses information to help enrollees and patients navigate the unfamiliar landscape of managed care, so that they can better assert their statutory and contractual rights to covered benefits and high quality care. Indeed, recent managed care legislation has greatly expanded consumers' substantive rights, including the right to appeal adverse coverage decisions to an entity independent of the managed care plan.²²³

222. See Rodwin, *supra* note 170, at 214–16. See also David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians*, 275 JAMA 1693, 1694 (1996) (arguing that disclosure of financial information is more likely to elicit distrust than trust between patient and physician).

223. See Tracy E. Miller, *Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights*, 26 J.L. Med. & Ethics 89, 89 (1998).

Many current disclosure laws are intended to help consumers exercise substantive rights.²²⁴ For example, provisions of insurance and HMO laws mandating specific disclosure of utilization review procedures and preauthorization requirements provide consumers with information regarding barriers erected by plans to physicians serving as patients' true representatives.²²⁵ States have been particularly careful to inform consumers about access to cutting-edge, potentially lifesaving but expensive treatments that insurers may refuse to cover as "experimental" or "investigational."²²⁶ Similarly, ERISA requires that plan participants whose claims are denied receive a detailed notice of denial.²²⁷ In recent decisions involving managed care, these provisions have been interpreted to mandate that beneficiaries desiring treatment subject to utilization review be given information regarding the specific review standards applied and the evidence that would be needed to enable the health plan to grant the treatment request.²²⁸

In addition, state insurance and HMO laws typically require disclosure to enrollees of procedures to register grievances and appeal adverse determinations, as well as information regarding public agencies such as ombudsman offices and consumer protection bureaus to which dissatis-

224. For example, section 711 of the Newborns' and Mothers' Health Protection Act, 29 U.S.C. § 1185 (Supp. III 1997), requires group health plans to disclose to participants and beneficiaries the existence of protection under federal law for coverage of postpartum hospitalization. See generally Miller, *supra* note 223 (describing various legislative advances involving disclosure of grievance and appeals rights). However, an opposite trend is evident for required disclosure to patients and enrollees of mandatory arbitration procedures for medical malpractice or coverage claims. Although several states have required specific disclosure language for health care arbitration agreements, most are preempted by the Federal Arbitration Act under the Supreme Court's decision in *Doctor's Assocs., Inc. v. Casarotto*, 517 U.S. 681, 683 (1996), which overturned notice provisions under Montana law. See also *Morrison v. Colorado Permanente Med. Group P.C.*, 983 F. Supp. 937, 943 (D. Colo. 1997) (overturning notice provisions of the Colorado Health Care Availability Act).

225. In California, for example, a plan must include in its disclosure form "[a] summary of, and a notice of the availability of, the process the plan uses to authorize or deny health care services under the benefits provided by the plan" and "[g]eneral authorization requirements for referral by a primary care physician to a specialty care physician." Cal. Health & Safety Code § 1363(a)(11), (13) (West Supp. 1999). Similar requirements have been enacted elsewhere. See, e.g., 1995 Ariz. Legis. Serv. 297 (codified at Ariz. Rev. Stat. Ann. § 20-1076(A)(3) (West Supp. 1998); 1996 N.Y. Laws 705 (codified at N.Y. Pub. Health Law § 4408(1)(c) (McKinney Supp. 1999)).

226. In New York, for example, plans must upon request "provide a description of the procedures followed by the health maintenance organization in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials." 1996 N.Y. Laws 705 (codified at N.Y. Pub. Health Law § 4408(2)(h) (McKinney Supp. 1999)).

227. See 29 U.S.C. § 1133(1) (1994).

228. See *Doe v. Travelers Ins. Co.*, 971 F. Supp. 623, 631-34 (D. Mass. 1997); *Crocco v. Xerox Corp.*, 956 F. Supp. 129, 142-44 (D. Conn. 1997).

fied individuals can turn for assistance.²²⁹ Federal regulations similarly require Medicare HMOs to give enrollees a description of grievance procedures.²³⁰ Requirements that plans inform enrollees of the outcomes of previous grievances and appeals—so that consumers can assess the thoroughness and consistency of health plans' determinations—are less common.²³¹ A recent GAO report found that most managed care organizations do not collect or report uniform data regarding complaints and appeals to regulators, purchasers or consumers.²³² However, this is beginning to change. For example, New York now requires health plans to provide consumer complaint information to subscribers upon request.²³³

Required disclosure of financial incentives can even be viewed in this light, in that it encourages patients to question their physicians more closely about treatment alternatives and to seek second opinions.²³⁴ Similar arguments support aggressive enforcement of disclosure regarding treatment alternatives themselves.²³⁵ In addition, because external review comes into play only when treatment has been denied, patients

229. See HMO Model Act, *supra* note 38, at §§ 8(A)(3)(k), 8(C)(3); Peter V. Lee & Carol Scott, *Managed Care Ombudsman Programs: New Approaches to Assist Consumers and Improve the Health Care System* (1996) (Report of the Center for Health Care Rights); Susan J. Stayn, Note, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 *Colum. L. Rev.* 1674 (1994).

230. See 42 C.F.R. § 417.124(b)(i)(v) (1998); see also 42 C.F.R. § 417.124(g) (1998) (substantively regulating grievance procedures for Medicare HMOs).

231. There can be a wide gulf between procedures on paper and in operation. For example, the California Supreme Court recently ruled that Kaiser Permanente could be held liable for fraud because it failed to follow its own procedures for mandatory arbitration of malpractice and coverage claims. See *Engalla v. Permanente Med. Group, Inc.*, 938 P.2d 903, 922 (Cal. 1997).

232. See General Accounting Office, *HMO Complaints and Appeals: Plans' Systems Have Most Key Elements, But Consumer Concerns Remain* 7 (1998) ("Public records of complaints and appeals could be useful sources of information about problems in HMOs and help purchasers and consumers select and monitor health plans.")

233. See 1996 N.Y. Laws 705 (codified at N.Y. Pub. Health Law § 4408(2)(d) (McKinney Supp. 1999)); N.Y. Ins. Law § 210 (McKinney Supp. 1999); see also 1996 Ga. Laws 751 (codified at Ga. Code Ann. § 33-20A-5(1)(xii) (Supp. 1998)) (requiring data on grievances to be made available to enrollees upon request). In addition, HCFA is beginning to require collection and reporting by health plans of complaints, grievances, and appeals. See *HCFA Gives Input on Compiling Complaints, Drafting Appeal Notice in Two M+C Letters*, 8 *Health L. Rep. (BNA)* 321, 321-22 (1999).

234. In late 1999, California enacted legislation assuring health plan enrollees the right to a second opinion from a qualified professional under certain circumstances, which increases the usefulness of financial incentive disclosure. See 1999 Cal. Legis. Serv. 531 (West), to be codified at Cal. Health & Safety Code § 1383.15, Cal. Ins. Code § 10123.68 (1999) (stating that "a health care service provider shall provide or authorize a second opinion by an appropriately qualified health care professional").

235. Resource constraints and pressures on physician loyalty increase the importance of traditional informed consent requirements regarding disclosure of treatment alternatives. Although many states now prohibit managed care organizations from using "gag clauses" to restrict physician discussion of expensive treatments that might not be covered under the patient's policy, courts have yet to address the link between health plan

whose physicians labor under financial incentives to conserve resources may never learn that a particular treatment is available, and therefore may not file a claim which can be subjected to formal review processes.²³⁶ This increases the importance of disclosure to patients evaluating their course of care.

2. *Therapeutic Disclosure and Professionalism.* — Perhaps the most important potential achievement of the agency rationale for disclosure is to further professional, therapeutic goals in medicine. Through both its direct and its deterrent effects, mandatory disclosure can be a constitutive force in the therapeutic process.²³⁷ By asserting a non-economic purpose for agency-based disclosure, the idea of therapeutic disclosure goes a long way toward solving two problems discussed above: the illogic of disclosure as an approach to fiduciary contracting and the risk that intemperate communication could jeopardize patient-physician trust and hence good medical care. As noted previously, the tension between economic and non-economic discourse is acute in today's rapidly changing health care system, which is attempting to merge competitive discipline and corporate control with traditional professional values and therapeutic bonds between individual patients and individual physicians. In business, informational oversight of agents is necessary to avoid diverting resources from their intended, presumptively efficient uses. In health care, by contrast, efficiency is rarely determinative when information is shared between patients and their agent professionals.

For example, informed consent law, the best established form of information-based regulation in health care, assigns primacy to bodily integrity. Reflecting the fiduciary essence of health care, power imbalances limit "autonomy" and "self-determination" through information because patients tend to rely on physicians' recommendations, and options can be framed so as to virtually assure a particular choice.²³⁸ Nonetheless, opening a channel for communication has instrumental utility, creating an environment in which the patient feels free to share private information with her medical team, articulate her personal goals and priorities, and

structure and treatment disclosure under informed consent law. See *supra* text accompanying notes 162–167

236. See Sage, *Advocates*, *supra* note 162, at 1566 n.312, 1601–02 (describing the external review procedures in New York and noting that their efficacy depends upon patients' knowledge concerning denied care).

237. Even legal process can have important therapeutic benefits. See Bruce J. Winick, *The Psychotherapist-Patient Privilege: A Therapeutic Jurisprudence View*, in *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* 483, 489–93 (David B. Wexler & Bruce J. Winick eds., 1996) (showing that the substantive and procedural rights afforded to the mentally ill can improve their medical condition). A potentially fruitful use of the therapeutic imperative is to redesign the framework for making coverage decisions in managed care. See William M. Sage, *Therapeutic Coverage: Reinventing Health Insurance Contracts* (unpublished manuscript on file with the author).

238. Reflecting this reality, informed consent law in New Zealand entitles the patient to a recommendation as well as to a description of alternatives. See Ron Paterson, *A "Code of Patients' Rights" for New Zealand*, 5 *Health Care Analysis* 43, 46 (1997).

ask the questions that will improve compliance with the course of therapy she selects.²³⁹ In this respect, the physician's "duty to disclose" is more accurately viewed as a "duty to educate."²⁴⁰ Therefore, even when de facto decisional authority rests with the physician, disclosure furthers a recognized construct of representation, although one based more on trusteeship than agency.²⁴¹

Moreover, because a patient can feel better or worse for many reasons, including but not limited to the physiologic response to a disease-causing agent, ensuring that the process of disclosure is compassionate and respectful is as important as ensuring that accurate information is imparted.²⁴² Offering information to the patient and deferring even nominally to her preferences preserves important dignitary values for both patient and professional.²⁴³ As Schneider observes, even though patients cannot and do not always desire to be autonomous decisionmakers, they still "want information from their doctors as a matter of courtesy and an expression of kindness and concern."²⁴⁴

In addition to physicians' individual disclosure obligations, information requirements can promote a broader therapeutic role for health

239. Unfortunately, physicians are often poor communicators. See M. Kim Marvel et al., *Soliciting the Patient's Agenda: Have We Improved?*, 281 JAMA 283, 286 (1999) (finding that most primary care physicians do not even allow patients to articulate fully their concerns).

240. Cf. Jay A. Gold, *Wiser than the Laws?: The Legal Accountability of the Medical Profession*, 7 Am. J.L. & Med. 145, 161-65 (1981) (reconciling professional expertise with patient autonomy in medical decisionmaking). Gold points out, furthermore, that because no clear line demarcates realms of physician as opposed to patient authority, "[t]here must . . . be a dialogue between physicians and laymen concerning all aspects of the decisions being made." *Id.* at 180.

241. Cf. Steven Brint, *In an Age of Experts: The Changing Role of Professionals in Politics and Public Life* 7-8 (1984) (distinguishing "social trustee" and "expert knowledge" professionalism); Hanna F. Pitkin, *The Concept of Representation* 210 (1967) (describing professional representation); see also Jerry L. Mashaw, *Bureaucratic Justice: Managing Social Security Disability Claims* 23-34 (1983) (distinguishing the "professional treatment" model of administrative decisionmaking from the "bureaucratic rationality" and the "moral judgment" models). Mashaw observes that, despite the fact that "the professional's art remains opaque to the layman. . . . [j]ustice lies in having the appropriate professional judgment applied to one's particular situation *in the context of a service relationship.*" *Id.* at 28-29.

242. Arrow noted the desirability of a strong physician-patient relationship in his classic article on health care, observing that the activity of production and the product of medicine are often the same. See Arrow, *supra* note 13, at 965.

243. As we shall see, dignitary values constitute an important link between the agency and democratic rationales for disclosure. See Jerry L. Mashaw, *Administrative Due Process: The Quest for a Dignitary Theory*, 61 B.U. L. Rev. 885, 886 (defining a "dignitary theory" as one "that focuses on the degree to which decisional processes preserve and enhance human dignity and self-respect"); see also *infra* text accompanying notes 401-409 (discussing dignitary theories of due process and public consent through disclosure).

244. Schneider, *supra* note 8, at 112. Schneider continues: "What they want from their doctors as much as anything—except health—is sympathy and encouragement, and information can be an expression of both." *Id.*

care institutions.²⁴⁵ In insurance relationships, for example, therapeutic disclosure implies designing a coverage decisionmaking process that maximizes information exchange during its operation. For example, health plans should review and incorporate in their decisions material provided by the patient in support of treatment.²⁴⁶ More generally, offering information to consumers can restore to them a semblance of control and reduce the sense of helplessness they may feel regarding managed care.²⁴⁷ Furthermore, health plans should communicate with patients in ways that place their requests in a broader context of science, ethics, and public policy.²⁴⁸ For example, the Oregon BlueCross BlueShield plan emphasizes the ethical as well as clinical and managerial role of its nurse transplant coordinators, whose discussions with enrollees typically include issues such as arguments against special treatment for the wealthy, the importance of consistency in plan decisions, tradeoffs between spending on individuals and on enrolled groups, and the need for sound scientific research.²⁴⁹ To date, disclosure laws have not addressed these matters. A provocative issue raised by such institutional interventions is determining how disclosure would be made, particularly with respect to the role of the patient's physician. Certainly, other individuals have more time to spend with patients than do physicians, and perhaps better communications skills, though none currently are vested with equivalent authority or public confidence.

Disclosure laws can also serve therapeutic goals by changing the behavior of physicians and other health care agents, even without a preceding change in marketplace demand for their services. Specifically, the possibility exists that mandatory disclosure requirements will induce agents to avoid situations that compromise their skills or loyalties, whether those relate to physicians' financial incentives or health plans'

245. See David Mechanic, Public Trust and Initiatives for New Health Care Partnerships, 76 *Milbank Q.* 281, 293-98 (1998) (advocating use of the Internet, videotapes, customer service programs, standardized communications protocols and other patient and provider educational aids).

246. In ERISA cases, courts are increasingly focusing on health plans' willingness to consider available information as an indicator of the legitimacy of the resulting decision. See, e.g., *Killian v. Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521-22 (6th Cir. 1998) (holding that refusal to review information submitted after the initial petition was arbitrary and capricious).

247. A recent study concluded that satisfaction with managed care increased if consumers had a choice of health plan, even if their ultimate enrollment decisions were the same. See Atul A. Gawande et al., Does Dissatisfaction With Health Plans Stem From Having No Choices?, *Health Aff.*, Sept.-Oct. 1998, at 184 (reporting results of a nationwide telephone survey assessing satisfaction with health plans).

248. As discussed below, nominally private managed care plans have assumed de facto responsibility for social allocation decisions, making disclosure important not only to agency cost reduction in market transactions, but to monitoring political agents as well. See *infra* text accompanying notes 393-399.

249. See Norman Daniels & James E. Sabin, Last Chance Therapies and Managed Care: Pluralism, Fair Procedures, and Legitimacy, *Hastings Center Rep.*, Mar.-Apr. 1998, at 27, 35 (1998) [hereinafter Daniels & Sabin, Last Chance].

restrictions on clinical decisions. This possibility reflects the difference between the agency rationale for disclosure in health care, where most agents are professionals, and in other industries, where they are not.²⁵⁰

Professionalism implies neutral expertise, peer-group consultation, and altruism—in the words of Roscoe Pound, “pursuing a learned art as a common calling in the spirit of a public service.”²⁵¹ When disclosure is neither required nor expected, physicians may pretend that conflicts of interest do not exist. On the other hand, a clear obligation to disclose conflicts of interest might induce physicians to pause and reflect before agreeing to financial incentives that jeopardize patient care. The threat of disclosure could accomplish this in two ways. First, telling patients might expose the details of potentially compromising arrangements to colleagues as well, shaming physicians into good behavior through peer pressure.²⁵² Second, publicizing a disclosure requirement might educate patients to expect information, so that physicians could not maintain silence about conflicts of interest without having patients draw adverse inferences.

Significantly, deterrence in a professional context might be accomplished without much formal enforcement, and does not rely on competitive forces per se. The essential element in its success is that the professional community accept the obligation as necessary and proper. Therefore, physicians’ disclosure duties regarding agency issues might best be framed as ethical rather than legal obligations.²⁵³ As long as it receives sufficient attention within the profession, an ethical obligation avoids the opposing risks of excessive intrusion into the physician-patient relationship or mere boilerplate compliance.

Overall, then, requiring disclosure of agency-related matters such as conflicts of interest is likely to be most useful if it changes patients’ expect-

250. Again, this fits into a fiduciary rather than a contractual framework. See Frankel, *Fiduciary Law*, *supra* note 191, at 830–31 (noting that self-interest is the norm in the world of contract, but that assumptions of altruism and morality underlie fiduciary relations).

251. Roscoe Pound, *The Lawyer from Antiquity to Modern Times* 5 (1953). Admittedly, physicians and other professionals often pay lip service to these ideals while stifling competition and supporting regulation that furthers their economic self-interest. See William M. Sage & Linda H. Aiken, *Regulating Interdisciplinary Practice*, in *Regulation of the Healthcare Professions* 71 (Timothy S. Jost ed., 1997). Still, belief in the purity of one’s motives is a central element of the physician’s professional psyche, particularly because selflessness and devotion to duty are fundamentals of medical training.

252. For a related point, see Hall & Berenson, *supra* note 179, at 398, 400 (proposing a “red-faced with embarrassment” standard for doctors to use in judging the propriety of their financial arrangements). Bringing these matters into collegial discussion might also lead to formal peer review, leveraging the performance-improving potential of professional processes. See *infra* text accompanying notes 350–353.

253. See Robert J. Levine, *Medical Ethics and Personal Doctors: Conflicts Between What We Teach and What We Want*, 13 *Am. J.L. & Med.* 351, 362 (1987) (arguing against formal legal requirements as tending toward an “ethic of strangers”). This responsibility already exists under the AMA’s ethical code, but has received little attention in the profession. See *supra* text accompanying notes 198–207.

tations regarding the informational content of therapeutic interactions, alerts patients to avenues for self-help when agents prove unsatisfactory, and helps reconcile professional norms with changing economic circumstances. Carrying these benefits of disclosure into the future, however, depends on developing an "institutional professionalism" that leads the organizations that increasingly control health care to honor disclosure duties as professional responsibilities, and not merely as avenues to avoid bad press and commercial disadvantage. Only if this occurs can putatively economic transactions such as contracting for insurance coverage and negotiating employee benefits begin to reflect shared beliefs about beneficence, autonomy, and the prudent use of common resources, qualities that are notably absent in prevailing versions of managed care.

III. THE PERFORMANCE RATIONALE: IMPROVING HEALTH SYSTEM PRODUCTIVITY THROUGH DISCLOSURE

A. *Information Deficits in Health Care*

A compelling justification for mandatory disclosure has been overlooked in the recent rush to legislate: the power of information to improve health system performance. The competition rationale and the agency rationale are regulatory responses to information asymmetry between health care providers and insurers, on the one hand, and individual consumers and patients, on the other. Underlying these theories, however, is an often unwarranted assumption that plans and providers themselves understand how to deliver and manage care. An underappreciated attribute of mandatory disclosure laws is their ability to help, or perhaps force, the health care system to figure it out.

Improved performance is often a tangible benefit of mandatory disclosure. Even in well-functioning markets, information is generally underproduced because the benefits of producing it are not fully capturable by producers. For this reason, economists often describe information as a "public good," justifying interventions such as government research funding or the granting of intellectual property rights. Mandatory disclosure laws can perform a similar function, stimulating information generation and overcoming barriers to information sharing.²⁵⁴ For example, underproduction of information because of its "public good" character has emerged as a principal justification for SEC disclosure requirements.²⁵⁵ In particular, securities law disclosure has been credited with

254. See, e.g., John C. Coffee Jr., *Market Failure and the Economic Case for a Mandatory Disclosure System*, 70 Va. L. Rev. 717, 722 (1984) ("[I]nformation has many aspects of a public good. . .").

255. See, e.g., Merritt B. Fox, *Retaining Mandatory Securities Disclosure: Why Issuer Choice is Not Investor Empowerment* (Mar. 29, 1999) (unpublished manuscript, on file with the *Columbia Law Review*) ("[E]ach issuer's private costs of disclosure exceed the social costs of its disclosure, while its private benefits are less than the social benefits."); Louis Lowenstein, *Corporate Governance and the Voice of the Paparazzi* 44 (Feb. 22, 1999) (Columbia U. Center for L. & Econ. Studies, Working Paper No. 132) (on file with the

stimulating changes in corporate governance practices that have increased overall shareholder wealth. As Lowenstein observes, you manage what you measure, and "good disclosure has been a most efficient and effective mechanism for inducing managers to manage better."²⁵⁶

The performance rationale for mandatory disclosure laws therefore offers a path of least resistance for administrative agencies seeking to promote meaningful change. Disclosure laws address Hayek's critique of command-and-control regimes as structurally unable to acquire and process information with the speed and expertise necessary to manage a large, complex society.²⁵⁷ Legislators and administrative agencies also turn to mandatory disclosure rules because of the difficulties of substantive rulemaking in the modern regulatory state.²⁵⁸ Rulemaking efforts affecting a wide range of industries and issues have been frustrated by bureaucratic inertia, economic analysis requirements, protracted litigation, and congressional backpedaling.²⁵⁹ If the procedural hurdles and political opposition are lower for disclosure requirements than for substantive standards, then mandated disclosure leverages agency rulemaking capacity.

American health care displays several features that make it particularly amenable to an "experimentalist" approach that emphasizes information acquisition and sharing.²⁶⁰ First, and most obviously, scientific

Columbia Law Review) (describing the federal securities laws as "[a] public-good built of many parts over the decades since the Roosevelt Administration") [hereinafter Lowenstein, Paparazzi]. Furthermore, disclosure laws can be designed to remedy residual externalities by distributing the additional costs of information production among those reaping benefits from it. See Ronald J. Gilson & Reinier H. Kraakman, *The Mechanisms of Market Efficiency*, 70 *Va. L. Rev.* 549 (1984) (analyzing the market for information about securities as distinct from the market for securities themselves).

256. Lowenstein, *Transparency*, *supra* note 192, at 1335–36. Similarly, environmental disclosure required by the Toxics Release Inventory (TRI) provisions of the Emergency Planning and Community Right-to-Know Act of 1986 directed the attention of corporate management, often for the first time, to the potentially harmful by-products of industrial processes. See Sidney M. Wolf, *Fear and Loathing About the Public Right to Know: The Surprising Success of the Emergency Planning and Community Right-to-Know Act*, 11 *J. Land Use & Envtl. L.* 217, 307–12 (1996).

257. See Hayek, *supra* note 62, at 524–25.

258. For example, the Occupational Safety and Health Administration (OSHA) issued its Hazard Communication Standard, 29 C.F.R. § 1910.1200 (1998), which requires disclosure to workers of information about toxic chemicals to which they might be exposed, as a cross-cutting alternative to sector-specific standards that had proved both slow to develop and highly vulnerable to legal challenge.

259. Both the National Highway Traffic Safety Administration (NHTSA) and OSHA have suffered greatly in this regard. See, e.g., Jerry L. Mashaw & David L. Harfst, *The Struggle for Auto Safety 1–26*, 147–71 (1990) (describing NHTSA's frustration with rulemaking and devolution into product recalls); Charles Noble, *Liberalism at Work: The Rise and Fall of OSHA 145–207* (1986) (examining OSHA as an increasingly constrained agency).

260. See Michael C. Dorf & Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 *Colum. L. Rev.* 267 (1998) (applying an experimentalist framework to regulatory federalism).

understanding of human illness is incomplete.²⁶¹ Second, the traditional professional model of care delivery lags other industries in organizational structure, data management, and communications resources.²⁶² Third, health care has little experience ascertaining and responding to consumer preferences, which guide production decisions in other industries. Fourth, cost-based reimbursement schemes and other regulatory distortions have often discouraged attentive management and continued innovation. These factors derive primarily from the long-unchallenged, competitively sheltered hegemony of the medical profession, which produced a high degree of fragmentation in both medical science and industrial organization. In combination, they suggest that producers of health care do not necessarily operate at the lowest point on their cost curves, and that health care markets are therefore productively as well as allocatively inefficient, marking the health care system as fertile ground for interventions to improve performance by increasing information generation and flow.

Information in health care tends to be both irregularly produced and poorly disseminated. Although professions often assert public-minded commitments to gathering and sharing relevant knowledge, professional characteristics are largely responsible for failures to do so. Few practicing physicians have the time, inclination, or opportunity to conduct research that meets the demanding standards of scientific journals.²⁶³ Full-time researchers suffer from limitations of both funding and perspective. Because so-called "basic" research is heavily subsidized by government, medical researchers have different motivations than do practicing physicians or patients, and produce information accordingly. At the same time, "clinical" research has become the near-exclusive province of academic physicians who are often insulated from market forces, and whose incentive systems may reward dramatic discoveries more highly than advances with routine application to general practice.

Neither is information efficiently distributed. Until recently, most physicians were in solo practice, and hospitals were single facilities lacking both incentives and resources to apply information in a coordinated

261. On the other hand, progress has been enormous since Thomas Jefferson wrote: "The state of med[i]cine is worse than that of total ignorance. Could we divest ourselves of every thing we suppose we know in it, we should start from a higher ground & with fairer prospects." Thomas Jefferson: Writings 1065 (Merrill D. Peterson ed., 1984) (letter to William Green Munford).

262. For example, the traditional generosity of insurance reimbursement allowed physicians and hospitals to remain largely ignorant of their own cost structures, and retarded the development of accurate accounting systems. See Charles T. Wood, A Health Care Accounting Standards Board Is Needed for the American Health Industry (Aug. 1998) (unpublished manuscript, on file with the *Columbia Law Review*).

263. For example, it is extremely rare for a peer-reviewed clinical journal to publish a sole-authored article, see Joost P.H. Drenth, Multiple Authorship, 280 JAMA 219 (1998), or an article by physicians in private rather than academic practice.

fashion.²⁶⁴ Furthermore, professional training socializes physicians to be almost compulsively individualistic, committed in the abstract to the ideals of science but in operation to practicing medicine idiosyncratically. Consequently, only a small percentage of medical therapies have been scientifically proven, and even definitive research supporting or refuting particular therapies is often misunderstood and misapplied in the broader professional community.²⁶⁵ Moreover, little attention was paid until recently to structural improvements in health care delivery that could yield large dividends in cost or quality.²⁶⁶

The most clearly defined aspects of medical practice have been those where the gains from innovation flow to the innovators. Drugs, medical devices, and biotechnology are obvious examples of patentable inventions which have attracted enormous levels of investment and have yielded significant clinical benefits.²⁶⁷ Federal legislation such as the Bayh-Dole Act piggybacks on the incentives created by intellectual property rights by allowing private firms to patent inventions derived from publicly funded basic research.²⁶⁸ However, medical technology comes at a high price, both in absolute terms and by channeling investment away from preventive care and public health interventions.²⁶⁹ Further,

264. A representative example is using preoperative patient education to reduce hospital length of stay for hip replacement surgery. Hip replacement was developed initially for patients who had suffered an accidental fracture. These patients were not identifiable in advance, and therefore had to be instructed in the use of crutches and other rehabilitation techniques following surgery, when they were in pain and often otherwise debilitated. As a result, hospital stays typically extended to several weeks. When elective hip replacement surgery became common, several days of hospitalization could be avoided by providing this instruction in the patient's home in advance of the operation. However, fee-for-service reimbursement and the lack of contractual connection among physicians, hospitals, and physical therapists perpetuated the established system until Medicare DRG payment and managed care introduced incentives for improved efficiency.

265. See, e.g., Ralph Gonzales et al., *Antibiotic Prescribing for Adults with Colds, Upper Respiratory Tract Infections, and Bronchitis by Ambulatory Care Physicians*, 278 JAMA 901, 903-04 (1997) (revealing widespread overuse of antibiotics); David Siegel & Julio Lopez, *Trends in Antihypertensive Drug Use in the United States: Do the JNC V Recommendations Affect Prescribing?*, 278 JAMA 1745, 1747 (1997) (finding that expert consensus has had little effect on the treatment of hypertension by practitioners).

266. See Robert H. Brook, *Practice Guidelines and Practicing Medicine: Are They Compatible?*, 262 JAMA 3027, 3029-30 (1989).

267. At the same time, professional resistance to granting patient rights in treatment processes, a position now incorporated in federal law, may deter clinical innovation in other areas. See Omnibus Consolidated Appropriations Act of 1996, Pub. L. No. 104-208, § 616, 110 Stat. 3009-67 (1998).

268. See Act of Dec. 12, 1980, Pub. L. No. 96-517, 94 Stat. 3015, 3028 (codified as amended at 35 U.S.C. §§ 200-211, 301-307) (1994); Rebecca S. Eisenberg, *Public Research and Private Development: Patents and Technology Transfer in Government-Sponsored Research*, 82 Va. L. Rev. 1663, 1663-64 (1996).

269. According to Lewis Thomas, most medical innovations are only "halfway technolog[ies]," in that they supplement rather than substitute for existing treatment, adding to expense in exchange for prolonging life or reducing symptoms. Lewis Thomas, *The Lives of a Cell: Notes of a Biology Watcher* 33-34 (1974). By contrast, the

sellers of proprietary products have strong incentives to market their merchandise, further skewing available practice information toward one subset of therapies. For example, one reason why research disputing the effectiveness of prescription medication is slow to change physician behavior is that opposite messages are being conveyed to physicians and patients in pharmaceutical advertising.²⁷⁰

At one level, managed care owes its existence to these informational lapses. Studies begun in the early 1980s have shown that patterns of medical practice vary in seemingly random fashion from state to state, and even from town to town.²⁷¹ Moreover, patients receiving more invasive, costlier care in the groups studied were neither demonstrably sicker to begin with nor likelier to benefit from treatment. These findings, which proved beyond doubt that medicine is still more art than science, stripped the cloak of infallibility from physicians' recommendations and legitimated third-party review of clinical decisions. If ERISA gave self-funded employers and health plan administrators the legal authority to redesign health coverage without regard to state insurance laws, small-area variation studies gave them the moral authority to challenge the elitism of the medical profession.²⁷² While employers and insurers had seldom dared to ask "medicine the great and powerful" to prove a connection between costly treatment and clinical benefit, the new studies made it much easier to demand such evidence from the man behind the curtain.

Managed care also seemed ideally suited to improve knowledge, coordination, and performance through what have come to be known as "organized systems of care." When Congress enacted the HMO Act of 1973,²⁷³ its prototype was the pre-paid group practice, such as Kaiser-Permanente or Group Health Cooperative of Puget Sound. Although

development of the polio vaccine was a "genuinely decisive" technology that rendered iron lungs and rehabilitation hospitals obsolete. *Id.* at 34-36. See also William M. Sage, *Funding Fairness: Public Investment, Proprietary Rights and Access to Health Care Technology*, 82 Va. L. Rev. 1737 (1996) (arguing that patent incentives often run contrary to global considerations of health care cost and access) [hereinafter Sage, *Funding Fairness*].

270. See generally Tamar V. Terzian, *Direct-to-Consumer Prescription Drug Advertising*, 25 Am. J.L. & Med. 149, 158 (1999) (discussing the effects and regulation of pharmaceutical companies' advertisements).

271. For example, rates of mastectomy for breast cancer may differ by a factor of thirty. See Gina Kolata, *Sharp Regional Incongruity Found in Medical Costs and Treatments*, N.Y. Times, Jan. 30, 1996, at C3. The exact cause of variation remains unknown, but patterns of training, local opinion leaders, and financial considerations all undoubtedly contribute.

272. The methodology of early small-area variation studies has been expanded using national databases to provide a detailed geographic portrait of the delivery of medical services. See *The Dartmouth Atlas of Health Care in the United States* (John E. Wennberg & Megan McAndrew eds., 1998).

273. Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified as amended at 42 U.S.C. §§ 300e-300e-1 (1994)).

these entities had originally been ostracized by organized medicine for negotiating fixed rates with payers and recasting physicians as salaried employees, over time they developed a reputation for organization, economy, and effectiveness.²⁷⁴ Because their physicians worked together in multi-specialty groups, and treated patients in dedicated hospitals and clinics, pre-paid group practices fostered a cooperative culture and created an environment where information could be readily acquired and shared. In addition, as large organizations, they could more easily invest in information technology and support services than could solo doctors or small partnerships. They also professed a long-term, population-based approach to medicine—emphasizing disease prevention and early treatment—consonant with group enrollment of beneficiaries. Finally, because they were chartered as non-profit entities, they established academic infrastructures that supported clinical research and developed treatment protocols for common illnesses. Between their philosophy and their structural unity, the best-known pre-paid group practices were therefore more conducive to learning how to do things better than was much of fee-for-service medicine.

Despite this promise, managed care generally has not met the challenge of improving medical practice. There are many reasons for its failure. First, even if managed care organizations are theoretically better at generating useful knowledge than their fee-for-service predecessors, in a competitive market they often cannot capture its value any more effectively. Improved processes of care cannot be patented, and are very hard to protect as trade secrets. In addition, as previously mentioned, financial success for managed care organizations tends to reflect actuarial skill more than clinical acumen.²⁷⁵ In the absence of sound risk-adjusters for managed care premiums, innovation centers around risk avoidance. Finally, meaningful advances take time, so that managed care organizations' actual investment in viable clinical information systems has seldom matched its hype, as Oxford Health Plan's financial collapse aptly attests.²⁷⁶

The structure of today's managed care plans also discourages innovation. Closed-panel organizations like the early pre-paid group practices and staff-model HMOs have largely given way to loosely organized provider networks that include hundreds of physicians and dozens of hospitals.²⁷⁷ Coordination or collaboration among these providers is extremely difficult, despite the promise of "virtual integration" using

274. See Starr, *supra* note 3, at 320–27, 428–30.

275. See *supra* text accompanying notes 101–105.

276. See J.D. Kleinke, *Managed-Care Meltdown: HMOs Face a New and Tougher Challenge*, *Barron's*, Dec. 22, 1997, at 51.

277. See Jon Gabel, *Ten Ways HMOs Have Changed During the 1990s*, *Health Aff.* May–June 1997, at 134, 136. There is some evidence that new types of organizations, ranging from capitated medical groups to practice management companies, have assumed responsibility from health plans for clinical innovation, but progress is slow. See James Robinson, *The Corporate Practice of Medicine: Competition and Innovation in Health*

telecommunications and computer technology. In addition, competition has been based primarily on price, with little attention to quality and, hence, little incentive to improve it.²⁷⁸ Moreover, consumers have been changing health plans frequently as employers seek better bargains, whereas stable enrollment is necessary to facilitate practice-based research and to motivate health plans to focus on long-term performance.²⁷⁹

Finally, the rise of managed care has adversely affected established forms of medical innovation. As managed care lowers private insurance premiums, it also reduces funding for conventional research, particularly clinical trials, in academic health centers.²⁸⁰ As is true of care for the indigent, clinical research has been funded primarily by cross-subsidization: Higher charges for insured patients at academic centers reflect, among other things, increased overhead associated with running a teaching and research enterprise.²⁸¹ Until recently, both private and government payers absorbed these costs without objection. Unlike their indemnity-insurer forerunners, however, today's managed care organizations bargain for prices that reflect only actual care delivered to their enrollees. This cost discipline implies diminishing resources for public goods like the production of medical knowledge.²⁸²

In the last few years, however, synergies between continuing demand for cost-containment and availability of new information technologies have launched an "information revolution" among health care providers and care management organizations directed at performance improve-

Care 99-105 (1999) (describing the organization and management practices of capitated medical groups in California).

278. See Meyer et al., *supra* note 30; *supra* text accompanying notes 32-33.

279. The term "health maintenance organization" was coined to trumpet the importance of disease prevention and early treatment in reducing overall expense as well as improving health. However, HMOs whose enrollees change plans every few years have little economic incentive to invest in preventive care, since any eventual savings will accrue to their competitors. Because of this, active competition among insurers to sell single-year coverage may not serve consumers' long-term interests as well as some degree of lock-in, even though the latter comes at the cost of limiting choice. The guaranteed renewal provisions of the federal Health Insurance Portability and Accountability Act and similar state laws do not solve this problem because they fail to control premium increases. See Geri Aston, *Carriers' Prices Undermine Insurance Law*, *Am. Med. News*, Apr. 6, 1998, at 1 (arguing that the complexity of these laws and the intricacies of carrier pricing have prevented most consumers from taking advantage of their rights).

280. See Sage, *Funding Fairness*, *supra* note 269, at 1745-46.

281. See David Blumenthal et al., *The Social Missions of Academic Health Centers*, 337 *New Eng. J. Med.* 1550, 1552 (1997).

282. Public goods are non-rivalrous, meaning they can be used by an unlimited number of consumers, while the cost of excluding any particular user is prohibitive. See Robert Cooter & Thomas Ulen, *Law and Economics* 40-41 (2d ed. 1997). Much health care information, including informal "best practices" as well as the results of empirical investigations, falls into this category. Certainly, compared with securities trading, the gains from day-to-day research in health care are less likely to be appropriated by the researchers.

ment.²⁸³ In addition, health care purchasers have begun to appreciate the effect that shared information has on performance. Corporate benefits departments are often active partners with managed care organizations in quality assessment and improvement activities, rather than merely serving as information conduits for individual enrollees.²⁸⁴ In other words, external reporting of information is explicitly linked to internal, often collaborative, analysis.²⁸⁵

Similarly, governments may rely on data collection and reporting requirements to incentivize performance on measures deemed to be socially important. Indeed, greater information processing capacity among insurers and providers in the private sector has increased governmental interest in using performance-based disclosure requirements to achieve community or national goals regarding access, cost, and quality.²⁸⁶ For

283. See Marvin V. Greene, *Medicine Starting to See Value in Data*, *Am. Med. News*, Jan. 18, 1999, at 26 (analyzing the use of data mining in medical tasks). Once the most wasteful features of fee-for-service practice were eliminated—such as mindlessly excessive periods of hospitalization or grossly overpriced physician services—and all the favorable risk pools were recruited, managed care was forced to attempt true industrial reengineering in order to ensure continued profitability.

284. Corporate America has embraced new industrial principles such as “total quality management” (TQM) or “continuous quality improvement” (CQI) for its own operations, which rely on institutionalized mechanisms for consultation, data gathering, and feedback. Similarly, health care information requirements that are put into place by large employers generally contemplate an interactive process between health plan and purchaser to identify potential areas of improvement and institute corrective action. See Donald M. Berwick et al., *Curing Health Care: New Strategies for Quality Improvement* 29–45 (1990) (adapting TQM principles to medicine); Millenson, *supra* note 118, 244–45, 259–65 (analyzing the introduction of continuous quality management by the Mayo Clinic).

285. This philosophy is evident in the disclosure requirements of the principal accrediting bodies for managed care, NCQA and JCAHO. NCQA’s performance measurement system, called HEDIS, was originally conceived as a way to frame continuing relations between health plans and employers, and only later became the basis of generally disclosed comparative ratings. For example, HEDIS data include the percentage of diabetic patients who receive retinal examinations and the percentage of heart attack survivors who are given beta-blockers. See Memorandum from Phylliss Torda, Vice President of Policy and Product Development at NCQA, to Persons Interested in Accreditation ‘99, at 4, 8, 16 (visited August 2, 1999) <<ftp://www.ncqa.org/docs/hedis/benchmk.doc>> (on file with the *Columbia Law Review*). Although superior performance on these indices undoubtedly matters to beneficiaries who suffer from these conditions, and may suggest to other consumers that overall quality is high, the principal motivation for measurement is to focus health plans’ attention on improving their scores.

JCAHO’s accreditation efforts serve equivalent purposes, although for different historical reasons. JCAHO surveys of hospitals focus on information that tends to establish the adequacy or inadequacy of internal error prevention, surveillance, and quality assurance initiatives. See Joint Commission on Accreditation of Healthcare Organizations, *Accreditation Manual for Hospitals* (1998). Violations are categorized according to severity and reported back to the facility seeking accreditation, which must file a plan of correction. In this way, disclosed information becomes the foundation for organizational performance improvement.

286. See Donald W. Moran, *Health Information Policy: On Preparing for the Next War*, *Health Aff.*, Nov.–Dec. 1998, at 9.

example, data on childhood immunizations are included in virtually every disclosure initiative, even though high immunization rates benefit society as a whole much more than they affect individual consumers, or even enrolled groups.²⁸⁷ Some states have been upfront about their performance objectives. One of the three prongs of Maryland's "report card" legislation consists of a policy report to the public that assesses overall managed care performance by comparing the state's health plans to national quality benchmarks.²⁸⁸

The potential for disclosure to drive system performance is also influencing federal legislation. The Clinton Administration's failed Health Security Act contemplated a national health board, with responsibility for measuring access to and quality of care.²⁸⁹ That provision was embedded in a detailed regulatory framework; more recent proposals have retained the concept on a free-standing basis. For example, several recent patient protection bills considered by Congress establish public bodies to set priorities but limit their enforcement power to informational measures, though with the implication that findings of significant deterioration attributable to managed care would precipitate substantive regulation.²⁹⁰ Performance justifications exist even for traditional forms of disclosure. For example, various states have enacted limited expansions of informed consent duties, generally in response to focused advocacy by patient groups.²⁹¹ These situations can be viewed as failures of agency, in that legislatures have been persuaded that patients are not being given appropriate choices.²⁹² However, disclosure laws of this type also have the potential to improve physician performance. If physicians themselves are

287. Performing well on such measures, of course, does appeal to many consumers and improves the overall public image of the plan. It may also attract families with young children, which are a generally healthy segment of the population.

288. See Health Care Access and Cost Commission, 1999 Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland (1999).

289. See H.R. 3600, S. 1757, 103d Cong. §§ 1501-1552 (1993).

290. See, e.g., Patients' Bill of Rights Act, S. 326, 106th Cong. § 402 (1999) (establishing private-public partnerships to improve organization and delivery of health care).

291. In California, physicians are required to disclose detailed information regarding alternative treatments for breast cancer and hysterectomy and are "urged" to inform patients of alternative treatments for prostate cancer. See Cal. Health & Safety Code § 109275(b)-(c)(1) (West 1996) (failure to inform patients in writing of alternative treatments for breast cancer is unprofessional conduct; state officials must develop standard disclosure form); Cal. Health & Safety Code § 1691 (West 1996) (failure to inform patients in writing of alternative treatments for hysterectomy is unprofessional conduct); Cal. Health & Safety Code § 109280 (West 1996) (requiring state officials to develop written disclosure form for alternative treatments for prostate cancer and urging physicians to disclose that information to patients).

292. An irony is that constituencies with sufficient political influence to secure legislative protection are also usually able to protect themselves in the marketplace. This is a general difficulty with using disclosure rules to govern spheres of activity that cut broadly across socioeconomic groups. See *infra* text accompanying notes 461-466 (describing the

poorly informed about clinical innovations, imposing a legal obligation on physicians to discuss specific alternatives forces them to learn about those treatments and might change their practices as a result.

B. *Challenges for Performance-Based Disclosure*

Restructuring the health care industry through government-mandated benchmarking and feedback would seem a pragmatic use of regulatory capital. As in other industries, disclosure laws can help address the "public good" problem for health care information by mandating collection and dissemination.²⁹³ Furthermore, sharing clinical "best practices" with universal applicability arguably offers a stronger justification for government intervention than does securities law disclosure, where much relevant information is company-specific. However, the performance rationale is a radical departure from the competitive and agency understandings of disclosure-based regulation discussed above. Although both emphasize performance measurement, disclosure laws intended to prod the health care system into improving itself are qualitatively different from disclosure laws intended to promote competition or reinforce private agency obligations because they contemplate an active rather than merely facilitative role for government. This approach can be contrasted with the federal securities laws, whose mission is limited to informing investors. The SEC penalizes faulty disclosure, not faulty performance, and takes pains to avoid substituting its judgment regarding the soundness of securities for that of the investing public.²⁹⁴ On the other hand, performance-enhancing disclosure is openly instrumental, challenging both physician authority and consumer sovereignty as organizing principles for the health care system.

Consequently, the process by which goals and priorities are established takes on great importance. The performance rationale presupposes that market behavior enforced by private law does not adequately define socially appropriate outcomes, and therefore relies on public and professional articulation of goals in addition to economic incentives.²⁹⁵

problems with disclosure laws and interest groups in the context of toxic chemical regulation).

293. See Pauly, *supra* note 144, at 46-47 (discussing the ways government can solve problems of information generation and dissemination).

294. My impression from conversations with senior officials is that the SEC selects items for disclosure and adopts standards for presentation based on its impressions of usefulness to securities buyers, and consciously resists the temptation to push the market in particular directions that reflect the agency's own preferences regarding quality and risk. Even so, SEC disclosure rules affect the range of risks in publicly offered securities by discouraging potentially embarrassing practices, focusing attention on disclosed information, and imposing transaction cost barriers on small issuers. See Jarrell, *supra* note 49, at 666-69 (suggesting that disclosure rules eliminated many risky offerings).

295. As Millenson observes, "information age medicine . . . demands much more than merely digitizing data. Plugging numbers into a computer is an easy trick. Changing people's expectations and behavior is something else again. True stewardship requires a

At the same time, locating health care disclosure laws at the juncture of competition and social policy creates significant tensions. These fall generally into two categories: the risk of government manipulation, and the risk that shared information will weaken private-sector competition.

1. *The Role of Government.* — The first category of potential problems with the performance rationale for disclosure arises from the significant influence that it allows government to wield over industrial conditions in health care, including supply, demand, and market structure. Considerable government control of health care is not new, of course. The extent of public funding is so great, giving programs like Medicare effective power to determine everything from the supply of physicians to the pace of hospital construction, that some experts describe the United States as merely maintaining the pretense of a private health care system.²⁹⁶ The danger of instrumental governmental involvement through disclosure is that the intrusiveness of its role is not obvious, heightening the risk of mischief or misunderstanding.

a. *Selectivity and Goal-Setting.* — Performance-related disclosure is most accurately viewed as a subset of ends-forcing regulation, such as the substantive standard-setting typical of federal workplace and environmental laws. It differs from those approaches in two principal respects. First, it avoids the task of establishing an absolute performance standard, contenting itself with narrowing gaps in relative performance, as well as promoting longitudinal efforts to improve quality over time. Second, it depends primarily on extra-governmental enforcement mechanisms such as competitive forces, grassroots activism, and reputational concerns to achieve its desired effect.

Once one recognizes the ends-forcing nature of performance-oriented disclosure, a key question becomes how to identify the performance criteria to be disclosed. The major limitation of performance-enhancing disclosure is its necessary selectivity. Publishing comparative data relating to pre-selected, standardized, "report card" parameters for quality creates a strong incentive to improve performance on the measures that were chosen for disclosure. However, no public regulatory process will have an easy time gauging which information is lacking, how much of it should be produced, and how the costs of producing it should be distributed.

Because social measures of health system performance are not necessarily congruent with private measures, moreover, establishing productivity goals requires a process outside the market paradigm.²⁹⁷ Increasing

relationship among doctors, patients, health plans, and employers that rests on a foundation of shared information." Millenson, *supra* note 118, at 313.

296. See Eli Ginzberg, U.S. Health System Reform in the Early 21st Century, 280 JAMA 1539 (1998).

297. For example, private purchasers acting with the purest motives, even with input from consumer advocates, are likely to focus on consumer welfare. A consumer welfare standard attempts to maximize consumer surplus, meaning that any efficiency gains from

attention to the items for which disclosure is mandated inevitably diverts resources from other uses which may be more valuable to society.²⁹⁸ Nonetheless, recent proposals emphasize private sector leadership in selecting performance measures, although whether this preference is grounded in policy considerations or derived from recent political rejection of government-dominated health systems is not clear.²⁹⁹ For example, the President's Advisory Commission recommended a bifurcated body, consisting of a public "Quality Council" to establish national goals and a private "Quality Forum" to standardize measures and reporting methods, but political gridlock stalled development of the public side, leaving the private side to move forward alone.³⁰⁰ Inevitably, this places established measurement tools like HEDIS and mobilized constituencies such as large employers in a position of advantage, which may not be socially optimal.³⁰¹

In the long run, a crucial issue is whether disclosure could, or should, be used to transform the health care system from producing med-

performance improvement must be passed on to buyers, and that other benefits are legitimate only to the extent that paying customers value them. Public processes, by contrast, could apply a total welfare standard, which would permit a broader range of factors to be considered, such as the potential to cross-subsidize care for the uninsured from productivity gains, or the opportunity to reap benefits outside of the health care system. See William M. Sage & Peter J. Hammer, *Competing on Quality of Care: Toward a Competition Policy for Health Care Markets*, 32 U. Mich. J.L. Reform (forthcoming Summer 1999).

298. One proposed solution to the problem of health plans investing only in measured outcomes, and one which would not overwhelm the system with measurement costs, is "rotation": creating and publishing hundreds of measures, but using only a dozen or two annually and not announcing the selected measures in advance. See Eddy, *supra* note 137, at 20-21.

299. See *id.* at 23 ("To minimize political influences, the core measurement set ideally should be developed in the private sector.").

300. See Linda O. Prager, *Implementation Fears Overshadow Quality Panel's Plan*, *Am. Med. News*, Apr. 6, 1998, at 3. In June 1998, Vice President Gore officially launched the privately funded Forum on Health Care Quality, whose purpose would be to develop detailed measures of quality for universal reporting and dissemination. The goal of the initiative is decidedly consumerist: to establish "a system where standardized, comparative information is available so consumers can choose their health plans based on quality, not just costs." Gore Announces Planning Commission for Private Forum on Quality Measurement, 7 *Health L. Rep. (BNA)* 1019, 1019 (1998). See also Tracy Miller & Sheila Leatherman, *The National Quality Forum: A "Me-Too" or a Breakthrough in Quality Measurement and Reporting?*, *Health Aff.*, Nov.-Dec. 1999, at 233 (describing the mission and organizational structure of the Quality Forum). Among the details yet to be determined is if or how the recommendations of this private body would be translated into a government mandate.

301. The primacy of purchaser interests (including NCQA's role as principal accreditor) is a sea change in private standard-setting, and reflects today's market-focused environment. During the previous era of professional hegemony, it was the provider-dominated JCAHO that assumed quasi-legal authority for setting industry standards. See Furrow et al., *supra* note 102, §§ 1-4, at 9-16 (describing the legal effect of JCAHO accreditation).

ical services to actually producing health.³⁰² Although the U.S. spends nearly twice as large a percentage of GDP on medical care as the average industrialized nation, it trails many nations in basic indicators of health such as infant mortality and life expectancy.³⁰³ If performance goals for plans and providers to disclose are set in health terms, they will not reflect market preferences, but a much broader social construct of quality.³⁰⁴ These considerations demonstrate the importance of acknowledging openly the justifications for disclosure, lest government intervention originally authorized to serve goals of market facilitation be channeled through regulatory hubris in very different directions.

b. *Effect on Market Structure.* — Information mandates also influence the size and organization of the entities responsible for disclosure, which can affect ultimate performance. For example, complaints have already been voiced that the detailed quality reporting requirements in HCFA's Medicare+Choice MegaReg tilt the playing field in favor of traditional HMOs.³⁰⁵ Not only are smaller organizations, such as PPOs, unable to afford sophisticated information management systems, but even many large insurance organizations, including Blue Cross plans, are too loosely constituted to assure adequate compliance by their affiliated providers.³⁰⁶

302. See, e.g., Arrow, *supra* note 13, at 941; Glied, *supra* note 13, at 143–44. The World Health Organization defines health expansively as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” See Daniel Callahan, *What Kind of Life: The Limits of Medical Progress* 34 (1990). This opens up a range of social goals not typically considered part of the health care system, such as education, housing, and nutrition.

303. See Anderson & Poullier, *supra* note 1, at 180–81, 189. Only in life expectancy at age 80 does the enormous investment America makes in medical technology and treatment give it a leadership position. See Glied, *supra* note 13, at 92–93.

304. The welfare consequences of a move from medical care to health are indeterminate. On one hand, health plans may begin to focus their attention on non-traditional interventions, ranging from public health measures to educational and recreational activities, that could yield benefits like improved school attendance, workplace productivity, and psychological well-being. For example, workers' compensation programs, despite their flaws in terms of fraud and bureaucracy, represent an example of health care focused on a specific goal: prompt return to productive employment. On the other hand, there is no evidence that medical organizations are well-equipped to perform these tasks, so that redirecting resources to the health care system may chill political debate and shortchange other mechanisms for improving social welfare. See Faith T. Fitzgerald, *The Tyranny of Health*, 331 *New Eng. J. Med.* 196 (1994) (arguing that too many social problems are brought into the purview of health care, which is often not the best place for them).

305. According to a leading health care attorney, “many PPOs believe it will be impossible for any organization other than a tightly managed HMO, which can keep total track of its members, to meet the quality assessment and performance improvement standards.” Robert Cunningham, *Medicare “Mega-reg” Adds to Challenges Faced by New Plans Hoping to Compete*, *Med. & Health Persp.*, July 6, 1998, at 2 (quoting Wendy Krasner).

306. When the MegaReg appeared, Blue Cross representatives warned that “[i]f everyone has to meet these standards, it would restructure the marketplace,” and observed that by limiting participation to integrated entities, the proposed regulation seems to run

This situation captures the tension between the competition and performance rationales for disclosure. As experience with securities law demonstrates, even disclosure regulation that is intended to be merely market-facilitating exerts incidental structural pressures on industry participants. The situation is more complicated for disclosure that is explicitly intended to improve system performance. A decision to mandate disclosure that requires encounter-level data should be based on an informed judgment that the organizational structure needed to produce those data is optimal from a performance perspective. In addition, the degree of structural determinism implied by disclosure should be weighed against other policy and political goals, such as professional autonomy and consumer choice. Organizations such as closed-panel HMOs create a normative environment for physician practice that may well be cost-effective, but to which most of today's medical professionals would have great difficulty adapting. Moreover, as demonstrated by the predominance of point-of-service plans and other broad provider networks in today's marketplace, consumers dislike the restrictive panels typical of tightly integrated organizations.

Similarly, responsiveness to disclosure requirements may vary according to organizational structure, with implications for performance. Disclosed information is sometimes used by interest groups to exert pressure through public awareness campaigns and lobbying efforts, or by aggrieved parties to bring suit under pre-existing laws and regulations. For example, reductions in toxic emissions from factories following the enactment of mandatory disclosure provisions in federal environmental law are largely attributable to the recognition by prominent, publicity-savvy corporations—who were vulnerable to securities liability for faulty disclosure—that adverse reports frighten consumers and discourage investors. More generally, Lowenstein asserts that recent advances in American corporate governance have resulted from “the voice of the paparazzi”: multidirectional, intense scrutiny and analysis of disclosed information prompted by widespread stock ownership and the modern media culture.³⁰⁷ However, this suggests that disclosure laws work better when they involve large, publicly owned corporations, which is not a universally accepted model for health care delivery.

c. *Privacy*. — Personal health privacy is a critical issue in today's information-rich health care system.³⁰⁸ Historically, the absolute confiden-

counter to the stated purpose of the new Medicare law, which was to expand choices for beneficiaries. HCFA Issues Medicare+Choice Rules, Concerns Voiced Over Provisions, 7 Health L. Rep. (BNA) 1022, 1024–25 (1998).

307. Lowenstein, Paparazzi, *supra* note 255, at 28–40.

308. A full discussion of privacy is beyond the scope of this article. For a sense of the difficult issues presented and suggested reforms, see generally Amitai Etzioni, Medical Records: Enhancing Privacy, Preserving the Common Good, Hastings Center. Rep., March–April 1999, at 14 (advocating institutional changes to safeguard health information privacy); Lawrence O. Gostin, Health Information Privacy, 80 Cornell L. Rev. 451 (1995) (describing a “conceptual framework” for understanding health information as a

tiality of doctor-patient communications served not only legitimate patient care and privacy interests, but also helped the medical profession preserve its economic power against managerial incursions by third parties.³⁰⁹ In managed care, ready access to information about individuals' health care needs and utilization offers clear therapeutic benefits in terms of service coordination and error prevention. Furthermore, information can be useful to managed care organizations in monitoring provider practices and promoting quality improvement through research. Finally, transactional information can help government set and assess national performance goals and risk-adjust payments to managed care organizations under Medicare and Medicaid.

However, the potential utility of this information to performance improvement must be weighed against ethical and legal concerns about its widespread availability.³¹⁰ Electronic information transfer multiplies the risk of inadvertent disclosure and misuse, while the strong link between coverage and employment in the American health care system raises concerns relating to employment discrimination and insurability.³¹¹ Further, the potential to gain commercial advantage from matching consumers to their health care needs greatly increases the value of this information, and therefore the temptation to exploit it.³¹²

Because disclosure laws designed to boost performance necessarily involve close analysis of actual experience, they threaten patient privacy in a more direct fashion than disclosure laws designed to serve other purposes. The fact that data analysis takes place primarily within the disclos-

particular and special form of privacy); Paul M. Schwartz, *The Protection of Privacy in Health Care Reform*, 48 Vand. L. Rev. 295 (1995) (arguing that the U.S. must develop fair information practices for health care data and proposing specific standards); Janlori Goldman, *Protecting Privacy to Improve Health Care*, Health Aff., Nov.-Dec. 1998, at 47 (suggesting that health privacy regulations are necessary not only to protect individualism, but also to make health data more useful).

309. See Starr, *supra* note 3, at 299-300; Charles D. Weller, "Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance, 69 Iowa L. Rev. 1351, 1372-75 (1984).

310. For example, HCFA proposed last year that individuals be issued a unique health identification number, as mandated by Congress in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health system efficiency and productivity was at the heart of the proposal, as described in an HHS white paper, *Unique Health Identifier for Individuals* (1998) (visited Oct. 8, 1999) <<http://aspe.os.dhhs.gov/admnsimp/nprm/NOIwp1.htm>> (on file with the *Columbia Law Review*). Shortly thereafter, the AMA announced its opposition to the use of a national health identifier on privacy grounds, following which Congress reversed itself and imposed a moratorium on the proposal's implementation. See Pub. L. No. 105-277, § 516, 112 Stat. 2681-386 (1998).

311. See David M. Studdert, *Direct Contracts, Data Sharing and Employee Risk Selection: New Stakes for Patient Privacy in Tomorrow's Health Insurance Markets*, 25 Am. J.L. & Med. 233, 251 (1999).

312. For example, the billion-dollar price tag paid in 1993 by a major drug company for a pharmacy benefit management firm was attributed by financial analysts to the value of the management firm's patient database. See Elyse Tanouye, *Merck Will Exploit Medco's Database*, Wall St. J., Aug. 4, 1993, at B1.

ing organization is some consolation, but that organization may be extensive, and information may be shared between internal and external processors, possibly including governmental bodies. Moreover, many large corporations have dual roles as employers and as health system managers, increasing the risk of discriminatory misuse. As Schwartz observes, the existence of both risks and benefits to information-sharing argues for a legal regime that maintains fair information practices.³¹³ Therefore, a corollary to disclosure policies that promote dissemination of data about care processes within managed care organizations should be enhanced protection of individually identifiable health information.

d. *Influencing Demand.* — A critical insight for understanding health system performance is that, unlike many other goods and services, the cost-effectiveness of health care is largely within the control of the buyer.³¹⁴ Broadly considered, health system performance has two crucial components: productive efficiency by health plans and providers, and changes in consumers' perceptions and behavior. Therefore, the most promising informational interventions in terms of performance gains may be those that influence people's health-related conduct and their expectations of the health care system.³¹⁵ Using information to form or modify consumer preferences is a common aspect of private, competitive behavior.³¹⁶ However, the use of informational mandates by *government*

313. See Paul M. Schwartz, *Privacy and the Economics of Personal Health Care Information*, 76 *Tex. L. Rev.* 1 (1997). For example, health plans and providers should be obligated to place consumers on notice about the uses of personal health information, and to create an information-rich environment with respect to information itself. Because the fiduciary contracting objections to consent described above apply to many such situations, however, this iterative disclosure duty is best seen as part of a public process that sets rational, justifiable goals for system performance.

314. Part of this phenomenon relates to the moral hazard inherent in insurance. The principal form of moral hazard is the tendency to overuse services when ill, a characteristic that can be traced historically to hospitals' and physicians' control over the structure of health insurance. See Starr, *supra* note 3, at 332–33. The tendency to engage in risky behaviors, which is the classic moral hazard associated with property and casualty insurance, plays a lesser role in health insurance. Even in the aggregate, moral hazard does not explain the variability of demand for health care, which likely stems from a host of non-insurable costs and other social and psychological factors.

315. For example, patient attitudes exert substantial effects on utilization of expensive medical procedures. See John Z. Ayanian et al., *Rating the Appropriateness of Coronary Angiography—Do Practicing Physicians Agree with an Expert Panel and with Each Other?*, 338 *New Eng. J. Med.* 1896, 1898 (1998) (over half of physicians listed patient or family request as very or moderately important in the decision to perform angiography).

316. The most familiar form of demand modification through information is advertising. Advertising, whether by insurers, health providers, or product suppliers, has ambiguous performance implications for the health care system. For example, the imposition by managed care organizations of cost controls on prescription drug use—such as utilization review, negotiated formularies, and physician financial incentives—led drug manufacturers to develop brand recognition and resurrect demand through aggressive marketing to end-users. Direct-to-consumer advertisement of prescription medications has ballooned in recent years, increasing patient awareness, but also contributing to a rapid rise in pharmacy benefit costs as a percentage of insurance premiums. See National

to influence the beliefs and activities of individuals can be controversial, especially when (unlike areas such as tobacco control) it is concealed within supposedly value-neutral disclosure regulation.³¹⁷

Because most acute illnesses, such as infectious diseases, have yielded to advances in medical science, the greatest sources of morbidity and mortality, and hence expense, are a small number of ubiquitous chronic illnesses such as coronary artery disease, diabetes, emphysema, and cancer.³¹⁸ Many of these conditions are preventable or even treatable through lifestyle changes such as diet, exercise, and smoking cessation.³¹⁹ In addition, treatments for these problems range from highly cost-effective interventions to so-called "flat-of-the-curve medicine," where large incremental costs are incurred for small incremental benefits.³²⁰ Patient preferences regarding intensity of therapy, as well as attitudes toward aging and death, can therefore fundamentally alter the structure of health care delivery and substantially lessen its cost.

Health services researchers, particularly those examining unexplained variation in the utilization of services, are increasingly being drawn to the demand side of the equation. The use of disclosure to alter

Institute for Health Care Management Foundation, Issue Brief: Factors Affecting the Growth of Prescription Drugs Expenditures 1 (1999) (noting that spending on prescription drugs grew twice as fast as total national health expenditures between 1993 and 1998); Terzian, *supra* note 270 (reviewing recent changes in FDA policy).

Managed care organizations are using a variety of strategies to counter this trend, including informational campaigns designed to offset advertising by drugmakers. Among other things, health plans are advising physicians on techniques to turn patients against expensive medications, highlighting both the power and the danger of demand modification through information. For example, health plans have reportedly urged physicians to temper patients' excitement over a new medication by telling them "I don't want *my* patients to be guinea pigs!" See Daniel B. Moskowitz, *Managed Care Plans Try to Cope as Drug Ads Spur Patient Demand*, *Med. & Health*, May 18, 1998 Supp. at 1, 2; see also Mark Hagland, *Viagra or Bust: Is Pharmacy Cost Crisis Unraveling HMO Utilization Strategy?*, *Med. & Health*, July 13, 1998 Supp. at 1, 3 (1998) (describing how some medical groups are using report cards and financial incentives to influence doctors' prescription habits). Scripted discussions of this type raise major agency concerns.

317. See *infra* notes 427-431 and accompanying text.

318. See Gray Ellrodt et al., *Evidence-Based Disease Management*, 278 *JAMA* 1687 (1997) (observing that ten percent of employees with severe or chronic diseases consume 70% of a group's health care costs).

319. See generally Center for the Advancement of Health and Milbank Memorial Fund, *Patients as Effective Collaborators in Managing Chronic Conditions* (1999) (summarizing evidence that patients can work with health professionals in carefully designed programs to manage chronic conditions). According to one family physician who contracts with a "disease management" company, "[i]n the treatment of diabetes, the drug of choice is education." Mark Moran, *Bridging the Gap Between Theory and Reality*, *Am. Med. News*, Apr. 26, 1999, at 29, 29 (quoting Charles Booras). See also Thomas Bodenheimer, *Disease Management—Promises and Pitfalls*, 340 *New Eng. J. Med.* 1202 (1999) (describing disease management for chronic diseases).

320. Cf. David M. Eddy, *Broadening the Responsibilities of Practitioners: The Team Approach*, 269 *JAMA* 1849 (1993) (arguing that treatments with little utility should yield to more cost-effective treatments in a world of limited resources).

consumer attitudes and behavior is termed "demand modification" or "demand management."³²¹ Information disclosure can reduce demand for health care through three mechanisms. First, disclosure can be used to construct feedback loops among health plans, physicians, and patients, involving individuals to a greater extent in managing their own care.³²² Second, disclosure can be used to convey information about disease prevention and health promotion. Third, disclosure can be used to influence patients' tendencies to use health care and their choices among possible treatments.³²³ Each of these can improve the global performance of the health care system. Demand-side interventions are being tested even in the ethically controversial province of end-of-life care.³²⁴

However, demand modification is a far cry from providing information to facilitate market transactions, where preferences are assumed to be exogenous. Although current law tends to view educational efforts as invariably positive social contributions, the process of informing consumers and patients also carries significant risks of manipulation, depending on who is providing information, in what manner, and with what incentives. For example, health plans may elect to disseminate voluntarily only

321. Demand management is the term used for interventions by managed care organizations to decrease utilization and cost. It has been defined variously as "the reengineering of consumer behavior to reduce the need for health care services . . . [the goal of which] is elimination of unnecessary and inappropriate care" and as "a set of structured systems that assist consumers to make informed decisions about their own health and health care." Alice G. Gosfield, *Disease Management, Demand Management, and Telemedicine: The Leading Edge of Managing Care*, in *Health Law Handbook* 235, 242-43 (Alice G. Gosfield ed., 1998) (quoting industry newsletters). Demand management programs typically focus on persuading and educating patients to take care of minor problems without hands-on medical assistance, to choose less intensive or invasive treatments, and to reduce risk factors for developing illness. Most such programs, administered by or under contract to health plans, make available to beneficiaries a toll-free number staffed by nurses, as well as supplemental print and electronic information. Although demand management programs are often closely linked to general quality improvement efforts, their explicit strategic objective is to reduce cost.

322. For example, informed consent requirements are increasingly seen as communication- and hence performance-enhancing, rather than merely deferential to patient autonomy, and are arguably more successful when used for this purpose. See Howard Brody, *The Healer's Power* 89-93, 95-96, 99, 104 & n.1 (1992); Schneider, *supra* note 8, at 110-13.

323. Changing patients' expectations not only alters their economic preferences, but also recalibrates the moral and legal debate over entitlement. See Leslie P. Francis, *Consumer Expectations and Access to Health Care*, 140 U. Pa. L. Rev. 1881, 1883-84 (1992) (arguing for legal protection of expectations).

324. For example, a recent study of patients with terminal colon and lung cancer demonstrated that patients systematically overestimate their chances of long-term survival and therefore elect expensive, life-extending therapy rather than comfort care. See Jane C. Weeks et al., *Relationship Between Cancer Patients' Predictions of Prognosis and Their Treatment Preferences*, 279 JAMA 1709 (1998). The authors conclude that enhanced communication between physicians and cancer patients about prognoses can help patients make decisions more consonant with their values and can reduce suffering from misguided heroic therapy. See *id.* at 1713.

information that will reduce costs, creating a need for mandatory disclosure laws to provide balance.³²⁵

At the extreme, demand management programs may seek to change underlying values as well as to better match patient preferences to choice of therapy. Recall Tversky and Kahneman's distinction between framing errors and valuation errors.³²⁶ Although some educators aim only to help patients frame choices more accurately by presenting information in ways that allow them to understand their individual values and to connect those values to a health care decision, others are less circumspect in their ambitions. For example, leading physician policymakers, including former Surgeon General Koop, recently proposed using informational tools to persuade people to adopt entirely different attitudes toward health risks and medical care.³²⁷ The lesson to be drawn from this well-intentioned effort, as well as the more obviously self-serving programs of some commercial organizations, is that there is a fine line between information and propaganda where demand for health care is concerned. Mandatory disclosure laws serving the performance rationale therefore must tread carefully in this area.

2. *Competition and Performance.* — The second category of potential problems with instrumental uses of disclosure connects to a broader inquiry into the relationship among information, industrial performance, and competition.³²⁸ In many industries, particularly technology-intensive ones where the pace of innovation is rapid, centralized control over information within tightly structured firms has given way to fluid processes of consultation and feedback involving changeable networks of semi-auton-

325. The best-known attempt to modify demand is a pilot project conducted in Colorado by Kaiser-Permanente, in which patients with benign prostatic hyperplasia viewed interactive videotapes prepared by a non-profit organization with strong academic ties. The videos were designed to match the benefits and risks of alternative treatments to the viewers' subjective preferences regarding survival and quality of life by showing interviews with actual patients who describe the results of their own choices given their individual goals. The result of viewing the videos was a marked decline in the percentage of patients electing surgery. Although the results of the prostate study were immediately hailed as showing the cost-reducing potential of consumer information, there was no inherent reason for informed consumers to choose less aggressive rather than more aggressive therapy. If the patients had elected more rather than less surgery, the outcome still would have been efficiency-enhancing in economic terms, but might never have been publicized by the HMO. See Albert Mulley, *Outcomes Research: Implications for Policy and Practice*, in *Outcomes into Clinical Practice* 13 (Tony Delamothe ed., 1994); Edward H. Wagner et al., *The Effect of a Shared Decisionmaking Program on Rates of Surgery for Benign Prostatic Hyperplasia: Pilot Results*, 33 *Med. Care* 765, 765 (1995).

326. See Tversky & Kahneman, *supra* note 84, at 453.

327. See James F. Fries et al., *Beyond Health Promotion: Reducing Need and Demand for Medical Care*, *Health Aff.*, Mar.-Apr. 1998, at 70, 73 (emphasizing self-efficacy, defined as the belief that personal behavior influences one's future, risk reduction, and self-management of chronic disease).

328. This parallels concerns articulated previously regarding the ways in which information can retard competition. See *supra* text accompanying notes 101-113.

omous groups.³²⁹ In health care, many firms and professionals now believe that information is the key to success, but nonetheless guard jealously their perceived informational advantages. Assessing the implications of the performance rationale for health care disclosure therefore requires determining whether optimal performance is to be achieved by sharing information with competitors or customers, or by protecting it within firms.³³⁰

a. *Business Confidentiality*. — One important question for mandatory disclosure is how to treat purportedly confidential business information. Certainly, concerns about giving information to rivals can deter voluntary disclosure in a competitive environment. If organizations believe that the information they share benefits others at their expense, either directly by revealing their strategies, or indirectly by impairing negotiations with providers or suppliers, they will not disclose that information. In markets subject to mandatory disclosure laws, regulated entities frequently protest against revealing information that might be appropriated by their competitors.³³¹ Current health care laws and legislative proposals vary in their approach to business confidentiality. Despite their increasing reliance on competitive markets, many insurance and HMO regulators continue to regard confidentiality as discretionary, which gives little comfort to reporting entities.³³² Similarly, federal fraud laws have been criticized for not limiting public access to information disclosed to enforcement authorities in order to obtain advisory opinions regarding proposed conduct.³³³ By contrast, the Patients' Bill of Rights Act of 1998 specifically

329. See Alan Hyde, *Silicon Valley's High-Velocity Labor Market*, 11 J. Applied Corp. Fin. 28, 28 (1998) (quoting with approval Anna Lee Saxenian's description of a "regional network-based industrial system that promotes collective learning and flexible adjustment"); Charles F. Sabel, *Learning By Monitoring: The Institutions of Economic Development*, in *Handbook of Economic Sociology* 138-39 (Neil J. Smelser & Richard Swedberg eds., 1994).

330. The growth of Internet communication has added to the complexity of this issue. For example, a major physician practice management company that has encountered financial difficulty in recent years announced its intention to bring suit against physicians who were impugning its reputation with their colleagues in Internet chat rooms. See Cathy Tokerski, *PhyCor Moves to Uncover Physicians' Online Identities*, Am. Med. News, May 24, 1999, at 1.

331. For example, OSHA's Hazard Communication Standard met considerable resistance on the ground that the identity and characteristics of toxic chemicals produced or used in the workplace had competitive value. The regulation ultimately incorporated considerable protection for manufacturers' trade secrets. See 29 C.F.R. § 1910.1200(i) (1998). See generally Kent Greenawalt & Eli Noam, *Confidentiality Claims of Business Organizations*, in *Business Disclosure: Government's Need to Know* 407-09 (Harvey J. Goldschmid ed., 1979) (discussing trade secrets).

332. See, e.g., *HIP of New Jersey, Inc. v. New Jersey Dep't of Banking and Ins.*, 707 A.2d 1044 (N.J. Super. Ct. App. Div. 1998) (holding that documents submitted as confidential in connection with an amendment to an HMO's certificate of authority must be released to the public if requested).

333. See American Health Lawyers Association, *Fraud and Abuse: Do Current Laws Protect the Public Interest?* 33 (1999) (reporting consensus among colloquium panelists).

excludes from its extensive disclosure requirements "individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider."³³⁴

Securities law experience suggests that exceptions for proprietary information should be construed narrowly when the purpose of disclosure is to benefit competition or to enhance agency obligations.³³⁵ Allowing certain types of information to escape public scrutiny detracts from the overall usefulness of disclosure to consumers. For example, the practices that managed care organizations prefer not to share publicly are typically compensation methods, coverage standards, and utilization review protocols that are extremely important both to consumers and to providers considering affiliation decisions. In addition, concerns about proprietary information in health care may be overstated, in that actual management practices are as yet unsophisticated. Consequently, resistance to disclosing them may reflect unwillingness to reveal ignorance or arbitrariness rather than protection of competitive advantage.³³⁶ If the emperor lacks clothes, that fact is itself undeniably valuable information to consumers.³³⁷

On the other hand, business confidentiality may require more nuanced treatment if the purpose of information is performance improvement. Two schools of thought are relevant, but lead in opposite directions. According to the first, improved performance requires strong property protection for confidential business information. A common regulatory approach to stimulating research by spurring private investment is to grant intellectual property rights.³³⁸ Because disclosure requirements should reinforce, not counteract, managed care organizations' existing incentives to innovate, one could argue for the need to

334. H.R. 3605, 105th Cong. § 121(e) (1998).

335. The SEC requires the party requesting confidential treatment to file unredacted documents along with a specific explanation of why confidentiality is necessary. If the request is granted by the agency, the information becomes exempt from disclosure under the Freedom of Information Act. See Rule 406 under the Securities Act of 1933, 17 C.F.R. § 230.406 (1999).

336. For example, I attended a presentation in 1996 by a senior information officer at Oxford Health Plans, who boasted that their systems were so refined that they entered into negotiations with hospitals with more information about the hospitals' costs than the hospitals themselves possessed. A year later, Oxford's share value plummeted after the organization admitted that computing errors had concealed huge losses of its own. See Julie A. Jacob, *Oxford Losses Raise Concerns for Industry's Staying Power*, *Am. Med. News*, Nov. 17, 1997, at 1.

337. As Gosfield observes, "the insistence on secrecy in managed care—from extensive confidentiality clauses in provider contracts to restrictive covenants imposed on managed care employees—manifests either a certain industry-wide delusion of grandeur or fear regarding the emperor's new clothes." Gosfield, *Guide*, *supra* note 34, at 223–24. Gosfield concludes that only the rates paid to providers and the long-term strategic plans of managed care organizations should receive protection from disclosure.

338. See generally Eisenberg, *supra* note 268 (discussing government patent policy to promote technology transfer in government sponsored research since 1980).

protect trade secrets and other confidential business information.³³⁹ In particular, data collected and analysis performed by disclosing organizations in order to calculate overall performance measures might properly be shielded from public access, except for the limited purpose of auditing by authorized parties.

A second response to business confidentiality is to look beyond the current industrial organization of health care and assess the issue in light of the continuously innovating, constantly improving health care system to which the performance rationale for disclosure ultimately aspires. In other industries, vigorous competitors have abandoned efforts to segment, isolate, and safeguard knowledge in favor of open architectures that promote fluidity and information sharing.³⁴⁰ If this is also a desirable outcome in health care, performance-oriented disclosure laws may accelerate this trend by reducing barriers to information exchange, in which case protection of allegedly proprietary information should be narrowly construed. For example, Robinson's description of risk-bearing medical groups as health care's performance leaders endorses benchmarking, best practices, and technology transfer as keys to long-term success.³⁴¹ Building on those improvements, Robinson envisions a new economic order based on scope, diversity, and innovation that is clearly distinguishable from the older view of managed competition among discrete, fully integrated corporate health systems.

b. *Content and Access.* — Improving productive efficiency through disclosure requires anticipating the ways in which producers might respond to information, and customizing disclosure requirements to facilitate those responses. Audience is one factor that differentiates performance-enhancing disclosure from its more consumerist counterparts. Because performance improvement requires internal use of information by health plans, hospitals, and physicians, the nominal audience for most current disclosure laws, the general or consuming public, is seldom the most meaningful audience. This should influence both the manner of disclosure and the choice of items to be disclosed. For example, while the ultimate measures of improved care management, such as reduced morbidity and mortality, may be of widespread interest, disclosure of in-

339. Patent protection is already conditioned on public disclosure, although not all confidential business information is patentable. However, there may be a trend toward allowing patents for the types of disease and network management processes central to managed care. See *State Street Bank & Trust Co. v. Signature Financial Group, Inc.*, 149 F.3d 1368, 1375 (Fed. Cir. 1998) (finding that a patent entitled "Data Processing System for Hub and Spoke Financial Services Configuration" was within the scope of statutory subject matter).

340. For example, automobile manufacturers no longer require suppliers to meet separate, proprietary qualifications, but share an industry-wide standard. See Susan Helper et al., *The Boundaries of the Firm as a Design Problem* 7-8 (Nov. 14, 1997) (unpublished manuscript, on file with the *Columbia Law Review*).

341. See Robinson, *supra* note 277.

intermediate parameters such as the processes and outcomes of care must be geared to use by experts, not lay consumers.

Similarly, disclosable information arguably should focus on areas subject to managerial control. This constraint does not exist for consumer-oriented disclosure, where highly relevant information may be randomly or extrinsically determined (such as real property values or passively held stock portfolios). For example, economic conditions, demographics, and emerging health hazards all influence the performance of the health care system. Because these factors are not necessarily within the control of reporting entities, however, measuring them would have an uncertain effect on production decisions.³⁴² The need to link quality measurement to improvable performance also reinforces the need for careful risk-adjustment of payment as well as of collected data, so that organizational incentives to improve performance match society's expectations.³⁴³

More generally, there is a tension between accountability and innovation. A challenge for disclosure intended to aid quality improvement is balancing the motivating effect of unfavorable information against the instinct to suppress it. Health plans and providers who might be damaged by disclosure have obvious incentives to conceal or falsify information. For this reason, some policy experts believe that raw data based on individual patient-practitioner encounters should be routinely communicated to a government agency or non-profit body, which would process the information and prepare reports for the public. On the other hand, an important part of the learning process for health care producers is generating, analyzing, and synthesizing the information to be disclosed.³⁴⁴ Efforts to insulate data *about* the health care industry from the potentially corrupting influence *of* the health care industry therefore may backfire if the principal goal of disclosure is performance improvement.

A compromise is to use independent audit requirements and strict penalties for fraud to ensure data integrity, while still encouraging self-reporting and self-evaluation. If external data analysis is performed, public disclosure should be supplemented with individualized feedback, in-

342. This also suggests that different types of regulated entities will vary in their ability to use information to improve performance. While an individual physician might be limited in possible responses to demographic or epidemiologic information, a large health plan might adjust its contracting strategies and clinical resources accordingly.

343. See Shewry et al., *supra* note 102.

344. Because clear rules seldom exist to guide medical decisions, for example, augmenting internal quality improvement processes to comply with disclosure requirements may prove more fruitful than waiting for data to be published and responding to criticism leveled from afar. See, e.g., C. David Naylor, *What Is Appropriate Care?*, 338 *New Eng. J. Med.* 1918, 1920 (1998) ("the art of medicine is unlikely to be managed away for many years to come"); Paul G. Shekelle et al., *The Reproducibility of a Method to Identify the Overuse and Underuse of Medical Procedures*, 338 *New Eng. J. Med.* 1888, 1893-94 (1998) (concluding that "expert" review panels of medical appropriateness are imperfect).

cluding appropriate benchmarks, that conveys results cooperatively rather than adversarially.³⁴⁵ Eventually, it may become necessary to develop an explicit "technology transfer" policy for government-subsidized informational activities that allows techniques arising from cooperative dialogue between disclosing entities and regulators to be reincorporated into internal quality improvement processes.

Another consideration is that assignment of blame may be incompatible with the free and frank discussion that leads to performance improvement.³⁴⁶ As health care becomes recognized as an advanced industrial activity rather than a series of discrete services provided by individual professionals, adopting sound institutional strategies for error reduction and quality improvement takes on heightened importance.³⁴⁷ Traditionally, accountability rested almost exclusively with individual physicians. However, research increasingly reveals that most medical errors, while human in proximate cause, are ultimately the result of faulty institutional processes.³⁴⁸ Within organizational settings, quality improvement activities will be most effective if the internal environment encourages persons involved in adverse events to report them. Improperly designed disclosure laws can chill this process. Suboptimal levels of performance may result, for example, if the law requires disclosure of individual practitioner involvement in adverse events even though meaningful quality improvement is more likely to occur at the health-plan level, or if corporate efforts to improve performance are not given the same protection from discoverability and collateral use as traditional peer review activities.³⁴⁹

345. For example, through most of its history, Medicare's Peer Review Organization (PRO) program was perceived as a policeman by practitioners, and therefore kept at a distance. This severely compromised its effectiveness in promoting health care quality. In its "Fourth Scope of Work," the PRO program is now attempting to reinvent itself as a source of useful feedback and technical assistance, rather than punishment. See generally Furrow et al., *supra* note 102, §§ 3-26 to 3-35, at 133-57 (discussing Medicare utilization and the PRO program). On the other hand, performance-oriented disclosure may yield information of use to state licensing agencies and other regulatory bodies charged with consumer protection and quality improvement.

346. By way of illustration, the law excludes evidence of subsequent remedial measures in cases alleging product defect on the theory that voluntary efforts to improve quality should not be penalized. See Fed. R. of Evid. 407. With respect to medical care, the need for peer review of professional judgments has given rise to a host of statutes granting immunity to physicians who participate in quality assurance activities and according privileged status to information derived from those proceedings. These legislative efforts culminated in the federal Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3784 (codified as amended at 42 U.S.C. §§ 11101-11152 (1994)). See also Furrow et al., *supra* note 102, § 4-28, at 227-28 (discussing the Health Care Quality Improvement Act).

347. See Sage, *Enterprise Liability*, *supra* note 54, at 195-97 (discussing the tension between individual accountability and institutional quality improvement).

348. See Berwick et al., *supra* note 284, at 35-37.

349. See Bryan A. Liang, *Error in Medicine: Legal Impediments to U.S. Reform*, 24 J. Health Pol., Pol'y & L. 27, 46-47 (1999).

These considerations take on added weight because of the potential that the performance rationale offers to leverage professional values. Despite its historical role in retarding coordinated performance improvement, the professional nature of most health care delivery is likely to reinforce the potential benefits from performance-oriented disclosure. Recalling Pound's definition of a profession,³⁵⁰ the technical knowledge inherent in the "learned art" of medicine argues for promoting change from within, using shared information. Moreover, the "common calling" and "public service" aspects suggest that physicians will be motivated to improve their practices, once identified through disclosure, because of peer influences and non-commercial incentives as well as marketplace effects.³⁵¹ Moreover, medical professionals are experienced at identifying service needs and mediating between the interests of individual patients and of society.³⁵²

However, using professional processes necessarily involves accommodating professional sensitivities. Physicians who willingly accept peer review are not always pleased to be in the public spotlight and may subvert efforts to share information to improve performance if they do not feel comfortable with the potential uses of the data collected.³⁵³ In the study of myocardial infarction mentioned above, for example, information on specific physicians and hospitals was not released to the public for fear of

350. See Pound, *supra* note 251, at 4-7.

351. The power of information to improve quality in health care through professional processes has been demonstrated repeatedly, particularly now that large-scale electronic databases can be combined with innovative approaches to practice review and provider education. In one recent study, data collected from over 250,000 medical records of heart attack victims were analyzed for clinical quality based on consensus guidelines and the results shared with physicians and hospitals. Three years later, mortality from myocardial infarction in the study regions had dropped by ten percent. See Thomas A. Marciniak et al., *Improving the Quality of Care for Medicare Patients with Acute Myocardial Infarction: Results from the Cooperative Cardiovascular Project*, 279 *JAMA* 1351, 1355 (1998).

352. See Mark A. Hall, *Rationing Health Care at the Bedside*, 69 *N.Y.U. L. Rev.* 693 (1994) (discussing physician rationing); Sage, *Advocates*, *supra* note 162, at 1621-25 (describing the inevitable involvement of the medical profession in resource allocation decisions).

353. The difficulty of balancing these considerations is illustrated by the National Practitioner Data Bank, which has generated such negative physician reactions as to cast doubt on its net utility. See Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3784 (codified as amended at 42 U.S.C. §§ 11101-11152 (1994)). For example, strategic behavior by hospitals to avoid reportable sanctions appears to be widespread. See Laura-Mae Baldwin et al., *Hospital Peer Review and the National Practitioner Data Bank: Clinical Privileges Action Reports*, 282 *JAMA* 349 (1999) (reporting results of study showing low and declining levels of hospital privileges actions). In addition, many physicians were initially so apprehensive about having their termination from managed care provider panels reported to the Data Bank that they insisted on "no-cause" termination provisions in their contracts, which greatly reduced the benefit of those agreements to them and their patients when managed care organizations decided to prune their networks. See Alice G. Gosfield, *Presentation to the American Medical Association* (Feb. 1993). It is not clear if these behaviors arise from physicians' sometimes irrational fear of malpractice litigation or from some other factor.

chilling the cooperation necessary for quality improvement.³⁵⁴ Whether these concessions can be made without eviscerating other valid uses of disclosed information must be addressed on a case-by-case basis.

C. *Strengthening the Performance Rationale*

Although consumerist justifications for mandatory disclosure have dominated political and policy debate, the preceding discussion suggests that the power of information is likely to be greatest when it is used to improve the production function of modern health care. Properly designed, mandatory disclosure can foster communication among health plans, hospitals, and physicians, as well as between these parties and consumers. This process has the potential to disseminate best practices, enlist patients as active partners in health management, and stimulate innovation that can generate additional productivity gains. By initiating a widely distributed process of data analysis and refinement, disclosure laws might also supplement top-down efforts by government and professional associations to develop standards and guidelines for clinical practice.

However, the performance rationale occupies an uncertain place in the debate over health care reform. Compared to disclosure laws motivated by competitive concerns, informational mandates geared to improving system performance have been slow to develop. For example, direct governmental efforts to improve health care information have focused mainly on creating clinical practice guidelines.³⁵⁵ These attempts have proved problematic for two reasons. First they are extremely expensive. Each guideline developed by the federal Agency for Healthcare Policy and Research (AHCPR) has cost between half a million and a million dollars to produce.³⁵⁶ Second, they are politically exposed. In the aftermath of the Republican landslide in the 1994 election cycle, AHCPR nearly lost its funding when a politically influential group of orthopedic surgeons objected to a guideline that criticized overuse of back surgery.³⁵⁷

More generally, performance-enhancing aspects of health care disclosure often have been neglected in favor of the less feasible competi-

354. See Marciniak et al., *supra* note 351 (reporting general results of study).

355. Clinical practice guidelines are defined by the Institute of Medicine as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." Gosfield, *Guide*, *supra* note 34, at 194.

356. See Physician Payment Review Commission, *Annual Report to Congress* 375 (1995).

357. See Neil A. Lewis, *Agency's Report Provokes Revolt*, N.Y. Times, Sept. 14, 1995, at A16. However, the National Guideline Clearinghouse project represents a step in the right direction. This project, a public-private partnership chiefly sponsored by AHCPR, has established an Internet-based repository containing several hundred clinical practice guidelines with the goal of helping health professionals adopt "best practices" for common health problems. See <<http://www.guideline.gov>>; Linda O. Prager, *Internet-Based Guideline Repository Unveiled*, Am. Med. News, Feb. 1, 1999, at 1.

tion rationale because they lack a natural constituency given the current politics of privatization. In an era of government retrenchment and budgetary constraints, informational requirements seem less "activist" or bureaucratic—and hence less suspect—if they are tied to self-help and the facilitation of market processes. A personal experience from the 1993 health reform effort illustrates how performance-oriented disclosure has been coopted by the rhetoric of competition. At meeting after meeting of the Clinton Administration's health care working group, experts on health care quality urged Ira Magaziner, the President's domestic policy advisor, to require the collection of standardized information about patient care from health plans and providers. They pointed out that information was indispensable to quality assurance and that comprehensive data measurement would improve understanding of care processes and heighten the efficiency of service delivery. Each time, Magaziner rebuffed the suggestion as costly, intrusive, and unnecessary.³⁵⁸ Frustrated, yet determined that the Administration consider the performance benefits of increased information, Magaziner's experts regrouped. Taking essentially the same list of data elements, they created a mock-up of a "report card" that might be used by consumers to choose among competing health plans under the Administration's proposal for managed competition. The success of recharacterizing regulation as market facilitation was apparent at the next meeting, when Magaziner's usual harangue was cut short by the unveiling of the report card, after which information requirements were given his full blessing and support.

Another example of performance-oriented disclosure that has taken on the trappings of informed consumerism are provider "report card" programs established under state law.³⁵⁹ Several states now collect and

358. Magaziner's disdain for what he perceived as government's tendency toward self-aggrandizement through the mindless replication of mid-level bureaucrats was captured in his favorite phrase: "checkers checking checkers."

359. One should distinguish "reporting," which denotes the filing of information with regulators, from "disclosure," which indicates an obligation to disseminate the information more broadly. State report card programs are not mandatory disclosure laws per se, in that the affected entities are not obligated to provide information directly to consumers. However, health care providers are legally responsible for reporting raw data, with the express intent that comparative data will be generated and publicly released.

Even without specific disclosure mandates, much reported health care information is either open to the public under the authorizing legislation or subject to general federal or state freedom of information statutes. For example, the Model HMO Act provides that "[a]ll applications, filings and reports required under this Act shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement [required by this Act]." Health Maintenance Organization Model Act, § 27 (1995). Most states have similar provisions. See, e.g., Minn. Stat. Ann. § 62D.23 (West 1996) (filings as public documents); Tex. Rev. Civ. Stat. Ann. art. 20A.27 (West 1981) (filings as public documents). Accreditation information is also generally available to the public upon request; JCAHO, for example, will disclose a variety of data with respect to hospitals it surveys. See Joint Comm'n on Accreditation of Healthcare Orgs., 1996 Accreditation Manual for Hospitals 16-17 (1996).

publish comparative mortality reports for hospitals with respect to particular diagnoses or procedures, such as cardiac surgery and coronary angioplasty.³⁶⁰ The major impetus for these initiatives was research revealing high morbidity and mortality in hospitals performing low volumes of technically sophisticated procedures.³⁶¹ It is no accident that states with histories of strong health planning laws, such as Pennsylvania and New York, took the lead in producing comparative quality information, sometimes after explicit certificate-of-need authority to approve construction of hospitals and other health facilities was curtailed. Contrary to expectations, these reports have had minimal influence on consumer decision-making.³⁶² Nonetheless, in keeping with the performance rationale, they appear to have induced many programs to improve and some marginal operations to close down.³⁶³ Some states compile and distribute compar-

Until recently, little reported information in fact reached the general public. The advent of modern computing and telecommunications, particularly the Internet, has led to the convergence of reporting with disclosure, since the marginal cost of distributing reported information is effectively zero. This raises additional questions about the instrumental use of information by government. See *infra* text accompanying notes 466-468.

360. These programs were initially subjected to harsh criticism from academic and public hospitals, who asserted that unadjusted mortality failed to account for greater severity of illness among their patients. More generally, many providers and professionals argued that patients would misinterpret information regarding mortality, that mortality was an imperfect indicator of quality, and that causes of high mortality were outside their control. See Arnold M. Epstein, *The Role of Quality Measurement in a Competitive Marketplace*, in *Strategic Choices for a Changing Health Care System* 207, 223-24 (Stuart H. Altman & Uwe E. Reimhardt eds., 1996). Nonetheless, provider report cards overcame many of these objections, and moved from radical fringe to mainstream practice. Pennsylvania's Health Care Cost Containment Council, the nation's most advanced report card program, now monitors hospital performance for fifty-nine medical conditions and procedures, and annually reports the information it gathers. See Pa. Stat. Ann. tit. 35, § 449.7 (West Supp. 1999). Pennsylvania recently expanded its outcomes reporting program to include health plans. See Linda O. Prager, Pa. Adds Payers to Mix in Latest Mortality Data Release, *Am. Med. News*, June 1, 1998, at 7. New York has published risk-adjusted hospital mortality rates for coronary artery bypass graft (CABG) surgery since 1989, and recently expanded its program to require state officials to issue comprehensive hospital report cards. See N.Y. Pub. Health Law § 2804-b (McKinney Supp. 1999); see also New York Requires Public Hospital Report Cards by 1998, *Am. Med. News*, Oct. 14, 1996, at 12.

361. See Constance Monroe Winslow et al., *The Appropriateness of Performing Coronary Artery Bypass Surgery*, 260 *JAMA* 505, 507-08 (1988).

362. See Mark R. Chassin et al., *Benefits and Hazards of Reporting Medical Outcomes Publicly*, 334 *New Eng. J. Med.* 394, 397-98 (1996) (concluding that health plans made no use of hospital death rates in purchasing surgical services).

363. See Edward L. Hannan et al., *Improving the Outcomes of Coronary Artery Bypass Surgery in New York State*, 271 *JAMA* 761 (1994) (suggesting that reputational considerations spurred hospitals to improved performance); Eric C. Schneider & Arnold M. Epstein, *Influence of Cardiac-Surgery Performance Reports on Referral Practices and Access to Care*, 335 *N. Eng. J. Med.* 251, 255 (1996). However, it is not entirely clear whether quality gains are real or the artifact of strategic behavior. For example, although risk-adjusted mortality for coronary bypass surgery in New York fell from 4.17 to 2.45 deaths per 100 patients over a recent four-year period, putting providers on notice that

ative data on individual physicians as well. New York, which began collecting surgeon-specific, risk-adjusted mortality rates for CABG surgery in 1991, initially agreed to release such information publicly only after New York *Newsday* successfully sued the state under the Freedom of Information Law. Now, however, the state enthusiastically endorses consumer use of its statistics.³⁶⁴

In some cases, however, rushing to join the competition bandwagon can compromise the usefulness of performance-oriented disclosure laws. For example, the National Practitioner Data Bank and similar clearinghouses containing reports of physician misconduct, such as license suspension or censure, loss of institutional privileges, and adverse outcomes in medical malpractice litigation, were originally designed to help state licensing boards detect interstate offenders, hospitals monitor staff privileges, and HMOs assess applicants to their provider networks.³⁶⁵ In part because of advances in technology, regulators are beginning to disseminate this information to the general public.³⁶⁶ In keeping with political fashion, these informational programs are promoted as aids to comparison shopping. However, at least one study has shown that their reporting and coding systems, while adequate for their original purpose, would be highly misleading if used by consumers.³⁶⁷ As this example demon-

data would be collected may have prompted an increase in reported risk factors. See Winslow et al., *supra* note 361.

364. Health officials had obtained surgeons' death rates as part of their initial survey of hospital CABG mortality rates the previous year. See Elisabeth Bumiller, *Death-Rate Rankings Shake New York Cardiac Surgeons*, *N.Y. Times*, Sept. 6, 1995, at A1. Since 1992, Pennsylvania has published an annual Consumer Guide to Coronary Artery Bypass Graft Surgery, listing risk-adjusted mortality rates not only for hospitals, but for heart surgeons in the state. See Prager, *supra* note 360, at 7.

365. See Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3784 (codified as amended at 42 U.S.C. §§ 11101-11152 (1994)).

366. In 1996 Massachusetts enacted landmark legislation requiring the Board of Registration in Medicine to develop comprehensive physician profiles for disclosure via the Internet. See 1996 Mass. Acts 307 (codified at Mass. Gen. Laws ch. 112, § 5 (1997)). See generally Jeffrey Donohue, *Developing Issues Under the Massachusetts "Physician Profile" Act*, 23 *Am. J.L. & Med.* 115 (1997); Paul Engstrom, *Doctor Records Online: Has Massachusetts Let a Genie Out of the Bottle?*, *Medicine on the Net*, Nov. 1996, at 1. California reached a similar decision regarding public access to disciplinary data in 1998. See Linda O. Prager, *California Latest Among States Releasing Disciplinary Data*, *Am. Med. News*, Mar. 2, 1998, at 1; *Public Access to Malpractice Data Proliferating in the States*, *Med. & Health*, Apr. 7, 1997, at 1-2. Although access to the National Practitioner Data Bank created by federal law remains limited to hospitals and regulators, amendments have been proposed to make its contents public as well. See, e.g., *Health Care Liability Reform and Quality Assurance Act of 1995*, S. 454, 104th Cong. § 203 (1995) (recommending study); *Health Security Act*, H.R. 3600, 103d Cong. § 5005(d) (1993) (allowing public access). The Medicare PRO program has also considered opening its physician files to the public. See Linda O. Prager, *Physicians Leery About PRO Changes*, *Am. Med. News*, Aug. 18, 1997, at 3.

367. See Lawrence Smarr, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 *Law & Contemp. Probs.* 59, 66-72 (1997).

strates, acknowledging these incompatibilities and making explicit the assumptions, risks, and benefits of performance-oriented disclosure would help disentangle it from the competition rationale and allow it to assume a more cohesive role in health policy.

In summary, productivity-based disclosure mandates respond to the lack of information among producers, rather than to the information asymmetry between producers and consumers that drives competitive formulations. The continuing imprecision of medical practice, combined with the as yet unfulfilled potential of managed care to improve information-gathering and dissemination, creates a receptive climate for this use of disclosure. Moreover, the performance rationale makes it possible to view mandatory disclosure as a critical component of the postmodern regulatory state. As Strauss has observed, the New Deal vision of bringing detached, expert judgment to bear on major social problems proved largely ephemeral.³⁶⁸ In response to this failure, Dorf and Sabel have proposed a system of "democratic experimentalism," in which subnational units of government enjoy considerable independence of action, and regulatory agencies at all levels "set and ensure compliance with national objectives by means of best-practice performance standards based on information that regulated entities provide in return for the freedom to experiment with solutions they prefer."³⁶⁹ This type of approach is particularly promising for regulating broad areas of behavior that generate large externalities, such as environmental injury.³⁷⁰ It is also a valuable tool to promote radical transformations of industrial organizations where the specific circumstances of the organization and the best paths to achieving its goals are impossible for outside parties to ascertain.³⁷¹ It is similarly useful where conditions vary from community to community, making it necessary to support decisionmaking at local levels. In health care, which shares these features to no small degree, feedback loops based on mandatory information disclosure might prove an effective bridge between regulation and industrial performance.

368. See Peter L. Strauss, *From Expertise to Politics: The Transformation of American Rulemaking*, 31 *Wake Forest L. Rev.* 745 (1996). Strauss concludes that administrative agencies have largely retreated from rulemaking into the more predictable world of adjudication, even though the latter makes policy less sweepingly.

369. Dorf & Sabel, *supra* note 260, at 267 (citing examples that range from regulation of nuclear power to child protective services).

370. See Bradley C. Karkkainen et al., *After Backyard Environmentalism: Towards a Performance-Based Regime of Environmental Regulation* (unpublished manuscript, on file with the *Columbia Law Review*).

371. For example, the chief economist of the World Bank has urged "decentralization along with . . . benchmarking and outside competition . . . as social learning mechanisms . . . not simply as 'best practice fora' but as part of the 'constitutional' process of rebuilding the organizational relationships from the ground up." Joseph E. Stiglitz, *Whither Reform? Ten Years of the Transition*, Keynote Address to the World Bank Annual Bank Conference on Development Economics (Apr. 1999) (recommending wholesale reevaluation of privatization efforts in Eastern Europe).

However, the performance rationale runs counter to the current politics of disclosure. The typical "patient protection act" is motivated by the belief that the health care system works, but that people are being denied access to it. The performance rationale derives from a contrary belief, common among experts but not the general public, that the system doesn't work (or at least doesn't work nearly as well as it might). The performance rationale also presents a deeper dilemma. Setting goals for system performance in health care requires both expertise and neutrality. Because of the possibility of bias and therefore manipulation, the superior potential benefit to society of ends-forcing disclosure compared with market-facilitating disclosure may be accompanied by greater skepticism. Moreover, no credible scenario exists whereby productivity gains alone halt longstanding trends in the growth of health care costs.³⁷² This reinforces the need for a social compact that can consider tradeoffs and reach consensus on sacrifices as well as aspirations. To this end, informational interventions in health care offer an opportunity not only to enhance productivity but also to sharpen public discourse, a topic to which we turn in the last section of this Article.³⁷³

IV. THE DEMOCRATIC RATIONALE: IMPROVING PUBLIC DELIBERATION THROUGH DISCLOSURE

A. *Information, Public Accountability, and the Common Good*

Thus far, our journey through disclosure laws in health care has revealed a striking irony: A form of regulation usually regarded as "market facilitating" is likely to have some of its best uses in connection with societal rather than private decisions.³⁷⁴ In this vein, a final justification for mandatory disclosure worth exploring involves public accountability, constraints on government, and the integrity of the American political process.³⁷⁵ In Madison's phrase, "Knowledge will forever govern ignorance;

372. See William B. Schwartz & Daniel N. Mendelson, *Eliminating Waste and Inefficiency Can Do Little to Contain Costs*, *Health Aff.*, Spring 1994, at 224, 226-32 (1994) (demonstrating that even substantial one-time reductions in health care spending will quickly succumb to continuing pressures from technology and demographic change).

373. Some scholars have criticized the practice of subjecting health and safety regulation to the political process as leading to irrational and inefficient results. See, e.g., Stephen Breyer, *Breaking the Vicious Circle: Toward Effective Risk Regulation* (1993) (attributing regulatory failure to problems with public perception, congressional reaction, and the technical regulatory process and recommending a professionalized bureaucracy of senior cross-sectoral regulators). Still, "bottom-up" generation of information through disclosure would even be helpful to "super-regulators" because it would offer an abundance of data to subject to scientific analysis.

374. The duality of health care policy is one of its most interesting features. See Stone, *supra* note 103 (describing competing visions of health insurance as private risk-reducing and public risk-sharing).

375. Cf. Cass R. Sunstein, *Informing America: Risk, Disclosure, and the First Amendment*, 20 *Fla. St. U. L. Rev.* 653 (1993) (making the case for the primacy of information as risk regulation on grounds of liberty, economic efficiency, and democracy).

And a people who mean to be their own Governors, must arm themselves with the power which knowledge gives."³⁷⁶

The preceding discussion suggests that economic analysis cannot solve all the problems confronting the U.S. health care system. Some choices about health care, including whether the indigent receive coverage or services, what medical technologies should be available to the average patient, and how much is too much for the nation to spend as a whole, are social problems that require balancing individual rights and preferences against collective obligations and interests.³⁷⁷ In particular, health care competes with other uses of society's resources, especially with respect to politically constrained government budgets. At the same time, health care is virtually unique among regulated industries in that it usually involves identified rather than statistical lives—amassing large public subsidies for that reason—and that it relies on the redistributive function of insurance to apportion benefits in accordance with need.³⁷⁸ Considerations of procedural fairness and distributive justice therefore frequently vie with considerations of overall efficiency in discussions of America's social commitment to health care, adding importance to the relationship between information and the political process.³⁷⁹

According to advocates of democratic participation such as Pateman, information is valuable to vibrant democracy no matter what specific the-

376. Letter from James Madison to W.T. Barry, in *The Complete Madison* 337, 337 (Saul K. Padover ed., 1953).

377. See Ezekiel J. Emanuel & Linda L. Emanuel, *Preserving Community in Health Care*, 22 *J. Health Pol., Pol'y & L.* 147 (1997) (arguing that political accountability is more important than economic accountability because it can ensure that tough allocation decisions are addressed and can work to improve health through nonmedical interventions); Richard D. Lamm, *Marginal Medicine*, 280 *JAMA* 931, 933 (1998) (noting that "[t]he best medicine for an individual is not always the best health policy for society").

378. Certain values, such as the sense of solidarity that accompanies universal access to shared social resources, and the compassion that prevents us from abandoning fellow human beings in need, are absent from or distorted by the marketplace. Instead, these preferences may only be expressed through social activities, such as political organizing and voting, which may even contradict private market behavior. See Mark Sagoff, *At the Shrine of Our Lady of Fatima or Why Political Questions Are Not All Economic*, 23 *Ariz. L. Rev.* 1283 (1981) (distinguishing between the respective positions people take as consumers and as citizens regarding environmental policy).

379. On the other hand, a few commentators reject the notion of a universal right to health care on closely reasoned economic grounds, preferring voluntary charity to compulsory participation because they believe that the former provides greater assurances of efficiency. See, e.g., Richard A. Epstein, *Mortal Peril: Our Inalienable Right to Health Care?* (1997). The flaw in this approach is that it assumes away many aspects of human behavior that make the study of health policy interesting, such as the different way we regard statistical and identified lives (including but not limited to our own), and the attitudes those perceptions imply toward both implicit and explicit redistribution of resources from young to old, healthy to sick, and rich to poor. Consequently, the assumption that individuals reveal their preferences through their decisions as consumers is questionable in health care. See Rice, *supra* note 22, at 77–80.

ory of democracy one endorses.³⁸⁰ For example, pluralist conceptions of democracy rely on majoritarian decisionmaking constrained by individual rights. In this context, information is necessary to help individuals recognize and defend fundamental rights against majority infringement. In addition, information helps the public monitor the apparatus of government, which is otherwise prone to various types of failure and abuse. On the other hand, a civic republican view of democracy favors outcomes that are the result of reflective deliberation.³⁸¹ Theorists of representative government, such as Bentham and James Mill, emphasize the importance of education to socially responsible voting. Others, such as Rousseau and John Stuart Mill, look beyond representative institutions to a "participatory society" marked by reasoned discourse framed around norms of conversation that prevail among the wider citizenry.³⁸² In either case, information allows citizens to form and value beliefs and preferences, and enables deliberative debate.

Just as markets fail from lack of information, so too can societies. Mandatory disclosure laws have a role in bringing difficult decisions into the open and providing the deliberative process with the information needed to resolve them.³⁸³ In a representative democracy, citizens often

380. See Carole Pateman, *Participation and Democratic Theory* (1970). Pateman's exposition is a reaction to "antidemocratic democratic theory," which regards mass apathy and elite control as necessary to preserving stability in democratic societies. *Id.* at 1-3.

Even with generally effective political institutions and guarantees of civil liberties, of course, modern society introduces a host of comprehension and agency problems to the use of information in civic life. See Timur Kuran & Cass R. Sunstein, *Availability Cascades and Risk Regulation*, 51 *Stan. L. Rev.* 683, 691-703 (1999) (describing public overreaction to risk information); David A. Goslin, *Decision Making and the Social Fabric*, *Society*, Jan./Feb. 1985, at 7 (describing problems of information overload and maldistribution). But see Richard D. McKelvey & Peter C. Ordeshook, *Information, Electoral Equilibria, and the Democratic Ideal*, 48 *J. Pol.* 909 (1986) (arguing that imperfectly informed voters nonetheless approximate informed outcomes). Furthermore, neither politics nor economics offers an empiric assessment of information as either beneficial or harmful. Instead, both mix theoretical justifications with impressionistic biases. For a sophisticated analysis, see James Boyle, *A Theory of Law and Information: Copyright, Spleens, Blackmail, and Insider Trading*, 80 *Cal. L. Rev.* 1415 (1992).

381. See, e.g., James G. March & Johan P. Olsen, *Democratic Governance* 81-83 (1995) (noting that "[d]emocratic discourse implies relevant and valid information," and identifying problems of political actors benefiting from public ignorance or misinformation and of experts manipulating political actors by misrepresenting knowledge).

382. See Pateman, *supra* note 380, at 17-35. For a normative account of participation that extends beyond the combination of majority rule and rights protection that constitutes procedural democracy, see also Amy Gutmann & Dennis Thompson, *Democracy and Disagreement* (1996). But see Lynn M. Sanders, *Against Deliberation*, 25 *Pol. Theory* 347 (1997) (noting serious problems of exclusion and lack of shared values in prevailing theories of public deliberation, and suggesting a model of democracy based on "testimony," meaning the narrative presentation of one's own experience to a broader group).

383. On the importance of information to health care allocation decisions, see Susan D. Goold, *Allocating Health Care: Cost-Utility Analysis, Informed Democratic Decision*

insist that deliberations that affect them be conducted in public view.³⁸⁴ For example, disclosure laws are commonly enacted to make transparent the inner workings of government, particularly following well-publicized incidents of corruption or political misbehavior.³⁸⁵ Examples include the federal Freedom of Information Act and the Federal Advisory Committee Act, and state analogues guaranteeing access to information and mandating open meetings of legislative bodies.³⁸⁶ The basic goal of these “sunshine laws” is to maintain or restore public confidence in the political process through disclosure.³⁸⁷ Similarly, provisions mandating disclosure of political contributions are common elements of fair election practices laws, and can also facilitate interim monitoring of public officials.³⁸⁸

Making, or the Veil of Ignorance?, 21 *J. Health Pol., Pol’y & L.* 69, 84 (1996) (“This information requirement is probably the greatest challenge facing all types of democratic decision-making, but is one that could be solved.”). For a general discussion of information as a basis for government accountability, see March & Olsen, *supra* note 381, at 162–65 (“Governors can be held accountable by the governed only when publicity, transparency, and critical scrutiny provide a basis for an informed citizenry.”). However, I am arguing not that all government decisions must be participatory, but only that participation is a relevant consideration for regulation through information. Cf. Jim Rossi, *Participation Run Amok: The Costs of Mass Participation for Deliberative Agency Decisionmaking*, 92 *Nw. U. L. Rev.* 173 (1997) (noting that participation can be counterproductive).

384. See generally James Russell Wiggins, *Freedom or Secrecy* 4–17 (1964) (discussing the history of access rights to legislative proceedings).

385. For the theory underlying a commitment to openness in democratic governance, see Gutmann & Thompson, *supra* note 382, at 95–127 (describing the value of publicity in deliberative democracy).

386. See Freedom of Information Act, 5 U.S.C. § 552 (1994) (mandating government agency disclosure of specified types of information); *id.* app. II §§ 1–5 (Federal Advisory Committee Act) (requiring agencies to open meetings to public discussion except where public interest suggests otherwise); *id.* § 552b (open meeting requirements); Cal. Gov’t Code § 6253.4 (requiring state and local authorities to establish guidelines for public access to records). See generally Steven P. Croley & William F. Funk, *The Federal Advisory Committee Act and Good Government*, 14 *Yale J. on Reg.* 451, 460–65 (1997); Patricia M. Wald, *The Freedom of Information Act: A Short Case Study in the Perils and Paybacks of Legislating Democratic Values*, 33 *Emory L.J.* 649, 655–64 (1984).

387. Other suggestions have been made for assuring transparency in administrative practice, such as disclosing all agency contacts with interested parties. See generally Jerry L. Mashaw, *Improving the Environment of Agency Rulemaking: An Essay on Management, Games, and Accountability*, 57 *L. & Contemp. Probs.* 185, 249–50 (1994) (advocating greater accountability in administrative rule-making).

388. See David W. Adamany & George E. Agree, *Political Money* 84–85 (1975). Particularly in political contexts, mandatory disclosure laws are subject to constitutional challenge based on First Amendment rights of speech and association. For example, required disclosure of campaign contributions can chill participation by politically unpopular groups. See, e.g., *McIntyre v. Ohio Elections Comm’n*, 514 U.S. 334, 357 (1995) (overturning state prohibition on anonymous leafleting because “anonymous pamphleteering is . . . an honorable tradition of advocacy and dissent . . . [that] exemplifies the purpose behind the Bill of Rights, and of the First Amendment”); *Buckley v. Valeo*, 424 U.S. 1, 67–68 (1976) (upholding disclosure requirements in federal Fair Election Campaign Act because they “directly serve substantial governmental interest”); see also Thomas H. Dupree, Jr., *Exposing the Stealth Candidate: Disclosure Statutes after*

The democratic rationale for disclosure also applies to information concerning private behavior, if in the aggregate it has public implications. For example, one impetus for the passage of the federal securities laws was failing public confidence in the stock and bond markets, which had devastating economic repercussions. Opening corporate boardrooms to public view through securities disclosure helped restore faith in the overall fairness of capital investment processes, and by extension, in the prevailing political model of American capitalism.³⁸⁹

Parallels to both the political and securities examples exist in American health care, which relies primarily on aggregating private activity to frame a "system" of coverage and services, but supplements it generously with public investment and control. The juncture of private and public interests is evident also in the tension between consumer-oriented disclosure (whether justified by reference to competition or agency) and performance-oriented disclosure over the appropriate metric for achievement in health care. If the success of the health care system is defined by the breadth of individual choice it offers, then centralized policies constitute unjustifiable incursions on private decisions.³⁹⁰ On the other hand, if success has directionality that individuals cannot correctly judge, or if individual criteria for success diverge from social criteria, then a greater role for expert supervision is warranted. Nonetheless, there needs to be a connection between the private realm and the expert realm.³⁹¹ That connection is the political process.

The democratic rationale for disclosure in health care therefore is closely related to the agency rationale. Health care is so expensive, so complex, and so essential to social well-being that it requires two sets of agents: private and public. In each realm, moreover, principal parties must determine which decisions they are capable of making, and which

McIntyre v. Ohio Elections Commission, 63 U. Chi. L. Rev. 1211, 1214 (1996) (arguing for a narrow interpretation of *McIntyre* under which anonymous television commercials could be prohibited).

389. In addition to disclosure, substantive regulation of brokers, dealers, and exchanges undoubtedly played a part in this achievement. See Walter Werner, *The SEC as a Market Regulator*, 70 Va. L. Rev. 755, 809–10 (1984).

390. This tension also leads us back to the debate between marketists and medicalists. See *supra* text accompanying notes 3, 179.

391. This mirrors a common criticism of participatory democracy. Even assuming an efficient process for soliciting views, conducting debate, and recording votes, someone other than the participants still must set the agenda. See, e.g., Jonathan Wolff, *An Introduction to Political Philosophy* 99–103 (1996) (elaborating Rousseau's model of participatory democracy, but noting that "[p]articipatory politics becomes far less appealing if the agenda is to be set by appointed officials" making the whole project "naive and even incoherent"). Although the argument is logically damning of absolutist theories of participatory democracy, if public participation is merely one important consideration in any decisionmaking process, there should be no objection to allowing public input when certain agendas are set.

are better delegated to experts.³⁹² The agency rationale demonstrated that mandatory disclosure rules can help insurance beneficiaries and patients monitor private agents such as managed care plans and physicians. The democratic rationale serves a similar function for society as a whole with respect to public agents, namely government and the organizations to which governmental responsibilities and public funds are assigned.³⁹³

Stated simply, the democratic rationale posits that information about global costs and benefits, such as the sources and uses of public investment and the mechanisms employed to distribute scarce resources, can expose the externalities that distinguish public from private decisionmaking. Although these issues have always been important, the emphasis placed on a competitive model for health care delivery, and the delegation of decisionmaking to profit-motivated managed care organizations (particularly with respect to public entitlements like Medicare and Medicaid), has heightened public concern about the underlying fairness of the system and therefore has intensified the need for information.³⁹⁴

B. *Contours of the Democratic Rationale*

The democratic rationale for mandatory disclosure in health care is seldom recognized explicitly. Nonetheless, laws enacted based on the competition or agency rationale often inform the broader public as well. For example, knowing that a high percentage of children enrolled in a given health plan receive immunizations tells us not only that current and prospective parents of young children should enroll in that plan, but that the plan believes (or so it would appear) in directing its resources to keeping everyone's children healthy. Moreover, the public meaning of information disclosed to achieve marketplace effects can overtake its private meaning. Notably, mailing forty million senior citizens information explaining their options under the new Medicare+Choice program may be an unintentional test of the deliberative value of information. Guided almost entirely by the competition rationale, HCFA has assigned a high priority to communicating with beneficiaries about their expanded "market choices."³⁹⁵ However, Medicare beneficiaries are not merely consumers of HCFA's products, they are a powerful political constituency. The information they receive about the new program will affect their political views as well as their market preferences—probably more so, given the

392. See Gold, *supra* note 240, at 145–49 (identifying the core problem in health care as "how experts are to be held accountable to nonexperts," and discussing the conflict between the "professional principle" and the "democratic principle").

393. Proposals have even been made for selecting specialized representatives to grapple with health care allocation decisions and other public matters. See, e.g., Goold, *supra* note 383, at 85–96. Monitoring such agents would present a particularly difficult challenge.

394. Daniels and Sabin term this "accountability for reasonableness," as opposed to market accountability. Norman Daniels & James Sabin, *The Ethics of Accountability in Managed Care Reform*, *Health Aff.*, Sept.–Oct. 1998, at 50, 51–52.

395. See *supra* text accompanying notes 18–20.

barriers that exist to competitive disclosure in the Medicare population.³⁹⁶ Of course, the democratic effects of information disclosure need not be serendipitous or manipulative. Rather, mandatory disclosure laws can serve deliberate, legitimate goals with respect to both consulting and educating the public.

1. *Information and Popular Consent.* —

a. *Public Spending.* — The “private” character of the American health care system is largely a myth. Nearly everyone who joins a health insurance plan or visits a doctor or hospital receives public funds, often generously. Direct government spending now accounts for nearly half of health care spending, approximately \$500 billion annually, to which can be added another \$100 billion or so in tax expenditures relating to employee health benefits.³⁹⁷ Unsurprisingly, this sum also represents a major portion of government outlays.³⁹⁸ Public willingness to make these investments requires confidence that the funds are being used for their designated purposes. Concern over the disposition of these funds is intensified by the integration and consolidation of insurers and providers into large corporate organizations, of which Americans have historically been suspicious.

Mandatory disclosure by health plans and providers of information about their conduct and performance can help the public monitor its investment.³⁹⁹ In particular, comprehensive reporting can facilitate de-

396. See *supra* text accompanying notes 75–80. One can assume that this fact has not been lost upon other interest groups, or upon Congress, and will no doubt tempt them to influence the disclosure process for political gain.

397. See Levit et al., *supra* note 2, at 99. Of course, it is unlikely that America will be impoverished by health care spending; to the contrary, it reflects our preferences as a wealthy society. See Glied, *supra* note 13, at 86–121. Nor is American industry at a demonstrable competitive disadvantage because employers incur high health care costs. See *id.* at 107–31; Uwe E. Reinhardt, *Health Care Spending and American Competitiveness*, *Health Aff.*, Winter 1989, at 5.

398. As a segment of the federal budget, Medicare spending alone exceeds every other program except social security and national defense. Office of Management and Budget, *A Citizen's Guide to the Federal Budget* (visited Nov. 2, 1999) <<http://www.access.gpo.gov/usbudget/fy2000/guide02html#Spending>> (on file with the *Columbia Law Review*). Moreover, fiscal discipline has become a central fact of American political life, primarily because tax revenues are limited. This is especially true for money raised through payroll taxes—the principal funding source for Medicare—since the ratio of contributing workers to retired beneficiaries is steadily declining by virtue of demographic change. Consequently, public dollars spent on health care are not available for other programs, or for tax or deficit reduction.

399. Similarly, disclosure laws can be used to increase public awareness of biomedical and health services research, and to help assure the integrity of programs that receive government funding. To this end, the Institute of Medicine recently recommended that NIH adopt a structured mechanism for broadening public input into research funding. See Institute of Medicine, National Academy of Sciences, *Scientific Opportunities and Public Needs* (1998) (visited Aug. 19, 1999) <<http://www.nap.edu/readingroom/books/nih/>>; see also Rebecca Dresser, *Public Advocacy and Allocation of Federal Funds for Biomedical Research*, 77 *Milbank Q.* 257, 259–62 (1999) (discussing the historical and current NIH mechanisms for soliciting public opinion on NIH funding allocation

tection and prosecution of fraud.⁴⁰⁰ (The punitive aspect of using disclosure to aid fraud enforcement, of course, puts this type of accountability in tension with performance-oriented disclosure initiatives.)⁴⁰¹ On a

decisions). With respect to research, a societal version of agency-based disclosure starts from the proposition that not only do physicians as caregivers have fiduciary obligations to individual patients, but physicians as scientists owe duties to the public as a whole. Despite the difficulties of constituting administrative agencies as detached, expert decisionmakers, government still relies on the accuracy and impartiality of science to inform its policies. However, medical researchers and other scientists are increasingly vulnerable to temptation from patent royalties and other sources of remuneration. For that reason, the National Institutes of Health and the National Science Foundation require disclosure of financial interests in connection with grant proposals, as does the Food and Drug Administration for clinical trials of new drugs and devices. See *Financial Disclosure by Clinical Investigators*, 21 C.F.R. § 4 (1998) (FDA rule requiring sponsors of new drugs and devices to submit information regarding the financial interests of clinical investigators); *Objectivity in Research*, 42 C.F.R. § 50.601–.604 (1998) (requiring institutions that apply for National Institutes of Health and other Public Health Services funding to monitor and report the financial interests of their employees); *Investigator Financial Disclosure Policy*, 60 Fed. Reg. 35,820 (1995) (National Science Foundation policy on conflicts of interest); see also David Blumenthal et al., *Participation of Life-Science Faculty in Research Relationships with Industry*, 335 *New Eng. J. Med.* 1734, 1734 (1996) (describing relationship between industrial research support and academic and commercial productivity). Although few of these reports reach the general public, disclosure is also favored by private entities with clearly public missions. For example, peer reviewed medical journals often require authors to submit information regarding conflicts of interest, which is then disclosed to readers. See Sheldon Krimsky & L.S. Rothenberg, *Financial Interest and Its Disclosure in Scientific Publications*, 280 *JAMA* 225, 225–26 (1998) (advocating more widespread implementation of disclosure policies by medical journals).

400. Extensive transactional reporting by providers and sophisticated information systems have always been considered essential to managing program expense in Medicare, which remains highly susceptible to fraud and abuse. The General Accounting Office estimated in 1992 that Medicare fraud represented nearly ten percent of program expenditures. See U.S. General Accounting Office, *Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse I* (1992). Medicare is still largely a fee-for-service program that pays millions of claims annually to thousands of participating health facilities and professionals, making monitoring problematic given limited government resources for investigation and enforcement. In addition, the enactment in 1965 of Medicare as a federal health entitlement required a political compromise with organized medicine that restricted government's ability to influence clinical practice directly, exposing it further to potentially fraudulent activity. See Theodore R. Marmor, *The Politics of Medicare* 72–93 (1970) (discussing events surrounding passage of Medicare).

401. Among other things, HIPAA directed the Department of Health and Human Services to create a Healthcare Integrity and Protection Data Bank for evidence of fraud, similar to the National Practitioner Data Bank for malpractice and disciplinary actions. See *Health Care Fraud and Abuse Data Collection Program: Reporting of Final Adverse Actions*, 63 Fed. Reg. 58,341 (1998) (to be codified at 45 C.F.R. pt.61). This proposal continues to generate controversy, as do other government policies that attempt to leverage professional documentation practices for fraud enforcement purposes. See William M. Sage, *Fraud and Abuse Law*, 282 *JAMA* 1179 (1999). See also 42 U.S.C. § 1320a-7b(a)(3) (1994) (imposing a duty to disclose to the government any illegitimate payments or benefits); Ronald J. Nessim, *Health Care Disclosure Statute: What Does It Mean?*, *Crim. Just.*, Winter 1999, at 34 (considering whether 42 U.S.C. § 1320a-7b(a)(3) (1994) can be used to prosecute attorneys who advise clients not to disclose certain prior

more general level, disclosed information can reveal matters such as distributional inequalities in funding of health care, unexpected apportionment of premium dollars among services, extent of capital reinvestment in health care assets, administrative cost and profit, and failure to achieve public health objectives. Overall, information about these issues is hard to come by, particularly with respect to major federal programs. For example, few Americans understand the regressive character of the tax subsidy for private health insurance,⁴⁰² or the lack of connection between paying Medicare payroll taxes and receiving coverage in retirement.⁴⁰³

One area in which public disclosure is increasing is the regulation of tax-exempt health care organizations. Despite the adoption of a market model of health care delivery, most hospitals and many HMOs and nursing homes remain nonprofit entities.⁴⁰⁴ The assets of these entities derive from charitable donations, and are therefore impressed with a trust to benefit their communities. The broader public also contributes indirectly to these organizations by virtue of the organizations' exemption from income and property taxes, as well as their ability in many cases to finance capital projects by issuing tax-exempt debt.

Although tax-exempt organizations must be organized and operated exclusively for charitable purposes, these terms have been poorly defined. Rather than engaging in detailed standard-setting, regulators are turning to reporting and disclosure laws to enforce community benefit standards and police conflicts of interest.⁴⁰⁵ Traditionally, tax-exempt health care

false claims, and concluding that the statute does not provide sufficient notice for doing so).

402. See Glied, *supra* note 24, at 79–81 (describing federal tax treatment of health insurance). Because the dollar value of the tax exclusion for employee health coverage increases with the generosity of the benefit package, the federal government sacrifices the most revenue to well-paid workers, and contributes nothing to the compensation package of low-wage workers whose employers cannot afford to sponsor insurance.

403. Rather than building reserves for the eventual cost of their own care, current wage-earners pay 90% of the cost of services to current beneficiaries, a funding scheme that will eventually collapse of its own weight as the population ages and the ratio of workers to beneficiaries drops. John. K. Iglehart, *The American Health Care System: Medicare*, 340 *New Eng. J. Med.* 327, 327 (1999). Even Medicare's supplemental insurance program (Part B), is funded 75% by general tax revenues and only 25% by enrollee premiums. See Marilyn Moon, *Medicare Now and in the Future* 183, 253 (1996). See generally Jill Bernstein & Rosemary A. Stevens, *Public Opinion, Knowledge, and Medicare Reform*, *Health Aff.*, Jan.–Feb. 1999, at 180, 185–86; Robert J. Blendon et al., *What Do Americans Know About Entitlements?*, *Health Aff.*, Sept.–Oct. 1997, at 111, 113.

404. See Hyman, *supra* note 181, at 749–54.

405. See T.J. Sullivan & Bradley E. Karlin, *State Community Benefit Needs Assessment, Planning, and Reporting Laws, 1999 Exempt Organizations Text 5–39* (Jan. 26, 1999) available in LEXIS, IRS Materials Library, Exempt Organizations Text File. For a policy discussion of community benefit standards as they might apply to health plans as well as hospitals, see Mark Schlesinger & Bradford Gray, *A Broader Vision for Managed Care, Part 1: Measuring the Benefit to Communities*, *Health Aff.*, May–June 1998, at 152. In addition to substantive standards, Schlesinger and Gray suggest that health plans be required to measure and report community benefit activities, although they acknowledge

organizations operated in greater secrecy than most for-profit businesses, and were accountable only to a small, self-perpetuating board of directors or trustees. Recent changes in IRS regulations require widespread disclosure of executive salaries and other information contained on IRS Form 990.⁴⁰⁶ In addition, a few states have expanded tax-exempt organizations' disclosure requirements to include measures of their contributions to their communities.⁴⁰⁷ Because tax-exempt organizations are fiduciaries to defined communities of beneficiaries as well as the recipients of broad public funding, disclosure of this information serves both to oversee public investment and to preserve trust between communities and their nonprofit health care providers, particularly through its potential to discourage self-dealing by exposing questionable practices to public scrutiny.

b. *Rationing*. — These examples of disclosure to monitor government policy address direct government investment. Because of the quasi-public nature of American health care spending as a whole, however, the way in which nominally private insurance pools ration resources also has societal importance.⁴⁰⁸ Managed care has heightened this concern for two reasons: the convergence of coverage decisions with professional judgments about service delivery, and the increasing enrollment of Medicare and Medicaid beneficiaries in managed care organizations that make these decisions internally rather than through the political process.⁴⁰⁹

the tension between improved performance on such metrics and the resources available to serve enrollees in the competitive marketplace. See *id.* at 162–63.

406. See *Publicity of Information Required from Certain Exempt Organizations and Certain Trusts*, 1999-17 I.R.B. (1999) (to be codified at 26 C.F.R. § 6104).

407. For example, under a recent Texas law:

A nonprofit hospital shall prepare an annual report of the community benefits plan and shall include in the report at least the following information: (1) the hospital's mission statement; (2) a disclosure of the health care needs of the community that were considered in developing the hospital's community benefits plan . . . [and] (3) a disclosure of the amount and types of community benefits, including charity care, actually provided. Charity care shall be reported as a separate item from other community benefits.

Tex. Health & Safety Code Ann. § 311.046(a) (West 1998).

408. "Rationing," as used in the health policy context, means the provision of services only to some of those who need them. Although a full discussion is beyond the scope of this Article, an extensive literature exists regarding the allocation of health care resources. See, e.g., Henry J. Aaron & William B. Schwartz, *The Painful Prescription* (1984); Victor R. Fuchs, *Who Shall Live? Health, Economics, and Social Choice* (1974); Einer Elhauge, *Allocating Health Care Morally*, 82 Cal. L. Rev. 1449 (1994); Maxwell J. Melilman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 Wis. L. Rev. 239 (1985).

409. To the extent that allocation decisions made by health plans implicate only private risk pools, information disclosure can be justified under the agency rationale, particularly if made with therapeutic intent and guided by professional ethics. See *supra* text accompanying notes 236–252. For a proposal connecting political autonomy and market autonomy, see Arti K. Rai, *Rationing Through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care*, 72 Ind. L.J. 1015, 1030–37 (1997) (suggesting informed democratic deliberation regarding a global budget for health care, followed by

For example, a core problem with respect to coverage decisions in managed care is how to invest the decisionmaking process with moral legitimacy as well as clinical and economic accuracy, and thereby to promote patient and public acceptance of adverse determinations. Because openness is a prerequisite to legitimacy, Daniels and Sabin place central importance on publicity, observing that “[b]ecause matters of distributive justice are at issue, . . . the limit-setting decisions and the grounds for them must be publicly accessible.”⁴¹⁰ They conclude that the best way to assure fairness and legitimacy is to “convert private MCO solutions to problems of limit setting into part of a larger public deliberation about a major, unsolved public policy problem[:]. . . how to use limited resources to protect fairly the health of a population.”⁴¹¹ This argument explicitly goes beyond consumer choice and consent to espouse a model of disclosure to promote public dialogue and support democratic institutions.⁴¹² Further, Daniels and Sabin assert that a legal mandate, or at a minimum a collective self-regulatory standard, is needed to implement disclosure because of the first-mover problem caused by fear of liability or adverse publicity.⁴¹³

Indeed, the issue of disclosure commonly arises in connection with coverage of novel, expensive treatments that are perceived by patients as potentially life-saving but that are resisted by payers as unproven. All health systems ration services, either by price, professional discretion, or explicit public policy.⁴¹⁴ In the United States, the proliferation of new

managed competition among health plans offering individuals a choice of benefit options and rationing schemes).

410. Norman Daniels & James Sabin, *Limits to Health Care: Fair Procedures, Democratic Deliberation, and the Legitimacy Problem for Insurers*, 26 *Phil. & Pub. Aff.* 303, 312 (1997) [hereinafter Daniels & Sabin, *Limits*]. Daniels and Sabin identify the setting of limits on an important social good such as health care, whether done by government directly or by private managed care organizations, as presenting issues not only of fairness but of legitimacy. See *id.* at 304; see also Norman Daniels & James E. Sabin, *Last Chance*, *supra* note 249, at 27–28.

411. Daniels & Sabin, *Limits*, *supra* note 410, at 323–24.

412. Daniels and Sabin advocate disclosure by managed care organizations to “clinicians, patients and would-be subscribers” of the *rationale* for deciding to cover or not to cover a new technology, and not merely the decision itself. *Id.* at 325–26. They emphasize the rationale because of their conviction that the legitimacy of the managed care organization’s decision rests on the legitimacy of the deliberative process underlying the decision, including its incorporation of reasons that are considered socially appropriate, and not merely on enrollees consenting to a known standard and having that standard applied with due process. See *id.* at 338–39 (drawing an analogy to public reasoning in judicial decisions).

413. See *id.* at 347–48.

414. See, e.g., Kevin P. Quinn, *Sandel’s Communitarianism and Public Deliberations Over Health Care Policy*, 85 *Geo. L.J.* 2161, 2162 (1997). Unlike many of its European counterparts, the American health system has not rationed health care directly, except perhaps by virtue of eligibility for coverage under public entitlement programs. For privately insured individuals, benefits typically encompass all “medically necessary” care within covered categories of services. Medical necessity, as traditionally invoked by insurers, implies both professional acceptability and clinical benefit, but excludes cost as a

technologies is essentially unrestricted, which decentralizes allocation decisions to the level of individual determinations regarding insurance coverage, and generally places it in the hands of private decisionmakers rather than government.⁴¹⁵ As Fleck observes, “[w]hat is most objectionable to health care rationing is that it is not self-imposed.”⁴¹⁶ Therefore, a valuable role for disclosure would be to assure beneficiaries that most resource allocation decisions remain implicit in system structure and professional standards,⁴¹⁷ and that any explicit allocation decisions—such as whether or not to cover emerging medical technologies—are consensual, rational, and non-discriminatory.⁴¹⁸ Consequently, recent disclosure laws

formal criterion. See Hall & Anderson, *supra* note 35, at 1658–62. Because of its overall cost-control mission, however, managed care has provoked widespread concern about hidden rationing. In a recent Kaiser-Harvard study, 61% of respondents in restrictive managed care plans said that they were very or somewhat worried that if they became sick, their insurer would be more concerned about saving money than about their medical care. See Henry J. Kaiser Family Foundation, *Is There a Managed Care Backlash?* (1997) (visited Oct. 7, 1999) <<http://www2.kff.org/content/archive/1328/mcarepr.html>>.

415. For example, the Food and Drug Administration demands that new drugs and medical devices be proved safe and effective prior to marketing, but does not consider cost. See Note, *Will Health Care Economic Information Lead to Therapeutic-Class Warfare or Welfare?*, 111 *Harv. L. Rev.* 2384, 2385 (1998). Moreover, physicians may legally use approved drugs or devices for unapproved indications (“off-label” use). New medical procedures not involving a drug or device are essentially unregulated. In countries with national health insurance, by contrast, case-by-case decisions regarding new treatments are often avoided because controls on capital investment and innovation are made at an early stage of political debate. See Timothy Stoltzfus Jost, *Health Care Rationing in the Courts: A Comparative Study*, 21 *Hastings Int’l & Comp. L. Rev.* 639, 663–69 (1998). Despite the apparently greater commitment to social solidarity in these systems, allocation decisions in practice are open to criticism. See *id.* at 688. In England, for example, age restrictions on renal dialysis are enforced through professional agreement without explicit patient or voter consent. See *id.* at 683–84. Similarly, the ability of wealthy individuals to opt out of national policies often belies the pretense of equality. Information, or lack thereof, therefore has a potent political role in those countries as well. One reason that England has been far more successful than the United States at constraining costs is that patients were relatively ignorant about treatment and therefore were deferential to physicians who (unlike American doctors) had been trained to practice conservatively. In fact, a recent report of the United Kingdom’s Office of Health Economics suggested that growing patient sophistication would increase the need for government to establish explicit, evidence-based rationing protocols to justify its allocation decisions. See Peter West, *Managed Care: A Model for the U.K.?* (1998).

416. Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 *U. Pa. L. Rev.* 1597, 1607 (1992).

417. Although this pattern of behavior can be criticized on many grounds, it is at least the “devil one knows.” See Hall, *supra* note 22, at 117–27.

418. For example, Elhauge posits that any system which requires ongoing tradeoffs between health care and other uses of money is inherently unstable, and therefore concludes that it is necessary for society to set an aggregate limit for health care spending. See Elhauge, *supra* note 408, at 1464–65. Within that limit, Elhauge advocates providing individuals a diversity of moral choice among health plans, each of which allocates its resources according to an explicit strategy of “health maximization.” This moral framework implies a central role for information, but one in which the role of choice and consent is less to assert an economic preference than to legitimize the setting of limits and

and legislative proposals often mandate disclosure of the procedures used by insurers to determine coverage of arguably experimental treatments.⁴¹⁹

The notion of “consent” to rationing, of course, is a sticky one—reminiscent in many ways of our earlier discussion of control and fiduciary contracting between physicians and patients.⁴²⁰ Although consent to all government decisions undoubtedly exists at some core level in democratic society, its exercise in any given instance is subject to practical constraints such as the existence of legal rights and remedies. Nonetheless, disclosure can play an important role even in these situations by furthering the diguitary value of democratic participation, much as information exchange between doctors and patients can be therapeutic even when the patient lacks meaningful ability to make a truly autonomous choice.⁴²¹

Information about allocation decisions is particularly important, both to beneficiaries and to the public at large, as Medicare and Medicaid come to rely on managed care organizations to deliver statutory benefits. In the traditional fee-for-service versions of these entitlement programs, systematic policies regarding coverage were established using recognized administrative procedures, and individual claims decisions were overseen by HCFA, with judicial review available in most cases.⁴²² Medicare and Medicaid’s conversion to managed care has housed many

the allocation of scarce resources in a democratic society. Elhauge would set the budget at an amount that guarantees everyone “adequate” health care, defined roughly as the level currently enjoyed by the middle class (which itself includes public support from a generous tax subsidy). See *id.* at 1491–92. However, one could equally argue for open political discussion regarding the appropriate budget amount, as well as other issues such as supplemental purchases by the wealthy and the level of societal commitment to investment in research and shared infrastructure. Information is indispensable to ensuring discussion of and securing consent to these types of rationing decisions. See *id.* at 1526–41; see also Paul T. Menzel, *Strong Medicine* (1990); Rai, *supra* note 409.

419. See, e.g., S. 1499, 105th Cong. § 101 (1997) (requiring disclosure of “procedures for determining coverage for investigational or experimental treatments as well as definitions for coverage terms”). Although this is a productive trend, information provided for this purpose is difficult to generalize and present in a useful, standardized format in advance of illness.

420. See *supra* notes 191–215 and accompanying text.

421. See Mashaw, *supra* note 241, at 888–95 (explaining how dignitary theories of due process avoid the “positivist trap” of only allowing procedural rights where substantive rights already exist). Mashaw also identifies transparency, along with predictability and rationality, as “process values that can make a worthwhile contribution to any process participant’s sense of self-respect.” *Id.* at 901.

422. See generally Eleanor D. Kinney, *The Role of Judicial Review Regarding Medicare and Medicaid Program Policy: Past Experience and Future Expectations*, 35 *St. Louis U. L.J.* 759, 762–65 (1991) (analyzing the experience of beneficiaries and providers in using litigation as a strategy to achieve policy objectives under the Medicare and Medicaid programs). Problems have arisen even in Medicare’s fee-for-service program. Evidence is mounting that the private contractors, called intermediaries and carriers, who process provider claims are making highly variable decisions and may be committing fraud. See General Accounting Office, *Medicare: Improperities By Contractors*

of these previously governmental functions in private surrogates. The relationship between this delegation and public fears about cost-motivated decisionmaking is not accidental. To the contrary, regulators concerned with Medicare's efficiency and long-term solvency both hope and intend that managed care organizations will be able to make tough choices that public entities cannot.

This conflict between what public bodies would like to do, and what they may do, is being played out in the courts.⁴²³ In *Grijalva v. Shalala*,⁴²⁴ the Court of Appeals for the Ninth Circuit concluded that Medicare HMOs are state actors, and must comply with due process requirements when making coverage denials.⁴²⁵ Nonetheless, most decisions undertaken by managed care contractors still take place removed from public view. Moreover, if Medicare shifts from its current benefit-based entitlement structure to a "premium support" approach that further distances the federal government from the operations of managed care organizations serving elderly individuals, it becomes less likely that courts will consider those organizations state actors. In either case, mandatory disclosure of matters such as coverage standards, grievance procedures, and the outcomes of appeals—measures recommended by the President's Advisory Commission and generally adopted in the Medicare+Choice regulations—could help preserve the public essence of these programs, notwithstanding their control by private organizations.

2. *Information and Education.* — Disclosure is also compatible with views of democracy that link political participation to moral and cognitive development. Many, if not all, democratic theories assert the legitimacy of leadership by elected representatives even if it conflicts with popular will. The classic statement is Burke's: "Your representative owes you, not his industry only, but his judgment; and he betrays, instead of serving you, if he sacrifices it to your opinion."⁴²⁶ Even the liberalism of John

Compromised Medicare Program Integrity (1999); General Accounting Office, Medicare Part B: Inconsistent Denial Rates for Medical Necessity Across Six Carriers (1994).

423. I do not approach the issue of state action as constitutional doctrine, which continues to be hotly contested, but as a matter of sound social policy in health care. For an early statement of the constitutional problem as applied to racial discrimination, see Charles L. Black Jr., Foreword: "State Action," Equal Protection, and California's Proposition 14, 81 Harv. L. Rev 69, 95 (1967) (considering state action "a conceptual disaster area").

424. 152 F.3d 1115 (9th Cir. 1998), vacated and remanded, 119 S. Ct. 1573 (1999).

425. The *Grijalva* ruling recently was vacated and remanded for consideration in light of *American Manufacturers Mutual Insurance Co. v. Sullivan*, 119 S. Ct. 977 (1999) (holding that a licensed but private utilization review entity evaluating workers' compensation claims is not a state actor). One can distinguish the latter case as involving privately funded benefits rather than a public entitlement. Regardless of the outcome on remand, *Grijalva* is noteworthy because of the battle it triggered between HCFA and the district court involved in the decision for control over the details of coverage procedures.

426. Edmund Burke, Speech to the Electors of Bristol, in *Edmund Burke on Government, Politics and Society* 156, 157 (B.W. Hill ed., 1976). See also Pitkin, *supra* note 241, at 209–40 (analyzing the controversy over the proper relation between

Stuart Mill looked to government to further public intellect and virtue.⁴²⁷ March and Olsen note that the “developmental agenda seeks to affect the operation of the polity by affecting the values, beliefs, and identities of citizens,” and that “[t]he objective may include not only education into the obligations and rights of the key identities of the polity but also the establishment of widespread agreement on many substantive purposes and ends.”⁴²⁸ This process can vary in its intrusiveness, contenting itself merely with alerting the public to (and facilitating discussion of) issues of common concern, or, on the other hand, asserting an active role in disabusing people of incorrect views and leading them to make enlightened decisions.

As noted previously, the most critical issue in American health policy is access to health care.⁴²⁹ Despite a booming economy, the number of Americans without health insurance rose to 43.4 million in 1997, or 16.1% of the population.⁴³⁰ This decline in access to health insurance, even as managed care succeeds in restraining cost, confirms that an issue of tremendous social importance is not being addressed adequately by market forces.⁴³¹ This is not a condemnation of managed care, only a recognition that its goals and the goals of society as a whole are not necessarily congruent. Moreover, people without insurance do not have ready

representatives and those for whom they act). By vesting control in the representative, this role comports more closely with the corporate fiduciary than the true legal agent, although the power to remove (or at least not reelect) distinguishes it from a trustee.

427. See March & Olsen, *supra* note 381, at 244.

428. *Id.*

429. See *supra* text accompanying note 3. Concerns over universality and nondiscrimination are not unique to health care, but exist in many regulated industries. Focusing on public utilities, Kearney and Merrill postulate a general transformation of regulation from direct oversight to market facilitation—not that different from proposals for “managed competition” in health care. See Joseph D. Kearney & Thomas W. Merrill, *The Great Transformation of Regulated Industries Law*, 98 *Colum. L. Rev.* 1323, 1327–29 (1998). They attribute this to simultaneous realizations by interest groups and policy elites that the risk of regulatory failure exceeds that of market failure. Implicit in this reasoning are two assumptions relevant to health care: first, that interest group capture is not the most important form of regulatory failure, and, second, that productivity gains from competition far outweigh distributional losses and can therefore buffer their effects. Information is important to both points. With respect to capture, information supports a broadening of political interests in health care beyond the provider lobbies whose interests have most been served by health care entitlement programs such as Medicare and Medicaid. With respect to productivity, information is the key to improving health system performance, as discussed in detail above. See *supra* text accompanying notes 254–259.

430. See Robert Pear, *Americans Lacking Health Insurance Put at 16 Percent*, *N.Y. Times*, Sept. 26, 1998, at A1. The increase is attributable to factors including declining Medicaid enrollment from both changes in welfare eligibility and, paradoxically, economic prosperity, along with a shift toward smaller enterprises and self-employment, risk pools in which insurance is often unaffordable.

431. The two phenomena may be connected. As noted previously, the risk-selection incentives in private health insurance can lead to the elimination of high-cost individuals from risk pools, effectively rendering them uninsurable. See *supra* text accompanying notes 101–104.

access to charitable services, which historically were supported by decentralized, provider-based cost-shifting of uncompensated care to private insurers and other paying customers. Evidence is mounting that uninsured individuals receive fewer health care services, and suffer greater morbidity and mortality, than those with insurance.⁴³² Managed care is practically, if not morally, responsible for this trend, as hospital margins are squeezed and physicians become unable, because of financial pressures or organizational constraints, to maintain traditional levels of charity care.⁴³³ The public is largely ignorant of these developments and the forces behind them. One useful focus of current health services research, therefore, is to develop reliable measures of access that can inform both expert judgment and political debate.⁴³⁴

In addition to population-based indicators such as possession of health insurance and utilization of services, measurement tools might be developed that are sensitive to subtle barriers to access among nominally insured individuals. Access to services may vary according to the manner in which health care financing and delivery is organized, and may be significantly worse for the insured poor, vulnerable subsets such as children and the elderly, geographically isolated residents of rural areas or inner cities, and members of disadvantaged racial, ethnic, or cultural groups. This information can be important to beneficiaries asserting rights, to communities establishing or monitoring health services, to citizens making voting and charitable decisions that set priorities and allocate resources, and to reviewing courts. For example, an innovative approach to the longstanding problem of racial disparities in access to medical care is to measure it carefully and publicize the results.⁴³⁵

However, it is not clear that society is willing to confront tough choices about access to health care or its flip side, rationing. This reluctance increases the difficulty of accomplishing democratic goals through information and creates risks of both paralysis and subterfuge. The key question regarding information about difficult social issues is "Do people really want to know?"⁴³⁶ Debate continues in bioethics and health policy

432. See, e.g., Centers for Disease Control and Prevention, *Health Insurance Coverage and Receipt of Preventive Health Services—United States, 1993*, 273 JAMA 1083 (1995).

433. See Peter J. Cunningham et al., *Managed Care and Physicians' Provision of Charity Care*, 281 JAMA 1087, 1087 (1999) (showing a decline in charity care associated with increasing market penetration of managed care).

434. See Marsha Gold, *Beyond Coverage and Supply: Measuring Access to Healthcare in Today's Market*, 33 Health Servs. Res. 625, 626 (1998).

435. See David B. Smith, *Addressing Racial Inequalities in Health Care: Civil Rights Monitoring and Report Cards*, 23 J. Health Pol., Pol'y & L. 75, 100-01 (1998). Information about racial disparities might have even greater effects under the performance rationale by alerting health care providers to inadvertent behavior. Admittedly, these are small steps given the severity and apparent intractability of racial disparities in health care access and outcomes.

436. The same may even be true of individuals' decisions about their own care. Much as Odysseus asked to be tied to the mast so he could resist the Sirens' song, Hyman has

between bedside rationing and its more explicit alternatives.⁴³⁷ Twenty years ago, Calabresi and Bobbit argued that direct decisionmaking about resource allocation may have adverse effects on public values such as the sanctity of life.⁴³⁸ They concluded that invisible allocation systems may be preferable to overt decisions when the latter would threaten the moral foundations of social relationships. Certainly, it has proved easier, if less efficient and effective, for the cost of indigent care to be shifted informally by physicians and hospitals to paying patients than to reach political consensus on a universal health care entitlement.

On the other hand, the piecemeal system of informal rationing that prevailed for decades had many flaws, including arbitrary exercise of discretion by physicians that often concealed unlawful or immoral biases. Moreover, managed care has upset whatever equilibrium existed, in terms of both funds available for social subsidies and public complacency about sub rosa rationing. As Daniels and Sabin point out, managed care has made Americans uneasy about the fairness of its procedures in part because they are hidden from view, and belief in a fair system is itself an important public value.⁴³⁹ Ultimately, only experience will demonstrate whether or not the American public will respond to an information-rich environment about health care with a stronger commitment to achieving egalitarian social goals.

Oregon's controversial Medicaid program partially tests these hypotheses. Through an extensive process of public education and community consultation, and despite legal obstacles, Oregon replaced rationing-by-eligibility, which confined coverage to the neediest of the state's uninsured population, with rationing-by-services, in which eligibility was expanded but benefits were limited to a defined list linked explicitly to a biennial budget allocation.⁴⁴⁰ More than five years after its initiation, the new system seems a success. Although the "prioritized list" is itself little used, primarily because most coverage decisions have been delegated to managed care organizations, public commitment to expanded access has survived economic downturns as well as upswings, and the percentage of

speculated that some people may prefer physicians who are "gagged" by health plans, so that they never need to know about expensive but remotely beneficial therapies that are unavailable to them. See David A. Hyman, *The Managed Care Backlash: Scenes From a Maul*, 24 *J. Health Pol., Pol'y & L.* (forthcoming October 1999). Schneider makes a similar point based on psychosocial rather than economic reasoning. See Schneider, *supra* note 75, at 110-13 (observing that some people choose not to become involved in determining their care).

437. See Hall, *supra* note 22, at 114-17.

438. See Guido Calabresi & Philip Bobbit, *Tragic Choices* 195-99 (1978).

439. See Daniels & Sabin, *Limits*, *supra* note 410, at 308, 311-12.

440. See David C. Hadorn, *Setting Health Care Priorities in Oregon: Cost-Effectiveness Meets the Rule of Rescue*, 265 *JAMA* 2218 (1991). The trigger for the restructuring was the death of a small boy who had been denied a bone marrow transplant under recent amendments to Oregon's Medicaid statute excluding certain high-cost services. See *id.* at 2219.

uninsured Oregonians remains at low levels.⁴⁴¹ Whether one can extrapolate this experience to the national level, or to other social problems in health care, is open to debate.⁴⁴²

A larger experiment, though one less studied empirically for its democratic effects, is employment-based health insurance. Political philosophers and legal scholars alike have identified the workplace as a forum for democratic expression and a training ground for political participation.⁴⁴³ Information is essential to that process. As Pateman writes, "employees must be in possession of the requisite information on which they can base their decision, . . . [which] in practice . . . would mean considerably more information being given to employees than is usually the case."⁴⁴⁴ To date, however, health policy researchers have examined America's unusual system of tax-subsidized, employer-sponsored health coverage mainly in terms of economic efficiency, while health lawyers have focused on subtopics such as ERISA and anti-discrimination law.⁴⁴⁵ We have already seen that many (though not all) large employers are active intermediaries for information relating to the health plans and providers that serve their workers. In addition, workers in large organizations willingly accept the redistributive aspects of the insurance risk-pools in which they find themselves, which contrasts with public attitudes toward government redistribution of health care costs. This resurgence of private intermediaries that arguably promote democratic values in health care contrasts with a longstanding historical trend of housing that role solely in the nation-state.⁴⁴⁶ Therefore, a potentially fruitful area for additional research is the effect of information on employee attitudes toward health insurance and on the process and outcome of corporate decisions about the scope and administration of benefits.

On the whole, the American polity shows some receptiveness to distributive justice in health care, but its degree of commitment falls far

441. See Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 *J. Health Pol., Pol'y & L.* 161, 165-69 (1999).

442. See, e.g., Gutmann & Thompson, *supra* note 382, at 199-229 (analyzing the debate over Medicaid funding of liver and heart transplants in Arizona from the perspective of deliberative democracy).

443. See, e.g., Pateman, *supra* note 380, at 67-84.

444. *Id.* at 69.

445. For an excellent example of the former, see Mark V. Pauly, *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance* (1997). Pauly concludes that both employers and employees would be better off if employer-sponsored health insurance were taxed like wage compensation rather than receiving preferential treatment.

446. Still, current employment-based tax subsidies reinforce a class system of health coverage in the United States. A recent article concluded that lower-wage firms were less likely to offer health insurance than their higher-wage counterparts. At the same time, however, low-wage workers were most likely to find health benefits in companies with many well-paid employees. See Jon Gabel et al., *Class and Benefits at the Workplace*, *Health Aff.*, May-June 1999, at 144, 145.

short of other developed countries. For example, an observer from abroad might connect the current popularity of "patient protection" legislation to economic prosperity and diminished concern over the cost of private health coverage, and might lament the fact that American voters apparently would rather fritter away their surplus income on marginally beneficial rights for people who already have health insurance than seize a precious opportunity to cover the uninsured. Educating the public to make tough social choices does not in itself predict which choices will be made. In any particular case, information might strengthen the fabric of society, or tear it apart. The risk of diminished social solidarity may be heightened in areas like health care, where personal and emotional responses often dominate rational ones.⁴⁴⁷ By making explicit the valuation assumptions and distributive consequences of existing forms of public support, fully informed democratic debate therefore could move the health care system toward either greater or lesser equality. Although large-employer insurance risk pools offer a promising example with respect to both information requirements and social solidarity, it is far from certain that the aggregate democratic response to information will be a productive discussion and not merely a random walk.

C. *Circumscribing Democratic Disclosure*

As might be expected from previous sections, the democratic rationale for disclosure also presents risks. For example, civic transparency can conflict with other uses of information-based regulation. Most significantly, whereas competitively motivated and agency-enhancing disclosure laws benefit from strong governmental oversight in order to assure accuracy and prevent manipulation by regulated parties, democratic considerations argue against bureaucratic control, particularly if disclosure of the government's own activities is at issue. Moreover, disclosure can allow government to escape enforcement responsibility for its weaker citizens and tempt it to exceed its authorized powers by harnessing private enforcement mechanisms.

1. *Honest Broker, Leader, or Propagandist.* — Using information to stimulate democratic processes brings to the fore several issues regarding mandatory disclosure that were less troubling when disclosure was focused on individual values and private transactions. Chief among these is the role of government in collecting and distributing information. Other rationales for disclosure presuppose that government has minimal self-interest in the information disclosed, and therefore can serve as both policeman and honest broker. For example, the competition rationale for disclosure creates a need for information intermediaries, and the per-

447. Cf. J. Harvie Wilkinson III, *The Law of Civil Rights and the Dangers of Separatism in Multicultural America*, 47 *Stan. L. Rev.* 993 (1995) (arguing that civil rights law should promote unity, not separatism, but failing to address deeply held beliefs to the contrary that confound real-world application of normative principles).

formance rationale contemplates a neutral, expert process of priority-setting. Even the agency role comfortably accommodates government control to the extent government lacks the conflicts associated with private agents like ERISA plans or physicians.

However, if the purpose of disclosure is to help citizens develop their "voice" and to assure the appropriate translation of political preferences into health system design, placing information intended to stimulate democratic deliberation under the control of government may reduce its value. Even if the purpose of disclosure is to lead public opinion in specific, productive directions, Americans' special preoccupation with government secrecy and the related possibility of government deception renders that use problematic. In other words, if the public views disclosure as a check *on* government, informational efforts conducted *by* government may provoke suspicion or disbelief.⁴⁴⁸ These role tensions are heightened by the fact that the federal government is the nation's largest health care purchaser as well as its principal regulator.⁴⁴⁹ Consequently, information nominally offered as an aid to private transactions may be disseminated with the ulterior motive of swaying public opinion toward reducing demand for health care.⁴⁵⁰ Conversely, information could be used to build support for tax increases and higher health care spending.

At the same time, private informational efforts geared at influencing public opinion for political ends suffer from a well-known litany of failings. As exemplified by the "Harry and Louise" advertising campaign funded by the Health Insurance Association of America in opposition to the Clinton Administration's 1993-94 health reform plan, political information circulated by organized interest groups (whether voluntarily or in response to disclosure mandates) will more often appeal to emotion than to reason.⁴⁵¹ Health care exhibits two disadvantageous characteristics in this respect. First, the complexity of putting forth to the public both the political questions and the facts that should underlie their resolution predisposes to "information overload." Second, health care frequently implicates deeply held personal and even religious beliefs, so that the "public

448. See, e.g., David Wise, *The Politics of Lying: Government Deception, Secrecy, and Power* (1973). Even before the full extent of American involvement in Vietnam was revealed, and prior to Watergate, a 1970 survey revealed that in one city 19% of those interviewed believed that the moon landing was a government hoax. See *id.* at 341-42. In addition, hesitancy about government motives may prompt concern about governmental threats to personal privacy, adding to prior worries over commercial use of health care information or private-sector discrimination.

449. See Mehlman, *supra* note 204, at 378.

450. See *supra* text accompanying notes 321-327.

451. See Haynes Johnson & David S. Broder, *The System: The American Way of Politics at the Breaking Point* 204-13 (1996). Particularly galling to supporters of the Clinton plan was the strong likelihood that the actors whose characters berated the Administration for imposing costly bureaucracy and limiting personal freedom themselves lacked health insurance.

conversations" prized by theorists of deliberative democracy can all too easily devolve into shouting matches.⁴⁵²

Such possibilities argue against housing informational oversight in a single entity, and in favor of informational pluralism that can dilute manipulative messages.⁴⁵³ As March and Olsen observe, "a democratic polity requires a rich *mélange* of information and suffers when there is monopolistic control over information or when an expert community is monolithic in belief or organization."⁴⁵⁴ Publicly-motivated disclosure therefore shares with disclosure as a market regulatory tool a commitment to heterogeneity of use and response. At the same time, however, this commitment weakens the potential for disclosure to channel health care productivity in particular directions by articulating clear goals for system performance.

2. *Enforcement and Equal Protection.* — No analysis of the democratic rationale for health care disclosure would be complete without examining whether disclosure-based regulation fulfills government's obligations to its citizens. Somewhat surprisingly, disclosure-based regulation can suffer from both under- and over-effectiveness problems compared with more direct, choice-restricting regulatory interventions such as minimum quality standards.

Mandatory disclosure laws finesse a general tension in regulatory policy between consumer sovereignty and consumer protection.⁴⁵⁵ With respect to market goods, disclosure laws reflect a political philosophy of deference to private behavior. Even where the subject of regulation is not traded in the market, disclosure laws nonetheless respect heterogeneity of preferences and consequently promote diversity of outcomes. In sectors such as health care, however, arguments can be made that informational interventions may harm consumers by replacing minimum quality standards with more random safeguards.⁴⁵⁶ To a considerable extent,

452. This tendency may expose a general weakness in the deliberative model. See Gary Remer, *Political Oratory and Conversation: Cicero Versus Deliberative Democracy*, 27 *Pol. Theory* 39 (1999) (emphasizing the importance of oratory and its emotional appeal in versions of democracy that extol politics as a virtuous activity). Of course, the abundance of data generated by mandatory disclosure laws can make even oratory better informed.

453. A free and vigorous press may also provide effective oversight and ensure informational pluralism, subject to protection of patient privacy and other legitimate concerns. Cf. Lowenstein, *Paparazzi*, *supra* note 255, at 40–43 (lauding the effectiveness of the "paparazzi" in prompting sound corporate governance).

454. March & Olsen, *supra* note 381, at 82–83.

455. Models to reconcile the tension have been proposed. See, e.g., Neil W. Averitt & Robert H. Lande, *Consumer Sovereignty: A Unified Theory of Antitrust and Consumer Protection Law*, 65 *Antitrust L.J.* 713 (1997).

456. The possibility even exists that disclosure can be used as a legal shield against the legitimate exercise of substantive rights. Much as cigarette package warnings have been relied upon as a defense to liability in tobacco-related lawsuits, health plans might argue that giving notice of management practices, such as physician financial incentives, relieves them of responsibility for any negative effect of those practices on patient care. On the

tolerating a diversity of medical and management practices as long as they are made public rejects equality as a guiding principle of health system design.⁴⁵⁷ More concretely, a disclosure-based regime that relies on new information and communications technologies to meet the needs of a broad population as both consumers and patients may inadvertently widen gaps in quality and access because of socioeconomic differences in availability of, and familiarity with, those technologies.⁴⁵⁸

One aspect of mandatory disclosure laws that predisposes to inequality is enforcement. Enacting a right to information invites government to determine how that right will be realized. Without direct monitoring, audit requirements, public penalties, a private right of action, or an equivalent mechanism, theoretically comprehensive disclosure duties are meaningless in practice.⁴⁵⁹ For example, even if courts eventually agree that disclosure of financial incentives is required by ERISA, the law's strict limits on lawsuits and damages make a right to such information largely illusory.⁴⁶⁰

other hand, current managed care reform proposals are decidedly schizophrenic, as likely to narrow choice and micro-manage professional practice as to empower people to make their own decisions. Often prompted by anecdotes of corporate malfeasance or apathy, these measures are defended by their proponents as limited reactions to circumscribed problems. This strategy neatly sidesteps the public resistance to big government that has menaced sweeping plans for health reform. For example, the spate of recent laws prohibiting "drive-through deliveries" by assuring women of two or three days of postnatal hospitalization reversed in an instant several decades of efforts to de-medicalize and de-paternalize childbirth. See David A. Hyman, *Drive-Through Deliveries: Is Consumer Protection Just What the Doctor Ordered?*, 78 N.C. L. Rev. 5 (1999).

457. Staking out an extreme position on both science and political equality, some policy experts even question the fundamental premise that contractual freedom in health care is beneficial. Using Glied's terminology, these "medicalists" maintain that the health care system should provide everyone with the services deemed appropriate by authoritative professional judgment and resist the "marketist" assertion that fully informed consumers should be allowed to accept tradeoffs between price and quality, or among different quality attributes. See Glied, *supra* note 13, at 17-35 (differentiating marketists and medicalists); cf. Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 Nw. U. L. Rev. 6 (1975) (analyzing the market forces, including consumer preferences, that prevent socially optimal cost/quality tradeoffs).

458. See Thomas R. Eng et al., *Access to Health Information and Support: A Public Highway or a Private Road?*, 280 JAMA 1371 (1998) (advocating universal access to health information and support).

459. As noted above, for example, evidence suggests that health plan compliance with current disclosure laws has been poor. A recent GAO report examined required disclosure by 16 HMOs serving Medicare patients, and found significant errors and omissions in all of them. See Robert Pear, *Government Says H.M.O.'s Mislead Medicare Recipients*, N.Y. Times, Apr. 13, 1999, at A18; *supra* note 68. Similarly, a survey of 18 health plans in Washington State revealed that none provided the information required by that state's 1996 Managed Care Disclosure Act. See Leigh Page, *HMOs Provide Inadequate Consumer Data, Study Finds*, Am. Med. News, Sept. 7, 1998, at 18.

460. See *supra* notes 26-39 and accompanying text. Neither is informed consent law likely to have a major influence on disclosure practices because of its strict standards regarding negligence and causation. The majority of states continue to evaluate the

Similarly, the effectiveness of mandatory disclosure laws often depends on the political and economic influence of the constituencies receiving information, factors which are arguably more variable for disclosure rules than for substantive rights.⁴⁶¹ The Toxics Release Inventory provisions of EPCRA are illustrative.⁴⁶² TRI has been credited with reducing emissions of listed toxic chemicals by forty-three percent within ten years, primarily because of boardroom-level concern at large companies over the effects on consumers and investors of adverse publicity, as well as the potential for inadequate disclosure to generate liability under federal securities laws.⁴⁶³ In part, this represents exactly the type of empowerment often envisioned by proponents of disclosure laws. However, most of the benefits of TRI disclosure accrue to previously empowered constituencies.⁴⁶⁴ Without enforceable, substantive standards, the indigent or vulnerable have little recourse against even egregious practices.

adequacy of disclosure based on what physicians ordinarily disclose rather than on what patients reasonably want to know. These two standards may yield significantly different outcomes because physician practices and patient expectations about matters such as physicians' individual experiences and financial incentives are likely to diverge. In addition, even if courts are receptive to expanding the scope of required disclosure, patients bringing informed consent suits must still demonstrate that their injury was related to the information not revealed to them and that they would have undergone a different course of treatment if they had been fully informed. See, e.g., *Aceto v. Dougherty*, 615 N.E.2d 188, 192 (Mass. 1993) ("Even if we assume that there was an obligation . . . to disclose his experience . . . Dr. Schmidt qualified as an experienced physician.").

461. For example, enforcement of OSHA's Hazard Communications Standard has been particularly uneven and has been criticized for elevating trivial violations (for which equally trivial penalties are assessed) over major lapses. See Occupational Safety & Health Admin., U.S. Dep't of Labor, Hazard Communications and the Right to Know (visited Nov. 4, 1999) <<http://www.osha.gov/oshinfo/reinvent/prog7.html>> (on file with the *Columbia Law Review*) (noting substantial criticism received by OSHA). But see Lowenstein, Paparazzi, *supra* note 255, at 27-30 (crediting widespread stock ownership with attracting sufficient press attention to stimulate broad-based performance improvement).

462. These provisions were enacted in response to an environmental crisis. Heightened fears of toxic chemicals occasioned by the Bhopal disaster and a similar but less serious domestic incident led Congress to require industrial polluters to report toxic emissions. See Rebecca S. Weeks, *The Bumpy Road to Community Preparedness: The Emergency Planning and Community Right-to-Know Act*, 4 *Envtl. L.* 827, 831-34 (1998).

463. See Karkkainen et al., *supra* note 370, at 9; see also Sidney M. Wolf, *Fear and Loathing About the Public Right to Know: The Surprising Success of the Emergency Planning and Community Right-to-Know Act*, 11 *J. Land Use & Envtl. L.* 217, 307-12 (1996). Furthermore, the initial success of TRI prompted Congress to expand EPA's substantive mandate to regulate toxic chemicals in the 1990 Clean Air Act Amendments, exemplifying the role of disclosure in informing regulators.

464. Cf. Shoshanna Sofaer, *Informing and Protecting Consumers Under Managed Competition*, *Health Aff., Supp.* 1993, at 76 (discussing information and vulnerable populations). Similarly, disclosure of chemical risks in the workplace under OSHA's Hazard Communications Standard helped mainly those with union representation or other qualified advocates. See also *Oil, Chem. & Atomic Workers Local Union No. 6-418 v. NLRB*, 711 F.2d 348 (Cir. 1983) (upholding right of unionized workers to access health and safety information for collective bargaining purposes).

In addition, TRI focused cleanup efforts on listed chemicals from large corporate emitters,⁴⁶⁵ potentially diverting resources away from more pressing environmental issues.

Allowing injured parties to sue improves compliance with disclosure mandates and conserves government enforcement resources, but has risks of its own. For example, the threat of high-dollar class action securities litigation is far more likely to induce prompt, accurate disclosure than are informed consent suits, which have strict standards for negligence and causation, or claims under ERISA, which precludes most money damages. On the other hand, private litigation is costly, and it is difficult to separate meritorious claims from frivolous ones.⁴⁶⁶ Moreover, disclosure made defensively to gain protection from liability tends to be overly detailed and legalistic, based more on what has survived scrutiny in the past than on what would be useful to recipients.

On the other hand, mandatory disclosure laws can also create an *overenforcement* problem that is potentially an illegitimate exercise of government authority, particularly in light of the government's sizeable financial interest in health care. Release of information can be used by the government informally to achieve ends that could not be achieved by formal legal means. As Kreimer points out, "in the McCarthy era, . . . governments at both state and federal levels sought to use the 'spotlight of public opinion' to discourage activities apparently beyond the reach of direct criminal sanction."⁴⁶⁷ At the extreme, one might ask whether disclosure by the government of information about private persons is constitutionally constrained. Although openness has undoubted virtues, a point may be reached at which aggressive use of information by the government offends constitutional norms.⁴⁶⁸ Similar arguments might even be made with respect to disclosure mandated by the government though released by private parties, although such actions would at least have the benefit of formal legislative or administrative adoption.

In summary, whatever our health care information requirements may be as consumers or patients, we also need information as citizens. That need arises because we believe health to be important to personhood, we understand that society's resources are limited, and we therefore conclude that the distribution of health care is a social decision.⁴⁶⁹ Drawing important information into public debate through

465. See 42 U.S.C. § 11023(f) (1994) (establishing size thresholds for TRI reporting).

466. For these and similar reasons, there is a trend in securities law toward allowing sellers of securities to select disclosure and enforcement regimes that match the preferences of buyers, rather than mandating a uniform "warranty" approach with comprehensive disclosure duties and severe penalties for noncompliance. See Alan R. Palmiter, *Toward Disclosure Choice in Securities Offerings*, 1999 Colum. Bus. L. J. 1.

467. Seth F. Kreimer, *Sunlight, Secrets, and Scarlet Letters: The Tension Between Privacy and Disclosure in Constitutional Law*, 140 U. Pa. L. Rev. 1, 11 (1991).

468. See *id.* at 35-39.

469. Of course, not everyone feels this way. See Epstein, *supra* note 379. Epstein's position is that health care is a perfectly appropriate subject for purely private

mandatory disclosure laws is at once an overlooked explanation for recent legislative proposals, a side effect of disclosure prompted by other concerns, and an opportunity to improve the health care system in the future. Yet it also provides cause to reexamine the relationship between Americans and their government, as well as their substantive commitment to procedural fairness and equal opportunity.

CONCLUSION

Laws mandating disclosure of information have become a familiar feature of the regulatory landscape of health care. Moreover, every indication is that federal and state governments are rapidly increasing their reliance on disclosure to safeguard the public against perceived abuses in managed care. Enthusiasm among health policymakers for disclosure as a regulatory strategy represents the conglomeration of many forces, some unique to health care and some reflecting more general themes of political philosophy and institutional failure. Because of this multifaceted heritage, current legislative proposals seldom articulate fully their reasons for regulating through disclosure, nor do they frame their provisions in ways that suggest a clear connection between legal mandates and the achievement of important policy goals.

Using information to achieve accountability in health care connects to a broader regulatory movement. The current popularity of disclosure laws reflects an ongoing, if often superficial, attempt by American society to grapple with the relationship between citizens and the state. Consider the following passage from President Clinton's Second Inaugural Address, which he delivered on January 20, 1997:

And once again, we have resolved for our time a great debate over the role of government. Today we can declare: Government is not the problem, and government is not the solution. We, the American people, we are the solution As times change, so government must change. We need a new government for a new century, a government humble enough not to try to solve all our problems for us but strong enough to give us the tools to solve our problems for ourselves⁴⁷⁰

Information-based regulation toes this rhetorical line with striking agility. Because disclosure laws influence private transactions without substituting direct government regulation, they illuminate all parts of the political spectrum, appealing equally to conservatives, who applaud "mar-

decisionmaking combined with purely private charity. Although atypical, this position is at least morally consistent. When challenged by Reinhardt, who distilled Epstein's discussion to the question whether the child of a poor person should receive health care as good as that available to the child of a rich person, Epstein simply answered "no." See Richard A. Epstein, Letter: Articulating a Social Ethic for Health Care, 279 JAMA 745, 745 (1998); Uwe E. Reinhardt, Wanted: A Clearly Articulated Social Ethic for American Health Care, 278 JAMA 1446, 1446 (1997) (reviewing Epstein's book *Mortal Peril*).

⁴⁷⁰ Transcript of President Clinton's Second Inaugural Address to the Nation, N.Y. Times, Jan. 21, 1997, at A14.

ket facilitation" and "bootstrapping," and to liberals, who favor "empowerment" and the "right to know." Disclosure laws also strike a responsive chord in the powerful cohort of Baby Boomers whose material needs have been satisfied through active, informed consumerism and who can comfortably translate that model to the political arena.

In an effort to go beyond the visceral appeal of information that often accounts for the political popularity of disclosure, and to articulate clearly why and how disclosure laws should be adopted, this Article has presented the first comprehensive survey and analysis of information-based regulation in the American health care system. The Article identifies four fundamental purposes for health care disclosure: market facilitation, protection of fiduciary obligations, directed quality improvement, and democratic deliberation. The Article asserts that achieving each goal is possible, but only if answers are found to difficult and interrelated questions. First, under what conditions can consumers make rational decisions about health care? Second, what mix of contractual and relational obligations to patients should physicians and health plans obey? Third, how should we define success for the health care system? Fourth, how can the political process balance individual rights and social obligations?

The Article's conclusions challenge the conventional wisdom among information advocates that more is always better. To the contrary, conflicts arise if we try to achieve all four goals for disclosure simultaneously. For example, the competition rationale for disclosure holds greater promise when directed at large employers and other expert intermediaries, not individual consumers. However, this adds to the burden on disclosure laws to further the agency rationale, and reinforces the need to define more precisely the contours of agency obligations in health care. Of all possible uses of disclosure, the performance rationale is most likely to create meaningful change in the health care system, but starts from a very different premise—ends-forcing oversight rather than consumer sovereignty. Finally, the difficulty of determining these ends, while untangling and resolving the social choices implicit in modern health policy, supports a democratic rationale for disclosure. If this rationale is to succeed, government agendas and processes must not contaminate the information that guides political debate. Yet this qualification puts the democratic rationale at odds with the realization of the other rationales, for which government offers itself as a much-needed neutral broker.

Where does this leave us? If anything, the complexity of the underlying issues makes disclosure an attractive component of health care regulation. The *mélange* of interests, goals, and constraints in American health care confirms that diversity and uncertainty are defining characteristics of the system, to which information is a potentially useful response. However, using disclosure laws productively requires not only market discipline, but a reinvigorated medical professionalism that en-

compasses institutional as well as individual actors, and a renewed commitment to public values and public decisions.

A central conclusion to be gleaned from the Article's analysis is that meaningful disclosure laws require theoretical cohesiveness, meaning that they should be crafted to achieve specific objectives. At the same time, however, regulatory interventions based on narrow ideologies, whether economic or political, tend to oversimplify prevailing conditions in the health care system and are unlikely to prove productive. Rather, disclosure laws that support a pluralistic approach to health system regulation, leveraging market forces, professional values, and social imperatives, are likely to have the greatest influence.⁴⁷¹

One can also make specific recommendations about the optimal milieu for health care disclosure laws. First, proposals to weaken or abandon the link between employment and insurance should take into account the role of employers as information intermediaries, and the potential of the workplace to serve as a laboratory for the development and exercise of democratic principles. Second, because contractual freedom has its limits in health care, attention should be paid to articulating and generating public acceptance of fiduciary standards that emphasize the dignitary value of information while allowing medical professionals and the institutions within which they work to factor resource constraints into clinical decisions. Third, the potential for disclosure requirements to lead to productive experimentalism in a multifocal, professionally motivated health care system argues strongly for aggressive goal-setting by public bodies, even if such regulatory instrumentalism runs counter to market failure models for disclosure. Fourth, having exploded the myth of America's private health system, one must recognize the impact of disclosure on politics and therefore on government performance, including monitoring past decisions and informing future ones. While ostensibly designed to support private behavior, disclosure laws may turn out to have even greater utility in defining and resolving collective problems of system performance and popular will.

The Article's approach can be applied as well to other regulatory contexts where disclosure laws have been enacted or are under consideration. A principal lesson is that the value of information nearly always depends on the potential for someone to act on it. Although creating a naked "right to know" can be seductive in the heat of politics, lasting benefit from disclosure generally requires the availability of choice

471. This Article has not delved deeply into the form and content of required disclosure. Nonetheless, one general point worth reiterating at this juncture is that new technologies such as the Internet may prove more accessible and useful to recipients, and less costly to regulated entities, than paper compliance. See *supra* note 99 and accompanying text. Certainly, consumers are turning more and more to the Internet when they have health care questions. See Larry Stevens, *Consumer Sites Stir Up the Surf, Med. on the Net*, June 1999, at 6 (describing the growth of dedicated consumer health care sites).

through entry and exit, ongoing control, political voice, or other forms of self-help through legal or extralegal mechanisms. As appealing as disclosure can be as a way to regulate complex, decentralized, evolving spheres of activity, another lesson is that information will have meaning only if a core consensus exists as to the objectives of that activity and the principles underlying it. For example, the rationale for disclosure determines whether information should be designed for use by experts (performance, some competition) or by the lay public (competition, agency, democracy). Disclosure laws sometimes serve larger, more sophisticated parties best; therefore, politicians and policymakers should examine carefully their own biases as to whom they are "protecting" and how. Moreover, instrumental uses of disclosure require a process for setting goals and evaluating progress toward them, while agency-oriented disclosure must take account of prevailing customs and ethics. Notably, economic and noneconomic frameworks for disclosure must be evaluated separately because they make different assumptions about sources and uses of information. However, policymakers should not assume all cost considerations implicate economics or that all other considerations are non-economic; as we have seen, competitive disclosure may be dominated by non-price issues such as quality, and democratic disclosure may largely concern public funding.

Finally, the fact that regulators frequently turn to disclosure as a less threatening, more cost-effective alternative to direct regulation should not blind them to the opposite risk of overreaching their mandates if information is released irresponsibly, especially in today's electronic environment where instant, universal, costless dissemination is possible.⁴⁷² Like other areas in which technologic capability outpaces social understanding, producing and sharing information is a natural outgrowth of contemporary culture. Disclosure laws can indeed provide valuable feedback to regulators and, in experimentalist fashion, inform subsequent administrative interventions. However, it is also tempting for government to encourage or require distribution of information as a placeholder solution to seemingly intractable political problems.⁴⁷³ In health care and elsewhere, care must be taken to ensure that disclosure-based regulation becomes an effective regulatory response to rapidly changing and socially

472. Cf. Ann Florini, *The End of Secrecy*, *Foreign Pol'y*, Summer 1998, at 50 (1998) (noting a current fashion for transparency in international affairs because of technology, democratization, and globalization, but pointing out that transparency alone does not ensure success).

473. Cf. Lee Clarke, *Mission Impossible: Using Fantasy Documents to Tame Disaster* (1999) (describing society's preoccupation with making highly detailed if unrealistic plans for cataclysmic, uncontrollable events such as nuclear disasters). Clarke's analysis suggests a healthy dose of skepticism when government offers symbolic solutions in the form of information.

valuable activities, and not merely an abdication of substantive responsibility for protecting the public.⁴⁷⁴

474. A question for future study is whether mandatory disclosure is a useful second-best approach. Second-best theory is being applied to regulation in other areas. See, e.g., Andrew P. Morriss, *Implications of Second-Best Theory for Administrative and Regulatory Law: A Case Study of Public Utility Regulation*, 73 *Chi.-Kent L. Rev.* 135 (1998) (concluding that second-best problems render efficiency-enhancement problematic, so that regulation should be justifiable on other grounds).