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JUDICIAL OPINIONS INVOLVING HEALTH INSURANCE COVERAGE: TROMPE L'OEIL OR WINDOW ON THE WORLD?

WILLIAM M. SAGE*

INTRODUCTION

In contrast to a few areas of health care law with strong traditions of research, such as antitrust and medical malpractice,¹ the contractual relationship between health insurer and insured has remained relatively untested empirically. There has been considerable research on access to health insurance and its cost, but relatively little on how insurance operates for those who have it. Studies which have been performed tend to focus on one important subset of coverage issues—disputes regarding the “medical necessity” of treatment or its “experimental” or “investigational” character—and apply an even narrower method: explaining the legal system by examining the written opinions of courts in cases they have decided.

A recent example of this genre is an ambitious, methodologically sophisticated, two-year investigation headed by Mark A. Hall and Gerard F. Anderson, and funded by the Federal Agency for Health Care Policy and Research (the “Hall study”).² The Hall study was designed to test several hypotheses regarding judicial treatment of coverage decisions.³ These included the effect on judicial outcomes of (i) the method of technology assessment employed by insurers, (ii) the severity of the patient-plaintiff’s illness, (iii) the contractual language used in the policy, (iv) the presence of procedural protections, (v) the substantive and procedural barriers to recovery under the Employee Retirement Income Security Act of 1974 (ERISA),⁴ and (vi) the changing perceptions of cost constraints in the health care system.

The authors of the Hall study performed multivariate analysis of data derived from 203 published opinions between 1960 and 1994.⁵ They found that the following factors were significantly associated ($p < .05$)⁶ with patients prevailing in coverage disputes: not being in federal appeals court, the insurance contract not expressly reserving interpretive discretion to the insurer, and seeking

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1. See Stephen Zuckerman et al., *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, LAW & CONTEMP. PROBS., Spring 1986, at 85.

2. See Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055 (1996).

3. Grant proposal on file with author.

4. 29 U.S.C. §§ 1001-1461 (1994 & Supp. I 1995).

5. Hall et al., *supra* note 2, at 1058.

6. A p-value of under .05 means that, statistically speaking, there is less than a one-in-twenty likelihood that the observed association was due merely to chance.

treatment for a life-threatening clinical condition.⁷ The authors were themselves surprised to report that the presence or absence of ERISA was not a significant independent predictor of outcome.⁸

The crucial caveat for this type of research is less whether it yields valid answers but whether it asks the right questions. Judicial decisions are visible, but are they important? That is, do they indicate how well our largely private, pluralistic system of health insurance accomplishes its public policy goals? If not, research on judicial decisions risks the absurdity of looking for the lost coin under the lamppost solely because the light is better.

There is also an inherent paradox about empirical research involving outcomes of litigation. By the act of engaging in it, we are perhaps admitting to ourselves that the legal system is dysfunctional.⁹ Research on decided cases asks why some parties “win” and others “lose.” This is important information not only to actual or potential litigants, but to policymakers concerned with the efficiency of the courts as a forum for resolving disputes.

In our common law system, however, the results of litigated cases are supposed to create or confirm law. If coverage decisions generated clear, binding precedent, there would be little to analyze statistically (and few valid objections to the results of such analysis), since the cases would state the law. An important realization is, therefore, that we only “study” decisions empirically *because* the cases do not state the law.¹⁰ In other words, empirical research on judicial decisions looks for subtexts where the text is unreadable.

This essay offers a few thoughts about using judicial decisions as the dataset for research into health insurance coverage. Part I offers a general overview of insurance coverage law. Part II considers why students of health insurance coverage gravitate toward studying published opinions. Part III then discusses what is wrong with the approach, and suggests alternatives. Finally, Part IV turns to what may be *right* with the approach, concluding that judicial opinions in coverage litigation may reveal the functionality (or dysfunctionality) of the coverage process in managed care. Although the basic critique which the essay presents applies to areas other than litigation involving medical necessity or experimental treatment, it offers special insights into issues like health insurance coverage where legal doctrine and public policy may not be congruent.

7. Hall et al., *supra* note 2, at 1067.

8. *Id.*

9. As discussed below, this is one reason why medical malpractice has been an intuitively appropriate subject for empirical research.

10. The grant proposal for the Hall study, *see supra* note 2, anticipated that most of the decisions considered would be from appellate courts, and concluded that this would be advantageous because such decisions were more likely to create binding legal precedent. At the same time, the study’s application of statistical methods of analysis to opinions implicitly recognized that little binding precedent was being created.

I. WHY COVERAGE LAW MATTERS

Insurance coverage, long a backwater of health law, has come to the forefront in recent years for very good reasons.¹¹ First, more medical treatments are available, many of which may be exceedingly expensive. Marginally beneficial treatments are now frequently recommended by mainstream members of the academic medical community, where they once were the province of fringe practitioners or outright charlatans. As a result, disputes are less often about naturopathy or Laetrile, and more often about chemotherapy, immunotherapy, bone marrow reconstitution and organ transplantation for life-threatening illness.

Second, and relatedly, cost has become of significantly greater concern to sponsors of health insurance, notably employers and government. Not only has this made insurers more likely to challenge proposed therapies, but it has led to the development of a variety of prospective methods to control expenditures—techniques which fall under the general rubric of “managed care.”

Finally, the nature of insurance in health care is ambiguous.¹² On one hand, it can be viewed as the efficient diversification of unsystematic but similar risks. On the other hand, it can be seen as a process of social pooling, and hence redistribution. Regulatory interventions in health care sometimes follow the former paradigm, sometimes the latter.

Coverage litigation has therefore become one of the American health system’s Crimeas: a designated battleground for opposing values. On one side are arrayed individual patients with idiosyncratic needs, and the physicians and hospitals who stand ready to serve them. On the other side can be found employers, insurers and government—in each case claiming to represent the interests of beneficiaries or taxpayers as a whole by denying relief to one member of the group. This is, of course, the core challenge of managed care: creating an efficient system of population-based health management which nonetheless accounts equitably for the interests of individuals.

Litigation resulting from opportunistic behavior by insurers and 20-20 hindsight by beneficiaries is not unique to health care, but affects the insurance industry broadly. Unsurprisingly, courts considering individual controversies arising under blanket policies have occasionally strayed from clear doctrine. Professor Jeffrey Stempel lists the common elements of disputes over insurance coverage language which “tend to bring results less doctrinaire and consistent” than in other areas of law: standard form contracting, unequal bargaining power, non-negotiated terms, ambiguity, and recurring equitable considerations.¹³

11. See generally Mark A. Hall & Gerard F. Anderson, *Health Insurers’ Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992).

12. 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., Duke Univ. Press 1994).

13. JEFFREY W. STEMPEL, *INTERPRETATION OF INSURANCE CONTRACTS: LAW AND STRATEGY FOR INSURERS AND POLICYHOLDERS* § 2.1 (Brown & Little 1994) (quoted in Peter Nash Swisher, *Judicial Interpretations of Insurance Contract Disputes: Toward a Realistic Middle Ground*

Managed care has intensified the problems facing courts asked to determine coverage. These derive principally from three sources: the fact that health insurance in the United States is governed by disparate bodies of law, the convergence of coverage and care in prepaid systems, and the increasing risk of conflicts of interest affecting payers and providers.

A. Same Problem, Different Rights

Well-insured patients with identical medical conditions seeking equivalent treatments are far from equals in a court of law. The relatively small group of individual policyholders and employees of state and local governments with private insurance are protected by state insurance regulations and have available a panoply of legal claims and remedies under state law if coverage disputes arise. The much larger group of persons insured through their workplace under ERISA have a limited set of rights and remedies, and the subset whose employers self-insure are denied the benefit of state regulatory intervention as well.¹⁴ Beneficiaries of government programs such as Medicare and Medicaid are subject to procedural restrictions on judicial review in addition to slightly different substantive standards.¹⁵ Federal workers receiving coverage through the Federal Employees Health Benefit Program (FEHBP),¹⁶ active duty military under the Civilian Health and Medical Program of Uniformed Services (CHAMPUS),¹⁷ and veterans covered by the Veterans' Administration health system are also treated somewhat differently than privately insured individuals.¹⁸

Moreover, these financing systems increasingly deliver services through the same corporate managed care entities. Consequently, an individually insured person, a worker whose employer purchases insurance, an employee of a self-insured firm, and a retiree who has enrolled in the Medicare product offered by her insurer may think they are dealing with the same "health plan." In fact, they may be subject to widely disparate rules. Because managed care organizations operate under readily apparent cost constraints, this different legal treatment of similarly situated individuals tends to offend notions of basic fairness.

B. Convergence of Coverage and Care

Coverage litigation prior to managed care was perceived as tangential to health care delivery. Disputes generally arose long after treatment had been rendered, and focused on payment rather than survival. Not only did this allow

Approach, 57 OHIO ST. L.J. 543, 560 (1996)).

14. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); see also Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251 (1997).

15. See Eleanor D. Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L.J. 1 (1987).

16. 6 U.S.C. §§ 8901-8914 (1994 & Supp. I 1995).

17. 10 U.S.C. §§ 1071-1106 (1994).

18. See 44 AM. JUR. 2D *Insurance* § 2057 (1982).

reviewing courts some detachment from compelling human equities, but it meant that health care policymakers did not connect coverage litigation with broader themes of access, cost and quality.

As the cost of medical care has risen, and as managed care organizations have combined financing with delivery of services, the relationship between coverage denials and inability to receive care has become clearer. In particular, precertification requirements for hospitalization and surgery have increased the urgency of resolving disputes, as well as raising the stakes for plaintiffs. Similar considerations apply when patients seek access to specialty services not readily available within a managed care network. At the same time, insurance organizations with selective physician networks, drug formularies, and strict utilization review standards are more likely to be implicated in patient injury resulting from coverage denied or improperly provided.¹⁹

C. Conflicts of Interest

By incorporating financial incentives for cost containment into provider contracts or otherwise promoting physician compliance with organizational goals, managed care has realigned the traditional parties to coverage disputes. For example, the recommendations of the physicians affiliated with the health plan and other providers consulted by the patient may differ. At the extreme, patients in managed care systems not only may be unsure of their insurer's financial obligations, they may be unaware that potentially beneficial treatment exists.

Informational asymmetries between managed care organizations and individual patients relating to coverage have taken on correspondingly greater importance. Unethical marketing practices and other potential opportunities for insurers to deceive beneficiaries have always influenced courts. Conventional insurance, however, presented limited opportunities for mischief. By contrast, coverage law in the era of managed care must monitor a broad array of intermediaries, including not only traditional insurance agents but also employee benefits personnel, claims administrators and utilization review entities, plus affiliated providers and their contracting vehicles.

Taking these factors in combination, coverage disputes are increasingly about providing fair and uniform access to medical treatment from competent agents making full disclosure. The world of insurance coverage law thus begins to resemble the more familiar arena of medical malpractice. In the discussion that follows, we will come back to this comparison in connection with the pros and cons of, and alternatives to, studying coverage law through reported cases.

II. WHY WE STUDY COVERAGE LAW USING REPORTED DECISIONS

At first glance, studying coverage law from judicial decisions strikes one as

19. See, e.g., *Wilson v. Blue Cross*, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990). But see *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992) (ERISA preempts available remedies for "medical decisions incident to benefit determinations").

sensible. Contractual provisions designed to apply across-the-board seem susceptible to legal interpretation apart from the facts of particular cases. For example, in the case of clauses excluding coverage of “investigational” or “experimental” treatment, the therapy, not the patient, is the apparent focus of inquiry. Therefore, judicial interpretation of insurance provisions could have systematic effects.²⁰

These expectations are not borne out in practice. Despite the fact that insurance is an aggregate endeavor, and the policy language interpreted by courts affects many people simultaneously, reported cases generally reflect unique needs and circumstances. As a result, coverage cases are seldom brought in class action form. Moreover, although a ruling overturning an exclusion for experimental treatment could theoretically change the policy for all patients requesting the same treatment, this does not seem to occur.²¹ Why, then, are reported opinions an attractive database for empirical research?

A. Judicial Decisions are Abundant

A major reason we tend to examine judicial opinions in coverage cases is that there seem to be a lot of them.²² However, the apparent abundance of formal judicial findings is largely artificial.

Most personal injury cases are tried before juries.²³ However, compared with medical malpractice disputes, there are relatively few jury verdicts in coverage disputes, a phenomenon probably explainable by ERISA. Though the percentage has declined in recent years, well over half of privately insured patients receive coverage through employment.²⁴ Coverage claims involving employer-sponsored

20. By contrast, medical malpractice cases tend to depend on highly idiosyncratic facts and, as discussed further below, are generally tried before juries whose reasoning is not revealed in written opinions. Some empirical work in malpractice has therefore explored the factors that cause plaintiffs to win or lose in jury verdicts and settlements. Moreover, many empirical studies of malpractice have focused on non-judicial measures of system performance, assessing global cost and efficiency from data such as malpractice insurance premiums, defensive medicine, correlation between negligent injury and litigation, and adequacy of compensation. *See infra* note 114.

21. In addition, a defendant insurer could be collaterally estopped from challenging a prior adverse determination regarding the meaning or legitimacy of a contractual exclusion. *See generally* *Parklane Hosiery Co. v. Shore*, 439 U.S. 322 (1979). *See also* *Clements v. Airport Auth.*, 69 F.3d 321, 330 (9th Cir. 1995); *Texas Employers' Ins. Ass'n v. Jackson*, 862 F.2d 491, 500 (5th Cir. 1988); 18 JAMES WILLIAM MOORE, *MOORE'S FEDERAL PRACTICE* § 132.01 (3d ed. 1997). Nonetheless, courts are reluctant to extend rulings from one case to another except through the more limited application of *stare decisis*. Consequently, although insurers may redraft contractual provisions in response to judicial decisions, they are seldom compelled to.

22. This seeming abundance may be deceptive when samples are subjected to rigorous statistical analysis. *See infra* Part III.A.

23. Kevin M. Clermont & Theodore Eisenberg, *Trial by Jury or Judge: Transcending Empiricism*, 77 *CORNELL L. REV.* 1124, 1136-37 (1992).

24. Mark A. Hall, *Rationing Health Care at the Bedside*, 69 *N.Y.U. L. REV.* 693, 779 (1994).

health plans must be brought under federal ERISA law, which broadly preempts related state law claims.²⁵ Although the Seventh Amendment to the U.S. Constitution guarantees the right to a federal jury trial upon request of a party in “suits at common law,”²⁶ disputes involving equitable remedies may be conducted as bench trials.²⁷ Claims for benefits under ERISA were traditionally regarded as equitable because federal pension law incorporates large portions of the law of trusts.²⁸

As a result, several federal appellate courts have denied the right to a jury trial in ERISA cases, although there are indications this may change with respect to claims for damages as opposed to injunctive relief.²⁹ Bench trials obligate the judge to issue a Memorandum of Findings of Fact and Opinions of Law, which may be published.³⁰ By contrast, a jury verdict in a medical malpractice case creates little official record, unless detailed rulings are issued on post-trial motions.

Whether or not brought under ERISA, suits in preauthorization cases requesting preliminary injunctions requiring insurers to pay for or provide treatment are decided by judges. In addition, a subset of coverage disputes arises under Medicare and Medicaid, both historically fee-for-service insurance programs. Challenges to Medicare or Medicaid benefit determinations are channeled through administrative adjudicatory mechanisms.³¹ Because beneficiaries have a right to judicial review (although not to a jury trial), many of these cases result in published opinions. Moreover, settlement opportunities are rare in public programs.

25. 29 U.S.C. §§ 1144(a) & 1003(a) (1994).

26. U.S. CONST. amend. VII.

27. See *Katchen v. Landy*, 382 U.S. 323, 337 (1966) (citing *Barton v. Barbour*, 104 U.S. 126, 133-34 (1891)).

28. See *Coar v. Kazimar*, 990 F.2d 1413, 1418 (3d Cir. 1993).

29. See, e.g., *Katsaros v. Cody*, 744 F.2d 270 (2d Cir. 1984). However, the Supreme Court recently suggested that the nature of the desired remedy, not the underlying claim, may determine the right to a jury trial. *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993) (denying claim for damages as not within category of “appropriate equitable relief”). Following *Mertens*, several federal district courts have required jury trials for benefits claims requesting damages. See, e.g., *Mullins v. Pfizer, Inc.*, 889 F. Supp. 69, 76 (D. Conn. 1995); *Hulcher v. United Behavioral Sys., Inc.*, 919 F. Supp. 879, 885 (E.D. Va. 1995); *Algie v. RCA Global Communications, Inc.*, 891 F. Supp. 870, 875 (S.D.N.Y. 1994); *Sullivan v. LTV Aerospace & Defense Co.*, 850 F. Supp. 202 (W.D.N.Y. 1994), *vacated in part* by 82 F.3d 1251 (2d Cir. 1996).

30. According to the *Bench Book for U.S. District Court Judges*, which sets forth guidelines for when trial courts are required to issue Findings of Fact and Conclusions of Law in civil cases and motions, bench trials must result in written findings, as must granting or refusing interlocutory injunctions (e.g., preliminary injunctions requiring coverage). A written opinion generally must also accompany a grant or denial of summary judgment. FEDERAL JUDICIAL CENTER, *BENCH BOOK FOR U.S. DISTRICT COURT JUDGES*, § 6.02 (4th ed. 1996).

31. See Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J.L. & MED. 301, 314-18 (1996).

Motion practice also exaggerates the frequency of judicial intervention in coverage cases. Even if a jury might theoretically be impanelled for an ERISA benefits trial, courts are limited to an abuse of discretion review in situations in which the ERISA plan document expressly reserves discretion to the plan administrator.³² Defendants therefore typically bring motions for summary judgment, which often generate written rulings. Additionally, some jury decisions in non-ERISA cases brought under state law may result in the assessment of punitive damages (which are rare in malpractice cases), occasioning post-trial motions to remit damages which must be decided as a matter of law by the trial judge.³³

Apart from identifying parties as plaintiffs, defendants, appellants or appellees, the Hall study does not detail the procedural posture of the cases it reviewed. Nonetheless, the distribution of cases between trial and appellate levels in the Hall study is suggestive. State supreme court decisions accounted for 9% of the opinions reviewed, state appeals courts 26%, state trial courts 3%, federal appeals courts 22% and federal trial courts 39%.³⁴ The larger percentage of federal trial court decisions may represent not only Medicare and Medicaid, but bench trials or motions in ERISA cases. The low percentage of state trial court opinions, on the other hand, may reflect non-ERISA cases decided by state juries. Assuming that juries favor plaintiffs, this hypothesis is supported by the fact that the insurer was the appellee in most federal appeals (66%) but was the appellant in most state appeals (55%).³⁵

B. Contract Cases Appear Self-Contained

The contractual nature of coverage disputes may favor research using judicial decisions. Parties to a contract form a voluntary relationship, the terms of which are subject to judicial enforcement but little more. Compared with tort claims, which convey intuitively a need to study broader social issues such as deterrence of negligence and compensation for injury, contract cases seem less concerned with factors beyond the agreement. In other words, tort analysis may predispose to extrinsic research because public policy issues are explicit. By contrast, such matters are implicit in contract analysis, which therefore tends to limit research to intrinsic data such as judicial interpretation.

This is not to say that coverage language is written on a blank slate. Insurance benefits provided by fee-for-service Medicare and Medicaid are not contracts but legislative entitlements. In addition, the terms of coverage are

32. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

33. There is another possible reason why coverage litigation often results in a final judicial determination. Lawsuits in coverage cases frequently represent last-ditch efforts by dying patients and their families. Unlike malpractice cases, which center on monetary compensation for prior injury, managed care litigation is all-or-nothing. The potential for compromise, and therefore for settlement, may therefore be reduced.

34. Hall et al., *supra* note 2, at 1061.

35. *Id.* at 1064.

frequently constrained by state insurance regulation.³⁶ Nonetheless, strong ERISA preemption of state regulation for self-insured employers, coupled with the absence of federal substantive requirements, has created a period of contractual free rein for many managed care agreements. Taking advantage of this legislative *laissez faire*, managed care plans and employers have greatly increased the range and significance of contractual limitations imposed on beneficiaries.³⁷

As managed care becomes the dominant form of insurance, and coverage and care converge, the current era of free contracting will probably come to an end.³⁸ Most importantly, federal legislators are beginning to amend ERISA to impose on managed care plans substantive limitations typical of state insurance regulation.³⁹ At the same time, both federal and state regulators seem more willing to dictate medical practice in the context of managed care than was the case in a fee-for-service environment.⁴⁰

C. Academics Understand Judicial Opinions

Quantitative and statistical work in law is a relatively recent phenomenon, reflecting lawyers' increasing level of engagement with the world outside the

36. THE POLITICS OF HEALTHCARE REFORM: LESSONS FROM THE PAST, PROSPECTS FOR THE FUTURE 51, 210 (James A. Morone & Gary S. Belkin eds., 1994). Insurance regulation includes limitations on contractual language as well as issues such as reserve requirements and mandated benefits. This has two consequences for judges evaluating insurance contracts. First, it reduces the range of possibilities available to contracting parties. In addition, however, it may create situations where compliance with regulatory requirements contradicts judicial principles of contract interpretation. For example, a court might berate an insurer for failing to state explicitly that a particular treatment was excluded from coverage, despite the fact that "laundry list" exclusions are disfavored by state regulators.

37. *See, e.g.*, *McGann v. H & H Music Co.*, 946 F.2d 401, 407-08 (5th Cir. 1991) (allowing employer to adopt self-insured ERISA plan with greatly reduced benefits for AIDS).

38. One aspect of the convergence of coverage and care tending in the opposite direction is the possibility that the professional practice standard to which physicians are held might be specified in a managed care contract. In *Dukes v. U.S. Healthcare, Inc.*, for example, the court left open the possibility that a contractual standard of care would allow insurers to claim ERISA preemption even in routine malpractice litigation. 57 F.3d 350 (3d Cir.), *cert. denied*, 116 S. Ct. 564 (1995). It will be interesting to see if contractual standards of care persuade researchers on medical malpractice to pay *more* attention to judicial opinions.

39. *E.g.*, Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified in scattered sections of 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.); *see also* Patient Access to Responsible Care Act of 1997, H.R. 1415, 105th Cong., 1st Sess.

40. *E.g.*, Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874, 2935-44 (codified at 29 U.S.C. § 1185, 42 U.S.C. §§ 300gg-4, 300gg-51 (1994)) (minimum hospital length of stay for postpartum care); Breast Cancer Patient Protection Act of 1997, H.R. 135, 105th Cong., 1st Sess. (minimum hospital stay for mastectomy and lymph node dissection).

courtroom. “Law and empiricism” follows naturally from previous scholarly movements—such as legal realism, law and society, law and economics, and critical legal studies—that drew upon extrinsic sources of information and analysis to explain and inform legal doctrine. The enormous expansion of the American health care industry, and its high degree of regulation, make empirical work in health law especially attractive.

Judicial decisions are a natural starting point for legal empiricism. Judge Posner finds it significant that legal scholars focus on the written opinion rather than the courtroom drama: “[Academics tend] to ascribe more importance to the opinion, to its reasoning, its rhetoric, etc. than to the decision itself. Yet these are secondary factors for most judges. For the judge, as for Hamlet, ‘the play’s the thing.’”⁴¹ Moreover, Posner notes that legal academics tend to study appellate decisions more intensively than those of trial courts, and that “opinions are virtually [the] only public product” of appellate judges.⁴² Mixing trial and appellate cases in empirical analyses therefore raises questions. According to Posner, the two tiers of judging differ significantly: trial judges are both affected and monitored by daily interaction with the litigants, while appellate judges play a “game” according to intellectually satisfying but more formalistic rules.⁴³

Published decisions therefore represent an easy extension of traditional legal scholarship to health care. With respect to coverage litigation specifically, ERISA’s broad preemptive effect has probably encouraged this focus by reducing the number and influence of legislative initiatives. This is likely to change as the “ERISA vacuum” begins to fill in response to recent judicial limits on preemption and heightened interest in federal regulation of insurance.⁴⁴

D. Additional Data Are Limited

Availability of information drives the direction of research. Reported cases are the most easily available source of information about coverage disputes, merely an electronic search away. Some data on a broader section of coverage disputes are also available, at least for federal cases. The Administrative Office of the United States Courts creates a record of each civil case terminated, including the subject matter and jurisdictional basis, the amount demanded, the dates of filing and termination, the procedural posture of the case at termination and, if a judgment was reached, the prevailing party and the amount awarded.⁴⁵

Whereas lawsuits are matters of public record, relatively little is known about

41. Richard A. Posner, *What Do Judges and Justices Maximize? (The Same Thing Everybody Else Does)*, 3 SUP. CT. ECON. REV. 1, 26 (1993).

42. *Id.* at 7.

43. *Id.* at 7, 29-30.

44. *E.g.*, Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified in scattered sections of 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.) (also known as the Kassebaum-Kennedy Act; applies to self-funded ERISA plans as well as insurance arrangements).

45. Clermont & Eisenberg, *supra* note 23, at 1133.

how insurers reach coverage decisions in non-litigated cases.⁴⁶ Unlike medical malpractice, where many liability insurers freely share data on their insureds, health insurers often assert proprietary interests in their coverage standards.⁴⁷ Even coverage determinations under government programs are obscure, largely a result of the low visibility of the private carriers and intermediaries with which Medicare contracts.⁴⁸ This may change if constitutional due process requirements are imposed on managed care organizations serving Medicare and Medicaid beneficiaries.⁴⁹

By contrast, medical malpractice data are far more organized and accessible. Research on malpractice tracks malpractice insurance premiums, claims and awards. For example, data on nationwide jury awards are available from Jury Verdict Research, although the database depends on voluntary submissions by the parties and excludes settlements.⁵⁰ Other important sources of information are malpractice insurers' records of filed and closed claims, and state and federally mandated reporting of settlements and judgments involving physicians.

The new regulatory focus on managed care should expand data availability in the coverage arena. For example, several states now require managed care organizations to disclose to beneficiaries information on grievance and appeals procedures for challenging coverage determinations.⁵¹ In addition, a few states require standardized reporting to regulators and the public of patient satisfaction with coverage, including disenrollment statistics and the number and outcome of benefit disputes. This information, however, is not necessarily indexed to filed or decided litigation.

E. Political Constituencies Are Underdeveloped

Politics explains some of these data differences. Medical malpractice has clearly demarcated, well organized constituencies on both sides, which has

46. See, e.g., William P. Peters & Mark C. Rogers, *Variation in Approval by Insurance Companies of Coverage for Autologous Bone Marrow Transplantation for Breast Cancer*, 330 NEW ENG. J. MED. 473 (1994). One exception is technology assessment, which has generated a rich literature. See, e.g., INSTITUTE OF MEDICINE, COMMITTEE FOR EVALUATING MEDICAL TECHNOLOGIES IN CLINICAL USE, *ASSESSING MEDICAL TECHNOLOGIES* (1985). However, the science of technology assessment tends to be divorced from its utility in avoiding or resolving coverage disputes.

47. Insurers may also have an interest in preserving ignorance, since the alternatives might be to develop more rational standards or to admit that the emperor lacks clothes.

48. *Medicare Part B: Inconsistent Denial Rates for Medical Necessity Across Six Carriers: Before the Subcommittee on Regulation, Business Opportunities, and Technology, Committee on Small Business, House of Representatives, reprinted in GAO/T-PEMD-94-17* (statement of Eleanor Chelimsky, Assistant Comptroller General).

49. See, e.g., *Grijalva v. Shalala*, 946 F. Supp. 747 (D. Ariz. 1996).

50. Stephen Zuckerman et al., *supra* note 1, at 90.

51. See William M. Sage & David Anderson, *Health Care Disclosure Requirements, in 1997 HEALTH LAW HANDBOOK* 185, 189-90 (Alice G. Gosfield ed., Clark Boardman Callaghan 1997).

encouraged research to support desired legislative reforms and has also provided a political outlet for studies which have been performed.⁵² Trial lawyers and consumer groups have stressed patient protection and the identification of “bad doctors,” while physicians and hospitals have emphasized the aggregate cost and inefficiency of litigation.⁵³

Regarding private insurance coverage, at least, political constituencies have thus far had less certain turf and less mature strategies. In particular, there is as yet no group (save employers, who are anxious to downplay their potential conflicts of interest as sponsors of health care benefits) arguing that there is “too much” coverage litigation or that the threat or outcome of it unacceptably increases health care costs. Insurers have kept a low profile, relying on ERISA and other arcane legal safeguards, rather than engaging in a debate between statistical and identified lives which they would surely lose.⁵⁴

Although coverage research is still a character in search of an author, there are now several likely candidates. For example, three of the ten largest jury verdicts of 1995 involved managed care.⁵⁵ As a result, trial lawyers who had long ignored medical malpractice cases because of legislative caps on damages and the need for special medical expertise are looking twice at corporate managed care defendants and the potential for lucrative claims of “bad faith” insurance denial or infliction of emotional distress.⁵⁶ Academic health centers, which feel increasingly vulnerable as both explicit government funding and private cross-subsidies for clinical research are reduced, are another important constituency for coverage research, as well as a significant source of intellectual horsepower. In response, the insurance industry can be expected to commission or encourage its own studies of the cost of mandated benefits, required appeals process, or unrestrained litigation, as has been the case with more actively

52. Though not the intention of its authors, for example, the most recent attempt to quantify defensive medicine immediately attracted the attention of tort reformers both within and outside of the medical community. Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q.J. ECON. 353 (1996). Obviously, widespread public interest is both an opportunity and a risk. Hensler notes that “[t]he highly politicized world of policy research challenges researchers to keep their political personae separate from their research analytic personae.” Deborah R. Hensler, *Researching Civil Justice: Problems and Pitfalls*, LAW & CONTEMP. PROBS., Summer 1988, at 55, 65.

53. One should note that the former is deliberately anecdotal, while the latter generally reduces the emotional appeal of severe patient injury by making dollars rather than lives the mode of discourse.

54. At least in medical malpractice, the counterpoint to a severely injured victim is a single physician making an individualized judgment—not a faceless corporation dictating aggregate policies—although this may be changing now that incidents of malpractice can be gathered together under the perceived responsibility of managed care organizations.

55. *Verdict Trends in 1995 Disregard the Clamor: Congressional Tort Reform Has Had Little Effect*, NAT’L L.J., Feb. 5, 1996, at C2.

56. As in malpractice, moreover, the plaintiff’s side generally prefers the sympathetic anecdote to the bigger picture—except, of course, to say that “it could happen to you.”

documented areas of insurance such as workers' compensation and automobile no-fault. Moreover, with all fifty states and the federal Congress firmly committed to consumer protection in managed care, the legislative can of worms (despite ERISA) has been opened wide. This should greatly increase interest in empirical studies of insurance contracting practices.

III. LIMITATIONS OF THE JUDICIAL DATASET

Empirical studies of judicial decisions suffer from significant limitations. Some of these pitfalls apply generally, while others take on special importance in health insurance coverage. As a result, these studies may not prove what they set out to prove—who prevails in coverage disputes and why.

A. Small Sample Size

Although there may be enough reported decisions in insurance coverage to attract attention, there are far too few to draw statistically meaningful conclusions except for very general issues. In some situations, this small numbers problems may prevent identification of trends that would reach statistical significance given a larger sample. In other cases, aggregating data to achieve statistical validity obscures important local variations, such as between courts in different jurisdictions.

In the Hall study, for example, the authors were surprised that only 203 cases relating to medical appropriateness and otherwise meeting their criteria for inclusion resulted in published federal and state court decisions between 1960 and 1994.⁵⁷ Because of their small sample size, the investigators were forced to abandon their original goal of performing a longitudinal analysis of cases to measure judicial responses to improved practices by the insurance industry or changing perceptions of the health care system.⁵⁸ Neither were they effectively able to study narrow but important questions identified in their original grant proposal such as the relationship between payer and outcome or the role of specific methods of technology assessment.⁵⁹

B. Long Time Lags

Like observational astronomy, reported cases reveal the universe as it was, not as it is today. Courts are necessarily reactive, weighing in only in identifiable, fully developed controversies.⁶⁰ In the Hall study, the median time to final disposition was 2.5 years, and many cases took much longer.⁶¹ In addition, sample size constraints required pooling of cases that would have been

57. Hall et al., *supra* note 2, at 1059.

58. Grant proposal on file with author.

59. Grant proposal on file with author.

60. SHELDON GOLDMAN & AUSTIN SARAT, AMERICAN COURT SYSTEMS: READINGS IN JUDICIAL PROCESS AND BEHAVIOR 8 (S. Goldman & A. Sarat eds., 1978).

61. Hall et al., *supra* note 2, at 1060.

“old” no matter how quickly they had been resolved.⁶²

The time delays inherent in judicial decision making create special problems for studies of industries like managed care which are in rapid transition. Examining judicial decisions in coverage cases may therefore suffer from irrelevance. For example, only six of the 203 cases studied by Hall and Anderson involved HMOs or other managed care plans.⁶³

Given the inevitable time lag, the lack of cohesiveness to current coverage law may even be a blessing in disguise. As discussed below, judges prefer to articulate narrow justifications for their decisions.⁶⁴ Because of their unusual facts and compelling equities, health care coverage cases often present an extreme example of this phenomenon. In managed care, changes in industry practice are occurring so rapidly that judicial attempts to make sweeping law would seldom synchronize with the state of the system at the time of the ruling.

C. Selection Bias

Just because there are a lot of coverage cases with reported opinions doesn't mean that most cases generate reported opinions, that most disputes give rise to litigation, that most coverage denials are disputed, or even that treatment options which might be denied are proposed in the first place.⁶⁵ Reported decisions are the tip of a very large iceberg. What occurs outside the purview of the courts is probably far more significant to the average patient—and therefore to public policymakers—than the opinions of judges.

There are many reasons why a litigated case might result in a final decision. It may indicate the failure of negotiation or an alternative mode of dispute resolution to achieve settlement or determine rights.⁶⁶ It may reflect uncertainty about the underlying law. It may indicate that the law, though clear, is objectionable to one or both parties. It may mean that the underlying facts have

62. *Id.* at 1059-60.

63. *Id.* at 1056. The authors attributed this to another problem with collecting reported decisions, selection bias from unlitigated cases, but it undoubtedly relates as well to the novelty of many managed care arrangements.

64. *See infra* notes 86-96 and accompanying text.

65. In medical malpractice cases, for example, Danzon has examined the relationship between court outcomes and settlements. She concluded that claims tried to verdict involve atypically large dollar amounts, more uncertainty about liability, and weaker evidence for plaintiffs. PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 50-51 (1985). Studies of legal decisions in other areas have also had to address sample selection problems. *See, e.g.*, Philip D. Drake & Michael R. Vetsuypens, *IPO Underpricing and Insurance Against Legal Liability*, *FIN. MGMT.*, March 22, 1993, at 64.

66. Gross and Syverud assert that despite liability insurance for defendants and contingent fees for plaintiffs, trials are too expensive and risky for most parties. They conclude that “[t]he main function of trials is not to resolve disputes but to deter other trials.” Samuel R. Gross & Kent D. Syverud, *Don't Try: Civil Jury Verdicts in a System Geared to Settlement*, 44 *UCLA L. REV.* 1, 63 (1996).

not been elucidated to the satisfaction of the litigants. Finally, it may suggest that interest groups are actively pursuing an available avenue for legal change.

At the same time, trends in legal doctrine undoubtedly influence the way parties behave when they make private ordering decisions.⁶⁷ This is what Mnookin and Kornhauser refer to as “bargaining in the shadow of the law.”⁶⁸ In addition, as Mather describes, trial courts are “cumulative policy makers,” with the outcomes of earlier cases prompting or deterring additional, similar litigation.⁶⁹ This is enhanced by the form of discourse in litigation, where parties frequently argue similarities to or differences from previous cases in order to obtain the desired result. Nonetheless, it is a leap of faith to conclude that cases not yielding final opinions—most of which are not even “cases” in the technical sense—mirror those that do.

Selection bias can significantly skew research findings. In the Hall study, for example, 57% of the cases that had definitive outcomes were resolved for the plaintiff.⁷⁰ This may mean that coverage law favors patients over insurers. However, it may equally signify the opposite—that insurers are unwilling to settle a large percentage of valid claims, perhaps because of advantages such as ERISA’s limitations on damages—or a range of intermediate positions.⁷¹ The essential point is to recognize that decided cases are not necessarily representative of the universe of actual and potential disputes.

Even the apparent direction of legal change may be misleading. Henderson and Eisenberg point out that a change in the percentage of cases won or lost by each side explains little; for example, plaintiffs may lose a larger fraction of

67. In a recent General Accounting Office survey of HDC-ABMT for breast cancer, nine of twelve insurers who decided to cover the procedure reported that litigation or the threat of it was a factor in their decision, and five characterized legal concerns as among the most important reasons for coverage. U.S. GAO, HEALTH INSURANCE: COVERAGE OF AUTOLOGOUS BONE MARROW TRANSPLANTATION FOR BREAST CANCER, *microformed on* GA 1.13:HEHS 96-83, at 9 (GAO Documents).

68. Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950 (1979).

69. Lynn Mather, *The Fired Football Coach (Or, How Trial Courts Make Policy)*, in CONTEMPLATING COURTS 179 (Lee Epstein ed., 1995).

70. Hall et al., *supra* note 2, at 1062.

71. Priest and Klein argue that selection bias should result in an approximately 50-50 division among decided cases, which is open to misinterpretation as indicating unsettled law. George L. Priest & Benjamin Klein, *The Selection of Disputes for Litigation*, 13 J. LEGAL STUD. 1, 5-6 (1984). Other researchers have extended this reasoning. For example, Clermont and Eisenberg compared bench trials with jury trials, and concluded that plaintiffs in two areas, product liability and medical malpractice, prevailed at a much higher rate before judges. They hypothesized that when these types of personal injury cases come before judges, defendants are overly confident and decline settlement opportunities, so that plaintiffs win a larger percentage of ultimate judgments. Clermont & Eisenberg, *supra* note 23, at 1162. See also Robert H. Gertner, *Asymmetric Information, Uncertainty and Selection Bias in Litigation*, 1993 U. CHI. L. SCH. ROUNDTABLE 75 (concluding that information asymmetries can explain deviations from the 50-50 rule).

decisions over time because they are bringing more cases in response to a *favorable* change in the law, while defendants are settling weaker cases more frequently and trying only the stronger ones.⁷²

Another important aspect of selection bias is its susceptibility to deliberate manipulation. For example, lower-cost forms of alternative dispute resolution such as mandatory, binding arbitration may be attractive to managed care organizations. However, these methods exist at the sufferance of the legal system, since submitting to binding arbitration implies a waiver of one's right of access to the courts. Balance among outcomes is a superficial indication of impartiality. Planning the organization's settlement strategy to produce an even split in decided cases may convince a reviewing court or legislature that a biased dispute resolution process is in fact fair, and may therefore discourage it from tinkering with or overturning it.

The authors of the Hall study discuss case selection issues in connection with the limited sample size. For example, they point to both long delays in resolution and the fact that the median cost of treatment at issue was between \$10,000 and \$50,000 as deterrents to litigating cases,⁷³ especially since ERISA generally limits damages to the value of the benefit denied.⁷⁴ In addition, they speculate that managed care gives rise to fewer litigated cases because many denials take place at the treating physician or supervising physician level, reducing patients' knowledge of their options.⁷⁵

Recall that the Hall study concluded that whether a case is governed by ERISA is not a significant predictor of outcome.⁷⁶ This finding suggests that another important selection bias may have escaped detection. Of the cases studied, 17% were Medicare, 13% Medicaid, 34% commercial insurance, 18% Blue Cross, 7% self-insured, 3% Taft-Hartley and 7% FEHBP or CHAMPUS.⁷⁷ The authors do not indicate what percentage of the commercial insurance and Blue Cross cases involved insured ERISA plans. Nonetheless, given that nearly half of employers self-insure,⁷⁸ the small number of self-insurance cases indicates

72. James A. Henderson, Jr. & Theodore Eisenberg, *The Quiet Revolution in Products Liability: An Empirical Study of Legal Change*, 479 UCLA L. REV. 479, 502 (1990).

73. Hall et al., *supra* note 2, at 1060.

74. 29 U.S.C. § 1132(a)(1)(B) (1994).

75. Hall et al., *supra* note 2, at 1061. The Hall study recognizes other selection biases as well. For example, the authors interpret the low win rate for patients with life-threatening conditions as evidence that insurers are more cautious about denying coverage to these patients. *Id.* at 1065.

76. On the other hand, the study found that federal appellate jurisdiction and contractually reserved discretion by the insurance plan favor defendants. *Id.* at 1067. These factors are closely linked to ERISA, making it problematic to consider them independent variables.

77. *Id.* at 1061.

78. *Managed Care: HMOs, PPOs, POs Now Cover Majority of Americans in Employer Plans*, 24 Pens. & Benefits Rep. (BNA) 316 (1997). Alternatively, the low percentage of self-insured cases may reflect dilution of the data set by cases from earlier decades when self-insurance was rare.

that ERISA plan beneficiaries are underrepresented in cases resulting in judicial decisions.

If most ERISA cases (or potential disputes) never reach decision, ERISA becomes a very important factor regardless of the outcome of reported opinions. As noted previously, ERISA restricts claims and damages, seldom confers a right to a jury trial, and limits judicial review in many instances.⁷⁹ Anecdotal evidence exists that many complaints are not pursued if defense counsel responds to claims as being preempted by ERISA. This strongly suggests that ERISA is a powerful deterrent to suit, and therefore a predictor of outcome as it should inform public policy.

D. Publication Bias

In addition to selection bias, judicial decisions suffer from reporting bias. Medical researchers are more likely to publish studies establishing causation or clinical benefit than ones demonstrating its absence,⁸⁰ Similarly, judges publish only a fraction of the opinions they write.⁸¹ As a result, legal reporters and on-line databases include a preponderance of rulings containing groundbreaking legal analysis or novel conclusions. Among other things, this tendency can lead legal researchers to overestimate the mutability and drama of the law.

Publication bias can also affect the geographic distribution of cases, which can change modal conclusions regarding the law. State appellate courts vary considerably in their publishing practices. Florida, for example, publishes more than three times as many opinions as California despite its much smaller population.⁸² Overall, state courts are generally more predisposed to publish their holdings than federal appeals courts, which have instituted fairly uniform controls on publication.⁸³

Appellate opinions are most clearly biased in favor of novelty. For example, Rule 53 of the Seventh Circuit Court of Appeals requires published opinions when the decision (i) establishes a new, or changes an existing rule of law; (ii) involves an issue of continuing public interest; (iii) criticizes or questions existing law; (iv) constitutes a significant and non-duplicative contribution to legal literature by a historical review of law, by describing legislative history, or

79. See *supra* notes 14, 23-29, and accompanying text.

80. Publication bias is widely recognized in medical research, where the intellectual (and sometimes financial) appeal of affirmative results leads to a high frequency of false positives in the clinical literature. See Kay Dickersin, *The Existence of Publication Bias and Risk Factors for Its Occurrence*, 263 JAMA 1385 (1990). This induced bias is particularly worrisome in meta-analyses which aggregate prior studies in order to draw statistically significant conclusions. Colin B. Begg & Jesse A. Berlin, *Publication Bias and Dissemination of Clinical Research*, 81 J. NAT'L CANCER INST. 107 (1989).

81. Professor Keeton's advice to new judges is simple: "Write opinions rarely." ROBERT E. KEETON, *JUDGING* 139 (1990).

82. RUGGERO J. ALDISERT, *OPINION WRITING* 13, 13 (1990).

83. *Id.* at 13-26.

by resolving or creating a conflict in the law; (v) reverses a judgment or denies enforcement of an order where the lower court has published an opinion; or (vi) is pursuant to an order of remand from the Supreme Court which is not merely ministerial.⁸⁴ Federal district judges also have discretion to request publication of their opinions in the National Reporter System, which selects cases using similar criteria, with the notable—and similarly bias-inducing—addition of cases with unique or unusual fact patterns.⁸⁵

E. Unstated Rationales

Coverage cases are notorious for results-oriented reasoning. A famous quote from Professor Keeton states that “[j]udicial opinions [in coverage litigation] are less than ordinarily enlightening about principled bases for decision. Often . . . the favorite generalization advanced by outside observers to explain a judgment against an insurance company at variance with policy provisions is the . . . aphorism: ‘It’s an insurance case.’”⁸⁶ Spotting ambiguities in policy language (or creating them) is a favorite pastime of judges in coverage cases, as is questioning the impartiality of plan administrators or allowing hindsight to color judgment. For example, an interesting finding of the Hall study was that patients for whom the treatment in question turned out to be effective were twice as likely to prevail in suits to recover damages for the benefit denial as patients treated unsuccessfully. Hall interprets this as indicating that courts are influenced by the unique attributes of cases they consider.⁸⁷

Opinions are written with many audiences in mind.⁸⁸ Why a court renders

84. *Id.* at 15-17.

85. WEST PUBLISHING CO., PUBLICATION GUIDE FOR JUDGES OF THE UNITED STATES DISTRICT COURTS 2-3 (1994). In addition, on-line services (Lexis and Westlaw) make available various unpublished trial opinions. Unlike unpublished appellate opinions, these may generally be cited as precedent in subsequent litigation.

86. ROBERT E. KEETON, BASIC TEXT ON INSURANCE LAW 341 (1971), *quoted in* Peter Nash Swisher, *Judicial Rationales in Insurance Law: Dusting Off the Formal for the Function*, 52 OHIO ST. L.J. 1037 (1991). Not all commentators are as cynical as Keeton. Swisher, for example, invokes a middle ground between Legal Formalism and Legal Realism to explain judicial reasoning in property and casualty insurance coverage litigation. *Id.* at 1045.

87. Hall et al., *supra* note 2, at 1067. This was true despite the fact that, unlike medical malpractice litigation, causation is not an element of liability in coverage suits. On the other hand, successful treatment implies lower damages, and is often limited to injunctive relief, perhaps making it easier for courts to justify their holdings.

88. According to Leflar, these include posterity, the bar, future judges, the legislature, current and future law students, newspaper readers, the judge himself or herself (to be satisfied with the decision), the parties (especially the loser), and fellow judges (to obtain a majority). Robert A. Leflar, *Some Observations Concerning Judicial Opinions*, 61 COLUM. L. REV. 810, 813-14 (1961). *See also* Ronald A. Cass, *Judging: Norms and Incentives of Retrospective Decision-Making*, 75 B.U.L. REV. 941 (1995) (examining the structural influences on judges’ incentives and behaviors).

a decision and how it explains that decision may therefore differ.⁸⁹ Preserving the legitimacy of the judicial system compels reasoning from interpretive principles, while discouraging results-oriented declarations. As Solan notes, there is necessarily a “gap between decision-making and rhetoric in hard cases,” although difficult decisions emphasize “seemingly scientific and neutral justification[s].”⁹⁰ Supporting this view, surveys of appellate judges frequently yield admissions of conflicts between individual equities or policy considerations and rules of law, although commentators differ as to which holds greater sway.⁹¹ Because some stated rationales are fabrications intended to clothe otherwise naked truth, drawing empirical conclusions from them may be hazardous.

Judges can also avoid hard decisions by retreating into procedural devices. These include mootness, lack of ripeness, lack of adversarialness, non justiciability, lack of standing, failure to exhaust administrative remedies, expiration of limitations periods, or non-compliance with filing requirements.⁹² The Hall study deliberately excluded cases which had been resolved on grounds other than the appropriateness of the treatment rendered.⁹³ However, it is possible that some of the excluded decisions were in fact based on judgments as to appropriateness, but were justified on technical or procedural grounds.

Even if the basis for a decision is not concealed, it may be framed strategically. For example, it is often prudent for a judge to issue as narrow a ruling as possible because the potential consequences of a broader statement are not knowable at the time.⁹⁴ According to Posner, the distinction between holding

89. One piece of evidence for this in coverage litigation is the frequency with which judges disclaim general applicability of their decisions. For example, the court in *Pirozzi v. Blue Cross-Blue Shield* concluded as follows:

Worth noting here is the modest breadth of this decision. It is not a green light signalling a general expansion of coverage under group health policies like the Plan. Rather, this decision is narrowly, but firmly, anchored in the specific expert medical testimony presented and in the terms and structure of the Plan’s experimental exclusion provision. Of course, a different experimental exclusion, or different expert testimony, or a plan that conferred broad discretion on the administrator might well require a different result.

741 F. Supp. 586, 594 (E.D. Va. 1990).

90. LAWRENCE M. SOLAN, *THE LANGUAGE OF JUDGES* 11, 177 (1993).

91. Llewellyn regarded many judicial constructions as merely providing a means to an already determined end, which he viewed as largely derived from “fireside equities.” KARL LLEWELLYN, *THE CASE LAW SYSTEM IN AMERICA* 79 (Paul Gewirtz ed. & Michael Ansaldi trans., 1989). Marvell, on the other hand, concluded that judges place more emphasis on policy implications. THOMAS B. MARVELL, *APPELLATE COURTS AND LAWYERS: INFORMATION GATHERING IN THE ADVERSARY SYSTEM* 144 (1978) (“If you can *achieve* justice in that particular case and still do no violence to the law, I’m willing to go along” was a representative comment.). Which set of concerns prevails may differ between trial and appellate courts. *Id.* at 157-58.

92. Posner, *supra* note 41, at 21.

93. Hall et al., *supra* note 2, at 1057.

94. MARVELL, *supra* note 91, at 223-24.

and dictum buttresses this practice by allowing judges to join opinions with which they do not wholly agree while still not “mortgaging . . . future votes.”⁹⁵ Similarly, judges frequently prefer to be perceived as constrained in their discretion, and therefore write opinions which portray the court as having but a single option.⁹⁶ These proclivities can confound empirical studies which seek to understand the causes underlying judicial outcomes.

IV. WHAT WE MIGHT LEARN FROM JUDICIAL DECISIONS

Despite these limitations, the study of judicial decisions has redeeming qualities. This section describes two ways in which published opinions in coverage cases can help us understand underlying policy issues. One approach is to simplify the empiric inquiry from “what can decisions tell us from their outcomes and reasoning” to “what can decisions tell us from their existence.” This avenue can yield information about disequilibrium and adversarialness in the health care system. A second approach is to use judicial opinions to assess the coverage system’s ability to bring facts under consideration and to assure fair process. These are essential contributors to the overall success of health insurance, and happen to be things that courts do well.

A. Why Courts Get Involved

Even if we cannot learn as much as we might hope from the content and outcome of reported cases, we can certainly glean information from their incidence. One explanation of the fact that coverage decisions have attracted attention is that the number of coverage disputes generating written opinions has increased markedly over the last decade. The Hall study found that the number of reported cases grew from 5 in the 1960s to 36 in the 1970s, 71 in the 1980s, and 200 in the 1990s.⁹⁷ Determining why judicial activity is on the rise may yield important insights into the health care system.

Courts may become active because circumstances are changing and a large number of individuals are aggrieved by the changes. For example, although Llewellyn regards most judicial outcomes as idiosyncratic, he admits that an accumulation of cases favoring one side may induce a shift of the underlying legal rule. He describes this as the result of “a newly emerging consortium of interests pressing hard against an outdated, maladaptive legal norm.”⁹⁸

95. Posner, *supra* note 41, at 20-21. It is not clear how the Hall study treated dicta, or even whether it identified them.

96. SOLAN, *supra* note 90, at 185. Posner calls this the “theory of power without responsibility.” Posner, *supra* note 41, at 20.

97. Hall et al., *supra* note 2, at 1060. The last figure was based on a linear extrapolation of cases from 1990 to 1994. Of course, the number of reported opinions in other areas of law has also increased during this period.

98. LLEWELLYN, *supra* note 91, at 100. One might ask whether these interests are deliberately bringing cases to the attention of courts. Neither malpractice nor coverage has spurred much “impact litigation,” in large part because the rewards for individual litigants and their counsel

The rapidity of change in the health care system during the recent transition to managed care is self-evident. Major factors include employer-driven cost constraints, federal budgetary retrenchment, and the integration and consolidation of insurance and provider organizations. Earlier transitional periods and their effect on coverage litigation also may be identifiable. For example, increases in reported decisions during the 1970s and 1980s may be related to the impact of new technologies on established underwriting practices and principles of insurance interpretation.

Another possibility is that the health care system is simply becoming more adversarial. In this view, not just the existence of change but its direction promotes litigation. In today's health care system, the erosion of trust produced by the inversion of financial incentives from fee-for-service practice to managed care happens to coincide with a general increase in the aggressiveness of medical consumerism. However, a judicial model of medical decision making is a radical departure from professional traditions in health care, and may have important implications for quality of care and patient satisfaction.

An increase in judicial decision making might also represent an alternative to legislative change. Courts have a recognized role in public policy making.⁹⁹ In product liability law, for example, Eisenberg and Henderson speculate that tort reformers failed in their legislative agenda, but still convinced individual judges that reform was needed, as demonstrated by declining plaintiff success rates through the 1980s.¹⁰⁰ In insurance coverage, one wonders whether concerns about cost, or more recently about the excesses of managed care, may have prompted judicial activism during periods of legislative inertia. For example, we know that federal ERISA law has limited state legislative intervention.¹⁰¹

In keeping with the earlier discussion of selection and publication bias, however, we should resist the temptation to assume that an increase in reported cases necessarily equates with an increase in underlying disputes. Nonetheless, because many state HMO and insurance regulators now require managed care organizations to maintain records of complaints and grievances, the hypothesis should be verifiable. Moreover, describing the sources of selection, publication, or other biases, should they exist, might be as revealing as confirming their absence.¹⁰²

are usually sufficient to ensure frequent judicial review.

99. Mather has identified several aspects of policy making in which courts engage: agenda setting, providing a forum for political argument, agenda building, mobilization of support or opposition, definition of local legal norms, creation of new legal norms, political symbolism and provision of political or legal resources. Mather, *supra* note 69, at 179.

100. Theodore Eisenberg & James A. Henderson, Jr., *Inside the Quiet Revolution in Products Liability*, 39 UCLA L. REV. 731, 751-54 (1992). The authors exclude shifts in accident trends, in the propensity to file claims and in settlement behavior as causes of the decline.

101. ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ." 18 U.S.C. § 1144 (1994).

102. These might include, for example, the tension between managed care organizations' concern about the public relations effect of high-profile litigation and the deterrent to settlement

B. How Courts Assess Non Judicial Processes

A supportable assertion about reported decisions in coverage cases is that virtually all underwent other levels and forms of review or appeal prior to litigation. Judicial proceedings might therefore shed light on the success or failure of these non judicial processes.

A correlate of the infrequency with which legal precedent is established in coverage litigation is the centrality of facts to the outcome of cases. Although concern about facts is a defining feature of health insurance coverage cases, it is also a staple of litigation in general. In the words of former U.S. Supreme Court Associate Justice Robert H. Jackson,

It may sound paradoxical, but most contentions of law are won or lost on the facts. The facts often incline a judge to one side or the other. A large part of the time of conference is given to discussion of facts, to determine under what rule of law they fall. Dissents are not usually rooted in disagreement as to a rule of law but as to whether the facts warrant its application.¹⁰³

An important lesson to be drawn from coverage decisions is that fact-finding in modern health care is extremely difficult. For one thing, medical science is generally complex and frequently uncertain. For another, the restructuring of provider organizations in managed care, and the associated financial incentives, have arguably diminished the availability and credibility of information. Therefore, we may be able to learn from judicial decisions how information regarding coverage and care is being shared—or withheld—in managed care organizations. Because accurate, abundant information is central to the long-term success of the health care system, understanding the judicial critique of the mechanism by which information is generated and exchanged in the coverage context could be valuable.¹⁰⁴

A second lesson relates to procedural fairness. Resource allocation is a critical subtext of insurance coverage litigation. Despite the contractual heritage of health insurance, the litigants and the judicial system are fully cognizant of the social implications of coverage determinations in terms of the cost and equitable distribution of health care.¹⁰⁵ Therapeutic health care is a difficult area for regulation in large part because lives seem more “identified” than “statistical.”

produced by limitations on damages under ERISA.

103. MARVELL, *supra* note 91, at 139.

104. There is an important relationship between disclosure in the context of coverage for experimental treatment and medical informed consent. See Nancy M.P. King, *Experimental Treatment: Oxymoron or Aspiration*, HASTINGS CENTER REP., July-Aug. 1995, at 6.

105. This sets coverage cases apart from medical malpractice cases. Except for concerns about the cost and efficiency of litigation as a method of dispute resolution, medical malpractice is not generally viewed as an issue of resource constraints. Either a treatment was delivered in accordance with the professional standard of care or it was not, and cases are independent of one another.

In such situations, a finding in favor of coverage allows the question of the marginal value of life to be neatly avoided.¹⁰⁶

Fairness is a prerequisite to resource allocation, and legal process is the principal guardian of fairness in democratic society. Another important reason to look at judicial decisions as a benchmark for the health care system is therefore that courts are well equipped to evaluate procedural fairness.¹⁰⁷ Judges in coverage cases are suspicious of decisions rendered without due process, and respond favorably to adequate procedural protections for patients and policyholders.¹⁰⁸ Judges' thresholds for procedural fairness are especially high in cases involving preauthorization of services for severe disease, with denial of coverage unlikely unless due process has been scrupulously observed.

We can therefore learn from judicial decisions how well private processes are operating, notably the manner in which coverage standards are developed and the conduct of individual inquiries and appeals. The increase in managed care enrollment by Medicare and Medicaid patients will add to courts' involvement in procedural review,¹⁰⁹ because government programs are subject to more extensive due process requirements than are private parties.¹¹⁰

CONCLUSION: CHARTING A RESEARCH AGENDA

A systematic way to approach empirical research is to identify the policy implications of coverage standards and formulate testable hypotheses. In medical malpractice, for example, the objectives of the tort regime are generally characterized as victim compensation and injury reduction. Health insurance presents a different set of policy concerns. Useful studies will assess the impact of contractual coverage standards (and legislative interventions regarding coverage) on measures such as administrative expenses, health care premiums,

106. Coverage litigation highlights the distinction between statistical lives and identified lives in our approach to valuing risks. A significant subset of reported coverage decisions involve high-cost therapies for life-threatening conditions. When risk estimated *ex ante* is converted into loss incurred *ex post*, and the loss involves human life, it is easy to second guess the earlier valuation.

107. Keeton observes that "good" judges are good because they are skilled at making hard decisions, not because their reasoning is always a model of logic. KEETON, *supra* note 86, at 2.

108. The Hall study did not identify a statistically significant correlation between internal process and case outcome, possibly because of small sample size. See Hall et al., *supra* note 2, at 1065-66. The authors have reported elsewhere, however, that courts' objections to internal technology assessment by insurers tended to focus on insufficient or poorly matched sources of information, lack of expert review, concern about financially motivated bias, and lack of current information about clinical benefit. Mark A. Hall et al., *When Courts Review Clinical Practice Guidelines*, MED. CARE (forthcoming 1998).

109. See *Grijalva v. Shalala*, 946 F. Supp. 747 (D. Ariz. 1996).

110. See *Shelley v. Kraemer*, 334 U.S. 1, 13 (1948) (The Fourteenth Amendment "erects no shield against merely private conduct."). However, when a private party's conduct has sufficiently received the imprimatur of the State, it may be deemed state action for purposes of the Fourteenth Amendment. See, e.g., *Flagg Bros. v. Brooks*, 436 U.S. 149 (1978).

medical innovation, patient satisfaction, and health outcomes. For example, the Institute of Medicine estimates that insurers deny only one or two percent of claims, while a much greater amount of care is unnecessary and diverts resources from other areas.¹¹¹ Because of the social as well as individual implications of insurance, these are weighty issues.

A threshold question with analogies to medical malpractice is whether courts are reaching efficient and accurate results.¹¹² For example, Sykes criticizes laws generally allowing “bad faith” claims against insurers because he believes that courts are seldom able to accurately distinguish opportunistic behavior from genuine and reasonable disputes.¹¹³ In health insurance cases, it will be important to assess the degree of correlation or mismatch between valid claims and coverage cases filed, and between valid claims and relief granted.¹¹⁴ At least for cases involving “medical necessity,” some objective scientific determination should be possible. Further studies will explore the cost of grievances and appeals, whether conducted internally to the health plan, through an independent review organization or via the courts.

The pace and direction of research will respond to political constituencies as well as to the interests of academics, and grantmaking bodies will undoubtedly react to both policy and political imperatives. For example, the medical malpractice research agenda of physicians has generally been more focused than that of consumers or attorneys.¹¹⁵ Consequently, more study has been devoted to the cost of malpractice litigation (groundless claims, administrative expense and defensive medicine), than to quality of care (the amount of substandard practice and the deterrent effect of litigation) or access to compensation for negligent injury. Political interests in health insurance will probably be dominated by taxpayers concerned about government expenditures under Medicare, large employers seeking to reduce benefit costs and, more likely than

111. See also Julie A. Jacob, *Managed Care Denials Less Frequent Than Expected*, AM. MED. N., Dec. 15, 1997, at 5 (describing recent studies).

112. There have been simple studies reviewing contractual exclusions and assessing the consistency of treatment of similarly situated individuals, but none has aggregated a large amount of data or drawn statistical rather than anecdotal conclusions. The Hall study included as an explicit goal measuring the potential for inconsistency in judicial decisions, but was hampered by small sample size. Hall et al., *supra* note 2, at 1056, 1058.

113. Alan O. Sykes, “Bad Faith” Breach of Contract by First-Party Insurers, 25 J. LEGAL STUD. 405 (1996).

114. Cf. Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 N. ENG. J. MED. 1963 (1996) (finding that severity of disability, not occurrence of adverse events during medical care or related negligence, is predictive of plaintiff recovery for medical malpractice); A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence*, 325 N. ENG. J. MED. 245 (1991) (finding gross mismatch between negligent care and filing of medical malpractice claims).

115. One reason malpractice reform is so important to physicians is because they suffer large psychic damages from litigation which are not compensated by insurance. Kessler & McClellan, *supra* note 52, at 357.

not, trial lawyers hoping to exploit the vulnerability of corporate organizations to legal claims. Recent recommendations of the President's Advisory Commission on Consumer Protection and Quality in managed care—including comprehensive procedures for internal and external review of coverage denials—have already prompted advocacy-based research on their likely cost.¹¹⁶

Managed care organizations will sponsor technology assessments and cost-effectiveness studies, as will academic health centers and pharmaceutical companies. Employers and other group purchasers will demand statistical proof from insurers and risk-bearing providers that they are receiving value for money, and will probably be compelled under ERISA to communicate this information to beneficiaries. Most importantly, government will mandate reporting by the full range of regulated entities, and will make that information available to researchers. Notably, the expansion of Medicare and Medicaid managed care will expand federal data collection to monitor cost, access and quality in insured systems, and to detect and deter fraud. All of this information will shed light on coverage standards and the processes for making coverage decisions and resolving disputes.

A caveat is that much of this research may not be a planned element of health insurance regulatory design so much as a by-product of data produced for other purposes. This is certainly true in other areas of health law. For example, the existence of comprehensive Medicare data allowed researchers to estimate defensive medicine by linking restrictions on medical malpractice litigation to service utilization.¹¹⁷

Although no one can predict exactly how the research agenda will evolve, it is virtually certain that we will witness an extraordinary expansion of empirical work on health insurance coverage over the next few years, much of it based on information extending well beyond judicial opinions. The simple reason is that the stakes—for identifiable constituencies and for society as a whole—are higher than ever before. Higher stakes provoke interest in promoting or resisting change, and greater interest generates data.¹¹⁸ Our challenge is to interpret those data correctly, and to apply the results responsibly.

116. See *Gauging Quality Regulation's Impact on Premium Costs*, MED. & HEALTH, Nov. 24, 1997, at 1; see also *Consumer Bill of Rights and Responsibilities* (visited Nov. 1997) <<http://hcqualitycommission.gov>>.

117. Kessler & McClellan, *supra* note 52.

118. Of course, there may be political issues, such as abortion, in which the stakes are too high and positions too polarized to admit research.