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A NATIONAL HEALTH CARE PROGRAM: WHAT ITS EFFECT WOULD BE ON AMERICAN TORT LAW AND MALPRACTICE LAW

Gary T. Schwartz†

At a conference at the University of Hawaii in March 1992, I predicted that by the end of the century the United States would adopt a national health program.¹ My prediction stemmed not from any assumption on my part that Bill Clinton would become the next president,² but rather from my assessment of public attitudes about health care. By the early 1990s the vast majority of Americans were protected by health insurance. My sense was that a broad consensus had emerged within public opinion, Democrats and Republicans alike, that it is awful to face without insurance the massive bills produced by modern medicine, and even more awful for Americans to be denied needed health care because of a lack of insurance or wealth.³ Such a consensus can easily foster legislation.

As it happens, most of the predictions I venture turn out to be without any merit. Yet this prediction has proved to be at least quite interesting. Over a year ago the President announced his own health plan. At first its chances of enactment seemed reasonably good. Nonetheless, after extensive discussions and politicking the plan was essentially rejected by Congress. Congress also considered a variety of other proposals, including the Chaffee plan, the Cooper plan, and the Mitchell plan. Time eventually ran out for any congressional action last term. This term will probably see Congress seriously considering bipartisan, mainstream proposals that would significantly extend the availability of insurance and hence move in the general direction of universal coverage. Just as limited congressional civil rights initiatives in 1957 and 1960 set the stage for comprehensive civil rights legisla-

† Professor, UCLA School of Law. Thanks to Samantha Ravich, Tom Rice, Elizabeth Wehr, and Paul Weiler.

¹ Gary T. Schwartz, *Synthesis & Prospects: Concluding Remarks by the Participants*, 15 U. HAWAII L. REV. 524, 784, 787 (1993).

² At the time, Clinton had the lead in the race for the Democratic nomination. But all Democrats were then running second to the incumbent Republican; and Ross Perot was rapidly gaining ground.

³ A week after the Cornell conference, polls showed that public opinion was divided on the Clinton health plan itself. But a huge majority of the public—82%—regarded it as “very important” that “every American receives health insurance coverage.” Adam Clymer, *Poll Finds Public Is Still Doubtful Over Costs of Clinton Health Plan*, N.Y. TIMES, Mar. 15, 1994, at A1, B8.

tion in 1964 and 1965, so a moderate health care bill in 1995 might be the precursor of more dramatic reform in subsequent years.

Accordingly, it makes good sense for a torts scholar like myself to assess what the impact of a national health care program would be on American tort law. This Article first considers how the health care benefits afforded by such a program should be accommodated or coordinated with personal-injury tort awards: that is, what happens to the collateral source rule? The Article concludes that the collateral source rule in the traditional form is untenable: Unless a strategy of subrogation can be rendered feasible, the rule should be abrogated in its application to health care benefits. Next, the Article ponders how the adoption of a national health care program would affect the claiming patterns of tort victims, the attitudes of tort juries in deciding cases, and the development by judges of tort doctrine. Given the foreseeable effects, such a program, in achieving health care reform, could also bring about tort reform, restraining the scope and cost of the overall tort system.

Finally, the Article looks at the particular problem of medical malpractice. The Article ignores the specific restrictions on malpractice claims that various congressional proposals would impose. Most of these restrictions are commonplace in state malpractice statutes, and have been extensively studied by others. Instead, the Article assesses how a national health care program would affect the entire economic and legal environment within which instances of medical malpractice occur. In the modern era, the combination of traditional medical ethics and extensive fee-for-service health insurance has probably elevated the malpractice standard of care to a level higher than that authorized by the Learned Hand test. A national health care program, by accelerating the trends toward cost containment in general and health maintenance organizations in particular, might succeed in bringing the malpractice standard down to a proper Learned Hand level. In addition, insofar as a national program would accelerate those trends, that program would tend to affirm a new function for the malpractice tort: that of offsetting the incentives for malpractice-like underutilization that cost containment arrangements can entail. Eventually, however, a national program might eclipse the traditional malpractice tort in many settings by subordinating state malpractice actions to new federal statutory standards.

I

THE COLLATERAL SOURCE RULE AND THE COORDINATION OF
HEALTH CARE BENEFITS WITH TORT AWARDS

In the modern era, half or more of tort awards relate to pain and suffering, while the remainder compensate for economic costs.⁴ Of the latter, perhaps sixty percent go for income losses, while forty percent arise from the costs of medical care.⁵ If a national health care program is enacted, any accident victim would be entitled to that program's insurance benefits. How should those benefits be accommodated with the medical-expense portion of personal injury awards? This is an essential question, which could be answered in one of three ways.

A. Three Policy Alternatives

One option is to have no coordination at all: the victim can promptly receive health insurance benefits and can later recover their fair-market value in a tort suit. This, of course, is the practice of non-coordinating duplication that is embodied in tort law's traditional collateral source rule.

Second, the collateral source rule could be abolished in favor of recognizing the primacy of health insurance. That is, the victim's health care expenses could be covered exclusively by health insurance, with no additional tort recovery for the same expenses. As part of tort reform, the collateral source rule has by now been abolished in several states.⁶

Third, tort law could be recognized as the exclusive remedy—with health insurance bowing out when the victim's medical needs result from a defendant's tortious conduct. To be sure, tort recoveries are both chancy and delayed in a manner that makes this option seem unattractive. Yet there are ways to implement the option that would avoid this problem. For example, the victim could receive medical benefits under health insurance, but the health insurer could then be given a subrogated cause of action against the tortfeasor. Alterna-

⁴ This statement is based on a study of New York State jury verdicts prepared by Judith W. Pendell and John R. Evancho of the Aetna Life and Casualty Company. This study was presented at a conference on Civil Justice Reform in the 1990s held at the New York University Institute of Judicial Administration on October 15, 1993. The papers from that conference, including a revised version of the Aetna study, will be published by the NYU Press.

⁵ Firm data on the internal allocation of tort awards for economic losses are not available. Workers' compensation reimburses for both medical expenses and income losses. Currently, health care accounts for about 41% of all workers' compensation awards. See John F. Burton, Jr., *National Health Care Reform and Workers' Compensation*, in JOHN BURTON'S WORKERS' COMPENSATION MONITOR, Nov./Dec. 1993, at 1, 3.

⁶ See FOWLER V. HARPER ET AL., THE LAW OF TORTS 194-98 (2d ed. Cum. Supp. 1 vol. 4 1994).

tively, the victim could secure a full tort recovery from the negligent defendant, but could then be required to reimburse the health insurer for health service costs earlier provided. Whether the particular technique is subrogation or reimbursement, the victim is denied a double recovery and ultimate liability is placed on the tortfeasor rather than the health insurer.

To illustrate the option of subrogation, consider workers' compensation, which from one perspective can be seen as an insurance scheme arranged by employers to benefit employees. The employee injured on the job by the tortious conduct of some third party can secure immediate reimbursement for her medical bills from the employer; but the employer can then bring its own subrogated suit against the third party, can intervene in the employee's tort suit, or can secure a lien against the employee's tort recovery.⁷ Another illustration of subrogation is afforded by the Federal Medical Care Recovery Act, adopted in 1962, which specifies that whenever the federal government is "authorized or required by law" to furnish medical services to a person injured by a third-party tortfeasor, the government "shall have a right to recover from [the] third party" for the services' reasonable value.⁸ This statute is often applied once the federal government has provided health care to injured veterans.⁹ Medicaid, which finances health care for the very poor, consists of programs administered by states under federal supervision. In recent months, the programs in Florida, Mississippi, and West Virginia have filed suit against major tobacco companies, seeking reimbursement for program outlays attributable to diseases allegedly caused by the companies' tortious conduct.¹⁰

To recap, the available policy options are the retention of the collateral source rule, the outright abrogation of the rule, or recogni-

⁷ See, e.g., CAL. LABOR CODE §§ 3850-64 (West 1989).

⁸ See 42 U.S.C. § 2651 (1988).

⁹ *E.g.*, *United States v. Theriaque*, 674 F. Supp. 395 (D. Mass. 1987). However, the Federal Social Security Disability Insurance program is lacking in any statutory provisions authorizing subrogation. See OFFICE OF TECHNOLOGY ASSESSMENT, IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS 35 (1993).

The federal Medicare program contains provisions which supersede the standards set forth in 42 U.S.C. § 2651. See *infra* note 27.

¹⁰ In Mississippi the state's suit is based on the state's understanding of common-law principles of subrogation. Telephone Interview with Tray Bobinger, Special Assistant to the State's Attorney General (Aug. 2, 1994). In 1994, Florida enacted legislation enabling the state's Medicaid program to secure reimbursement from tortfeasors. The Florida statute evidently requires the state to prove the tortious conduct of tobacco companies and other defendants; yet the statute professes to eliminate affirmative defenses such as assumption of risk and comparative negligence. See FLA. STAT. § 409.910, as amended, ch. 94-251 (1994).

Subrogation in California Medi-Cal is provided for by CAL. WELFARE & INST. CODE § 14134.71(a) (West 1991).

tion of subrogation¹¹ as an alternative to the rule. When the tort claim is for malpractice, the Clinton bill took a clear position: the option of abrogation would become the law.¹² The victim's medical expenses would be covered by health insurance, the victim would not recover those expenses in a later malpractice action, and the health insurer would not have a subrogated claim against the party guilty of malpractice.¹³ Malpractice aside, the Clinton bill acknowledged the general problem of coordination by calling for a Commission on Integration of Health Benefits. This Commission would have studied "the feasibility and appropriateness of transferring financial responsibility for all medical benefits . . . to health plans."¹⁴ One job of the Commission, then, would have been to consider whether the collateral source rule as applied to health care benefits should be abolished for all cases of tort liability.

Of course, the collateral source rule is a creature of state law. Even if a national commission recommends no federal action to displace the rule, state lawmakers—both legislators and judges—would presumably remain free to decide whether state law should accept the collateral source rule as applied to health care benefits covered by any new national program. Accordingly, my discussion of the rule here has two audiences: a prospective national commission and state lawmakers themselves.

B. Evaluating the Alternatives

Evaluation begins by considering the availability of insurance in the nineteenth century, when American courts first adopted the rule.¹⁵ Markets for first-party insurance were only then developing. Only a few plaintiffs were protected by health insurance, disability insurance, or life insurance. From the defendant's perspective, the presence of insurance for the victim was a genuine fortuity, and the presence of high policy-limits insurance was even more fortuitous. In these circumstances, the core common-sense fairness ideas supporting the collateral source rule were quite strong. Insurance was entirely a matter of individual choice; most plaintiffs declined to exercise that

¹¹ For convenience in exposition—and in line with common legal parlance—this Article will now employ the term "subrogation" to refer to both subrogation and reimbursement, since their outcomes are essentially the same. Technically, reimbursement is a supplement to the collateral source rule, while subrogation can be seen as an alternative to the rule.

¹² S. 1757, 103d Cong., 1st Sess. § 5305(1) (1993).

¹³ The Clinton bill also addressed the coordination of health care benefits and workers' compensation. This coordination issue is considered by another article in this symposium. See Debra T. Ballen, *The Sleeper Issue in Health Care Reform: The Threat to Workers' Compensation*, 79 CORNELL L. REV. 1291 (1994).

¹⁴ S. 1757, 103d Cong., 1st Sess. § 10201(c) (1993).

¹⁵ See, e.g., *Harding v. Town of Townshend*, 43 Vt. 536 (1871).

choice; those who did buy insurance were behaving in a distinctly thrifty way and were paying for insurance directly out of their own pockets.

Compare this to the situation of collateral sources in the last decades of the twentieth century, when many jurisdictions reconsidered the collateral source rule. Most of the disability insurance that currently protects Americans is provided to all or most Americans as a matter of federal law or other collective practices. Social Security Disability Insurance (SSD), financed by the Social Security payroll tax, covers all Americans who, having spent a certain number of years in the workforce, are then totally disabled for a period of at least a year; Supplemental Security Income (SSI) provides means-tested benefits to other Americans who suffer total disability.¹⁶ Short-term disability insurance is generally provided not by individual policies, but rather by employers through sick-leave programs, and by public programs in several states.¹⁷

As far as health-care expenses are concerned, only about one-eighth of the population is without health insurance, although an additional two-ninths have insurance policies with "inadequate" coverage.¹⁸ Put more affirmatively, about sixty-five percent of the population have extensive health insurance, and over eighty-five percent have health insurance in some form. That is, health insurance, while by no means universal, has become very common. Moreover, for most of those insured, the protection of insurance is not really a matter of individual choice, thrift, and expense. Older Americans' health insurance is provided by the federal government by way of Medicare; the Medicaid program affords health insurance for low-income welfare recipients.¹⁹ For most other Americans with health insurance, it is provided by employment-based group plans.²⁰ Moreover, employer furnished group health insurance is not simply a matter of bargaining between employer and employees. Rather, that insurance tends to result from a large federal subsidy. Although the money the employer pays for employee health insurance coverage is essentially income that the employer furnishes to employees, the federal Internal Revenue Code declines to recognize this as taxable in-

¹⁶ See Kenneth Abraham & Lance Liebman, *Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury*, 93 COLUM. L. REV. 75, 83-85 (1993).

¹⁷ See STEPHEN D. SUGARMAN, *DOING AWAY WITH PERSONAL INJURY LAW* 130 (1989).

¹⁸ See Abraham & Liebman, *supra* note 16, at 81-82.

¹⁹ *Id.* at 83.

²⁰ *Id.* at 80 n.16.

come.²¹ The Code hence makes health insurance a cheap way for employers to provide important income-like benefits to employees.

On balance, then, high levels of health insurance and moderate levels of disability insurance are now common practices rather than exceptions. Moreover, this insurance is provided collectively rather than through individual choice; indeed, much of this insurance is either provided directly by government or promoted by strong government subsidies. As noted, the circumstances surrounding collateral sources in the nineteenth century gave the collateral source rule an enormous commonsense appeal. Dramatic changes in those circumstances by the late twentieth century have resulted in a loss of much of that appeal. What remains would be eroded even further were health insurance to become a right guaranteed by federal law to all Americans and financed primarily by employers and the federal government.²²

In light of this analysis, note the special case of life insurance. Though many states in recent years have abrogated the collateral source rule, these abrogations have typically excluded life insurance.²³ Similarly, the Clinton medical malpractice proposal would have abrogated the collateral source rule in its application to disability insurance and health insurance—but not life insurance.²⁴ Why should life insurance be excluded from these abrogations? At least one explanation is that life insurance continues to be acquired in accordance with nineteenth-century norms.²⁵ Many people purchase life insurance, but others do not. Even for those who do buy life insurance, the face amount varies dramatically from policy to policy, and remains a mat-

²¹ See I.R.C. § 106(a). This federal policy dates back to a 1943 special ruling by the Internal Revenue Service. Ronald J. Vogel, *The Tax Treatment of Health Insurance Premiums As a Cause of Overinsurance*, in NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER? 220, 223 (Mark V. Pauly ed., 1980). In 1982, the “cost” to the federal government of this tax exemption exceeded the federal government’s expenditures for Medicaid. See Charles E. Phelps, *Tax Policy, Health Insurance, and Health Care*, in MARKET REFORMS IN HEALTH CARE 198, 200 (Jack A. Meyer ed., 1983).

²² Granted, a tax or fee imposed on employers might, as a matter of “incidence,” back up and be paid by employees, at least in part. Yet all the various proposals for a national health program would preserve much of the important federal tax subsidy. (For discussion of the consensus in favor of this subsidy, see Michael Kinsley, *Share the Health*, NEW YORKER, July 11, 1994, at 42, 48-49.) Moreover, most of the proposals recently considered by Congress offered generous subsidies to low-income consumers and to small businesses which would purchase insurance for their employees.

²³ 2 ALI REPORTERS’ STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 166 (1991). That is, even after abrogation, if the victim of a fatal accident is covered by a life insurance policy, his family receives the proceeds of that policy, and can then recover in full in a wrongful death action against any tortfeasor.

²⁴ S. 1757, 103d Cong., 1st Sess. § 5305 (1993).

²⁵ Another explanation is that a “whole” life insurance policy is a mixture of pure insurance and a savings plan. Yet “term” life insurance, which also is quite common, is insurance plain and simple.

ter of individual choice.²⁶ Furthermore, the cost of a life insurance policy—including a policy with a high level of coverage—is borne by the individual who purchases the policy. That we preserve the collateral source rule in its application to life insurance suggests that when collateral sources adhere to nineteenth-century norms we continue to find the rule attractive. Yet the rule appears quite odd when society's institutions provide insurance-like benefits to all or most persons without much regard to individual choice and at little or no explicit individual expense.

One illustration of the latter point is the federal Medicare program, which does not allow double recovery by the accident victim. Rather, Congressional amendments render Medicare a "secondary payer"; Medicare does not reimburse health care expenses that have already been paid for (or are expected to be paid for) by "liability insurance" including "self-insur[ance]."²⁷ Illustrating the point in a somewhat different way is the status of the collateral source rule in certain foreign countries, such as England and Sweden.²⁸ In these countries, the rule remains in effect for individually purchased collateral sources, such as life insurance. But the rule is given a restricted scope: it tends not to apply to benefits that are provided to most citizens by national programs or other collective arrangements.²⁹ Thus in England the accident victim who has been treated by the National Health Service cannot recover in tort for the fair market value of that treatment;³⁰ nor can the Swedish victim who has received medical services from that country's social insurance program.³¹

As applied to collateral sources such as a national health care program, then, commonsense notions of fairness fail to support the collateral source rule,³² and the rule is increasingly rejected in foreign legal systems. Even so, the rule can be defended on grounds of deter-

²⁶ Social Security survivor's benefits are essentially a substitute for the retirement benefits that the wage-earner would have been entitled to had he or she survived.

²⁷ 42 U.S.C. § 1395(b)(2)(A)(ii) (1988 Supp. IV).

²⁸ See generally PETER CANE, *ATYAH'S ACCIDENTS, COMPENSATION, AND THE LAW* 325 (5th ed. 1993); Gary T. Schwartz, *Product Liability and Medical Malpractice in Comparative Context*, in *THE LIABILITY MAZE* 28, 74-75 (Peter W. Huber & Robert E. Litan, eds., 1991); Patricia M. Danzon, *The Swedish Patient Compensation System: Lessons for the United States*, 15 J. LEGAL MED. 199 (1994).

²⁹ See CANE, *supra* note 28, at 324-30; Danzon, *supra* note 28, at 213 & n.41.

³⁰ See JOHN G. FLEMING, *THE LAW OF TORTS* 246 (8th ed. 1992).

³¹ See Danzon, *supra* note 28, at 202, 213-22.

³² Moreover, in these situations even more elaborate theories of justice provide the rule with little or no support. Consider Jules Coleman's recent account of corrective justice. According to Coleman, to the extent that society adopts social-welfare programs that compensate for losses, principles of corrective justice do not impose on the tortfeasor any obligation to afford a second round of compensation. JULES L. COLEMAN, *RISKS AND WRONGS* 403-04 (1992). Coleman derives from this particular finding an "inescapable truth about corrective justice": that it is "conditional" on a variety of "social, political and legal practices." *Id.* at 404.

rence. To fully deter parties who might engage in tortious behavior, those parties should be required to confront liability for all the costly consequences of their tortious conduct. If, for example, the typical injury caused by a defective power tool results in \$4000 in medical expenses, \$6000 in lost income, and \$10,000 in pain and suffering, a tort regime that imposes liability for only \$16,000 would run the risk of losing twenty percent of its deterrence efficacy.

Of course, full deterrence could also be achieved by the third option: allowing the victim to collect exclusively from her health insurer and then giving that insurer a subrogated cause of action against the tortfeasor. This arrangement looks like it could achieve the best of all possible worlds. The victim receives full (but not double) compensation; for the sake of deterrence the tortfeasor bears full liability; and in a competitive market the revenue derived from subrogation requires the health insurer to reduce the price of the insurance policies it offers.

In evaluating the subrogation option, one needs an estimate of how much deterrence in fact would be lost if the liability of tortfeasors were reduced by (say) twenty percent. At this point, the economists' models should be supplemented by a realistic and perhaps skeptical appraisal as to how much deterrence the current tort system actually provides.³³ Moreover, evaluation of the option should also acknowledge that subrogation carries with it a considerable overhead, the cost of which must be debited against whatever the deterrence advantages of subrogation might be. Indeed, these overhead costs are sometimes prohibitive, persuading insurers to make no effort to enforce their subrogation rights.

Emphasizing all the practical problems that surround subrogation, the recent ALI Reporters' Study rejected it as a solution to the problem of collateral sources.³⁴ According to the study, subrogation generally does not work now, and cannot be "rehabilitated" to work in the future. Yet here the study seems unduly to limit its horizons, because experience shows that subrogation functions well in some contexts. For example, as noted above, the California employer who has paid an injured employee in workers' compensation can then proceed against a third-party tortfeasor by way of subrogation. When I ask lawyers whether employers exercise their rights, I am told they do so "all the time."³⁵ Though the law relating to subrogation is complex,³⁶

³³ My own views on this point are set forth in Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377 (1994).

³⁴ 2 ALI REPORTERS' STUDY, *supra* note 23, at 170-71, 177-80.

³⁵ Telephone Interview with Leonard Mandel (Apr. 27, 1994).

³⁶ In California, for example, there are complicated rules under which the employer's subrogation rights are scaled down to the extent that its negligence contributed to the worker's injury. *Arbaugh v. Proctor & Gamble Mfg. Co.*, 43 Cal. Rptr. 608 (Ct. App. 1978).

these complexities are simply absorbed into the thriving litigation practice. Another example of subrogation in action is provided by auto property-damage cases. Take the automobile accident in which A negligently damages B's car, and A is then slow in acknowledging his fault. When this happens, B can collect from her own collision insurer, and that insurer can then bring a subrogation claim against A and A's liability insurer. In fact, these subrogation claims are routinely asserted. The regional office of State Farm, one of southern California's major auto insurers, includes a formal "Subrogation Department." Most of the time, I am told, subrogation functions smoothly; only in a minority of cases do "things get pretty involved."³⁷

Admittedly, there are special features about auto accidents and workers' injuries that contribute to the administratability of subrogation. From information on the claim form the collision insurer receives from its insured, the insurer can usually figure out whether there is some third-party motorist who would be a good target for a subrogation claim. Moreover, the companies that write collision insurance policies also write liability insurance policies. All auto insurance companies thus stand on equal footing; each can be on either side of a subrogation claim. Given this equality of interest, the major auto insurers in southern California have been able to enter into an "intercompany arbitration agreement" that enables them to resolve in a low-cost way particular subrogation claims that prove difficult to settle.³⁸ As far as workers' compensation is concerned, an employer's stake in subrogation is especially large, since the employer bears liability for both health care costs and income indemnity. Moreover, the employer, unlike a mere health insurer, has immediate knowledge of the circumstances of the accident, since the accident happens on the job site and must be reported by the employer for purposes of workers' compensation. Additionally, when the possible third-party tortfeasor is a product manufacturer, the employer also knows the product: the employer originally purchased the product from the manufacturer.

While acknowledging these special features, one can still say that the ALI Reporters' Study was premature in writing off as usually impractical the subrogation alternative. Indeed, the foreign experience with subrogation seems promising. In Germany, a large percentage of all tort claims are brought against defendants by insurance companies and social-security agencies that provide benefits to victims under national mandates.³⁹ In the Canadian province of Alberta, all hospitals are part of a public hospital system, and Alberta's hospital legislation

³⁷ Telephone Interview with Glen Linton (Apr. 20, 1994).

³⁸ *Id.*

³⁹ See B.S. MARKESINIS, *THE GERMAN LAW OF TORTS* 670-71 (2d ed. 1991).

gives this system a subrogated claim against the tortfeasor who has injured the patient. These claims, I learn, are "routinely" asserted, with "little apparent hassle."⁴⁰ This experience in Alberta seems especially relevant because it is close to home, and close to health insurance as well.

But foreign successes may not be importable. Additional homework needs to be undertaken to identify the relevant variables that determine here the administratability of subrogation. A commission like that proposed by the Clinton bill would be in a good position to do this homework. Such a commission, having conducted its own inquiries, could reach reliable findings as to when and at what cost subrogation works. The remaining question concerns how much deterrence would be lost were the collateral source rule reversed and the quantum of tort liability hence reduced by (say) twenty percent.⁴¹ Certainly this question is in some sense "factual." Yet the relevant facts—call them, perhaps, "counterfacts"—are not of the sort that would conveniently yield themselves to a short-term commission investigation. Accordingly, the efforts of any federal commission can be expected to go part of the way, but not all the way, toward providing an adequate factual basis for an eventual congressional decision on the application of the collateral source rule to health care benefits.

II

HOW A NATIONAL HEALTH CARE PROGRAM COULD AFFECT THE TORT SYSTEM

As discussed in Part I, adoption of a national health care program could easily lead to the reversal of the collateral source rule, a reversal that could reduce the size of tort awards by perhaps twenty percent. As significant as such a reversal obviously would be, this is only one of several ways in which a national program might affect the operation of the tort system. Other possible effects are the subject of this Part, which will discuss how a national program could moderate the litigiousness of accident victims, how it would relate to the propensities of tort juries, how it might influence the attitudes and policies of tort courts, and why it might be thought to contribute to the underlying rate of accidents that give rise to tort claims.

⁴⁰ Telephone interview with Professor Lewis Klar (Sept. 19, 1994).

⁴¹ My own sense is that a 20% reduction in the quantum of tort liability would increase the rate of negligent conduct by perhaps five percent. (The background analysis that supports this impression is provided in Schwartz, *supra* note 33.) Whether the administrative costs of subrogation (once they are determined) are less than the "costs" of such a five percent increase is a question that obviously raises vexing problems of measurement.

A. Victims

Many factors affect the inclination of accident victims to bring suit. Certainly one of these factors is the economic hardship the victim suffers. A recent survey of tort plaintiffs conducted by the Rand Corporation shows that fifty-two percent of those plaintiffs, in explaining their decisions to sue, listed as "very important" the point that "I needed someone else to pay me compensation because I had no other way to cover all my expenses."⁴² These "expenses" can be the ordinary costs of living that the victim can no longer pay when an injury interrupts his income. The expenses can also be the victim's medical bills. The Rand data indicate that the annual economic costs of accidents are about \$176 billion.⁴³ Of this \$176 billion, almost half (more than \$86 billion) is the cost of inpatient and outpatient medical care. These are expenses that presumably would be covered by a national health care program.⁴⁴ Granted, about sixty-five percent of Americans already are adequately insured for their health care expenses.⁴⁵ Even so, a national health care program would render "universal" the scope of adequate insurance. Indeed, the limitations in current insurance practices comprise the very problem that such a program is designed to solve. Should the program be adopted, a much smaller number of accident victims will encounter the hardship of medical bills in the aftermath of injuries.

Asserting a claim can be a matter of psychological orientation; it can also be a matter of rationally pursuing an economic asset. As Part I noted, the adoption of a national health care program would probably result in the repeal of the collateral source rule (either its outright abrogation or its replacement by subrogation). Should this happen, whenever an accident victim and her lawyer consider whether to file a tort claim they would know that the repeal of the rule has considerably reduced the value of that claim. Several states, as part of 1970s tort reform, have already abrogated the collateral source rule in medical malpractice actions. The consequences of this trend have been con-

⁴² DEBORAH R. HENSLEY ET AL., COMPENSATION FOR ACCIDENTAL INJURIES IN THE UNITED STATES 171 (1991) [hereinafter RAND INJURY STUDY].

⁴³ *Id.* at 52-53.

⁴⁴ An additional \$11.5 billion of economic costs relate to "special equipment, home health, etc." *Id.* Some of these additional costs might well turn out to be reimbursable under a national health care program.

Still, it should be noted here that the National Safety Council's recent calculations suggest that the income losses due to accidents considerably exceed medical expenses. See NATIONAL SAFETY COUNCIL, ACCIDENT FACTS 3 (1992). One explanation for this difference in findings is that the Rand study did not include the economic costs of *fatal* accidents. See RAND INJURY STUDY, *supra* note 42, at 8. These costs would be primarily income losses, not medical expenses. Note also my prior assumption that about 40% of the economic losses recoverable in tort are health care expenses. See *supra* text accompanying note 5.

⁴⁵ See *supra* note 18 and accompanying text.

sidered by recent empirical studies. While the results of these studies have been mixed,⁴⁶ some suggest that the abrogations have quite significantly reduced not only the cost but also the number of malpractice claims.⁴⁷ The adoption of a national program with universal coverage would increase to 100% the number of tort victims with adequate health insurance. Should that adoption then lead to the repeal of the collateral source rule, the combination of the rule's repeal and universal coverage can be expected to noticeably reduce the number of tort claims filed.

B. Juries

For both understandable psychological reasons and rational economic reasons, then, if a national health care program is adopted fewer tort suits (relative to the number of injuries) will be brought.⁴⁸ When suits *are* brought, what can be said about the likely attitudes of tort juries? Since the nineteenth century, the personal-injury bar in the United States has believed that juries sympathize with injured victims and hence resolve many doubts in those victims' favor. It is routinely the plaintiff's rather than the defendant's lawyer who requests a jury trial. Furthermore, when the evidence at trial favoring the defendant is strong enough, the defendant's lawyer typically moves for a directed verdict—fearing that the jury will disregard the evidence and rule for the plaintiff. Yet when the evidence strongly supports the plaintiff, his counsel generally refrains from asking for a directed verdict. Confident that the jury will accept the evidence and rule for the plaintiff, counsel sees no reason to incur the risk that a directed verdict entered by the trial judge will be reversed on appeal.

To be sure, the accuracy of lawyers' views as to the proplaintiff preferences of tort juries is somewhat difficult to confirm with empirical evidence.⁴⁹ But if the available evidence does not provide confir-

⁴⁶ See OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 9, at 69.

⁴⁷ According to Patricia Danzon's work, repeal of the collateral source rule results in a reduced claim frequency of 14% and a reduced claim severity of 18%. Patricia M. Danzon, *Malpractice Liability: Is the Grass on the Other Side Greener?*, in TORT LAW AND THE PUBLIC INTEREST 176, 197-98 (Peter H. Schuck ed., 1991). The effects found by Danzon are larger than those noted in other empirical studies, yet her results have a ring of truth about them. Given the pattern of collateral sources in modern America, the repeal of the rule *ought* to produce the results she describes.

⁴⁸ Tort liability doctrines in countries such as England, France, and Japan are not much different from tort liability rules in the United States; yet the rate of litigation in those countries is sharply lower than the rate in ours. While there are several reasons for this, certainly one of them is that those countries provide accident victims with health care and income-interruption benefits that both reduce the cash value of a tort claim and relieve the accident victim of much of the potential economic hardship of his accident. See Schwartz, *supra* note 28, at 74-76.

⁴⁹ The plaintiff win rate is actually higher in cases tried by judges than in cases tried by juries. Kevin M. Clermont & Theodore Eisenberg, *Trial by Judge or Jury: Transcending*

mation, neither does it deliver refutation;⁵⁰ and it is hard to believe that experienced tort lawyers misunderstand the basic directions of jury decisionmaking. One can therefore accept without much difficulty the lawyers' typical view that juries commonly sympathize with injured victims.

That sympathy is certainly due, at least in part, to jurors' beliefs that injured tort plaintiffs are experiencing real economic hardship. While over eighty-five percent of Americans are currently protected by some health insurance,⁵¹ the likelihood of insurance is a point that juries might be unaware of, or might forget in the course of their deliberations. Indeed, because of the collateral source rule the jury cannot be told that the plaintiff is covered by an ample health insurance policy; and the jury could easily infer from the lack of evidence that the victim is in fact without insurance coverage. Yet if a national program featuring universal coverage is adopted, all accident victims will have a federal right to insurance coverage for all their medical bills, including those bills that result from injuries. Jurors will certainly be aware of that right, both because of the enormous publicity generated by the debate about health care reform and because the jurors will receive their own health insurance through the new national program. Their knowledge of universal coverage can be expected to reduce (though not eliminate) jurors' current tendency to resolve doubts in favor of accident victims. In this respect, juries will be more balanced in their appraisal of the evidence in tort cases. The consequent reduction in plaintiffs' chances of winning will be appreciated by the plaintiffs' bar. This too could reduce the number of suits filed.

C. Judges

Considered so far have been the attitudes of tort plaintiffs and tort juries. What about the attitudes of tort judges? How might a national health care program affect the policy preferences of appellate judges as they decide how broadly to define the scope of tort liability rules? On occasion, new doctrines of liability are developed specifically to cover medical expenses. For example, in *Potter v. Firestone Tire & Rubber Co.*⁵² the California Supreme Court recently held that the person exposed to a toxic substance and hence subjected to a signifi-

Empiricism, 77 CORNELL L. REV. 1124 (1992). Moreover, the plaintiff win rate in jury trials has been going down in recent years. Edward Felsenthal, *Juries Display Less Sympathy in Injury Claims*, WALL ST. J., Mar. 21, 1994, at B1.

⁵⁰ As Clermont and Eisenberg note, bench trials occur only in cases in which neither side demands a jury; and there is no a priori reason to believe that these "no demand" cases are a fair cross section of the larger set of all cases that go to trial. Clermont & Eisenberg, *supra* note 49, at 1160, 1174.

⁵¹ See *supra* note 18 and accompanying text.

⁵² 863 P.2d 795 (Cal. 1993).

cant, but less than fifty percent, risk of developing a serious disease can—even absent any current physical injury—recover for the “cost of future periodic medical examinations intended to facilitate early detection and treatment of [that] disease.”⁵³ Consider medical monitoring services that would satisfy the *Potter* requirements of “reasonableness and necessity.”⁵⁴ These services would almost certainly be deemed “medically necessary”⁵⁵ by any national health care program that Congress might adopt, and hence would be included within that program’s insurance coverage. With the program in place, appellate judges, in considering whether to approve the *Potter* rule, would undoubtedly be aware of this coverage.

So long as the collateral source rule remains in effect, approving *Potter* would *not* mean that plaintiffs who would otherwise go uncompensated will now receive compensation; rather, *Potter* would signify that plaintiffs, having already been compensated once, can now receive a second round of compensation. The judges’ likely lack of enthusiasm for this result would discourage them from endorsing *Potter*. To be sure, the adoption of a national health care program might induce either national or state lawmakers to remove medical benefits from the scope of the collateral source rule. Should this happen, judges’ approval of the *Potter* cause of action would accomplish almost nothing. The recovery that plaintiffs could claim under *Potter* would be netted down to almost zero by the benefits paid under the national program.⁵⁶ Judges’ perceptions of the futility of this outcome would likely dampen their support for the *Potter* doctrine.⁵⁷

But if a national health care program might influence judges’ attitudes towards specific liability issues, the relevance of such a pro-

⁵³ *Id.* at 821, 823-25. The *Potter* court also held that absent current physical injury a plaintiff cannot recover for fear of acquiring a disease unless the future likelihood of contracting the disease is more than 50%. *Id.* at 816. Of course, if this prospect is more than 50%, the plaintiff might be able to recover for the future disease itself, since it is a more-likely-than-not consequence of present conditions.

⁵⁴ *Id.* at 824.

⁵⁵ See *infra* text accompanying notes 154-55.

⁵⁶ Keep in mind that in most cases plaintiffs in *Potter* situations receive nothing for the emotional distress they experience as they anticipate the possibility of future disease. See *supra* note 53.

⁵⁷ Now modify the earlier assumption, and assume that lawmakers replace the collateral source rule with subrogation. If so, then the judicial endorsement of the *Potter* cause of action would provide no immediate benefits to exposed plaintiffs. Nevertheless, a concern for deterring potential toxic polluters might lead judges to express interest in *Potter*. Indeed, it would be interesting to see to what extent judges would find persuasive a deterrence rationale for expanded liability when that rationale is essentially isolated from the conventional practice of providing actual compensation to victims. Note *McDougald v. Garber*, 536 N.E.2d 372 (N.Y. 1989), in which the New York Court of Appeals declined to award damages for loss of enjoyment of life to a comatose plaintiff, reasoning that those damages would be unable to provide the plaintiff with any meaningful compensation. *Id.* at 375.

gram to tort liability doctrine can be assessed even more broadly. Many scholars believe that a driving force operating on modern tort law has been the desire of judges to provide compensation—that is, insurance protection—to the victims of serious injury.⁵⁸ In these scholars' view, the insurance rationale for modern tort liability has diverted tort law from attending to its proper goals of deterrence⁵⁹ and corrective justice.⁶⁰ My own view is that these scholars have seriously overestimated the significance of the insurance criterion in the formulation of modern tort doctrine.⁶¹ Yet even I acknowledge that a loss-spreading impulse has operated as an undercurrent in modern tort law, making it easier for trial judges to accept inappropriate jury findings and encouraging appellate judges to reject or devalue legitimate arguments against liability.⁶² If a national health care program is adopted, judges would be aware that the insurance mandated by federal law now covers accident victims for the medical care they need. Granted, those victims' income losses would remain; still, judges might be less inclined to rely on loss-spreading notions to approve either individual verdicts or new causes of action. If so, then the growth of tort liability would be constrained.

D. Summarizing and Complicating

To recap, the adoption of a national health care program probably would restrain the number of tort suits filed, diminish the percentage of jury verdicts favoring plaintiffs, and dampen the willingness of appellate courts to broaden the rules of tort liability. Furthermore, if the program leads to the repeal of the collateral source rule, this would reduce the size of tort verdicts by perhaps twenty percent. In short, the implementation of a national program would tend to constrict both the effective scope and the actual cost of the current regime of tort liability. At the least, that program would slow down the rate at which the current tort system would otherwise grow. Either way, health care reform would include important "tort reform" implications that have gone largely undiscussed.⁶³

⁵⁸ See, e.g., George L. Priest, *Modern Tort Law and Its Reform*, 22 VAL. U. L. REV. 1 (1987); Ernest J. Weinrib, *The Insurance Justification and Private Law*, 14 J. LEGAL STUD. 681 (1985).

⁵⁹ See Priest, *supra* note 58.

⁶⁰ See Weinrib, *supra* note 58.

⁶¹ See Gary T. Schwartz, *The Beginning and the Possible End of the Rise of Modern American Tort Law*, 26 GA. L. REV. 601, 620-47 (1992).

⁶² *Id.* at 641-47.

⁶³ They are, however, noted by Professor O'Connell in his article in this symposium. Jeffrey O'Connell, *Blending Reform of Tort Liability and Health Insurance: A Necessary Mix*, 79 CORNELL L. REV. 1303 (1994). Moreover, O'Connell's discussion reaches a conclusion contrary to my own. O'Connell shows that recent decades have witnessed an expansion *both* of

Having worked out these implications, I should now acknowledge certain complicating factors. First, my discussion has assumed that a national health care program would cover essentially all the health care costs of accident victims. In fact, even a program as ambitious as the Clinton plan anticipated leaving some costs to patients, including a "cost sharing" charge for particular services and monthly insurance premiums. Under the Clinton plan, the consumer who elected a health maintenance organization (HMO) would have encountered low fees for individual services⁶⁴ and probably a low premium as well.⁶⁵ On the other hand, the plan would have enabled consumers to select a fee-for-service option that would have entailed a much higher cost-sharing burden and probably a substantial premium.⁶⁶ Consumers who enrolled in this option would have faced costs (especially after an injury) that would be quite significant. But everyone would know that all Americans have ready access to the lower-cost HMO. Moreover, most Americans would probably have elected the HMO, which hence would be recognized as the "democratic" choice. Accordingly, the person electing fee-for-service would be seen as willing to pay a higher price in exchange for a more aristocratic arrangement.⁶⁷ Jurors and judges would probably perceive this person as having voluntarily assumed a financial risk, having knowingly accepted a financial burden. Given this perception, juries and judges would not see that burden as a circumstance justifying any special tort-law solicitude.

tort *and* of public and private insurance. O'Connell hence concludes that the increase in insurance leads to more tort liability rather than to less.

The data presented by O'Connell are certainly relevant, and I commend his efforts in bringing them together. Yet his evidence does not really prove that the growth in insurance has *caused* the growth in tort; more precisely, O'Connell does not show that the expansion in tort would not have been more rapid had insurance coverage remained constant.

Moreover, as noted above, a national health care program would be universal, official, and dramatic in a way that is uniquely likely to affect the attitudes of judges and juries. Also, O'Connell does not consider evidence suggesting that the repeal of the collateral source rule has restrained medical malpractice claims. See Danzon, *supra* note 47.

Many insurance schemes—such as workers' compensation and Social Security Disability—are so complex that the applicant feels the need to secure the services of a lawyer, who is then in a good position to advise the victim of his tort prospects and to offer representation in any tort suit. Through this process, the provision of insurance can indeed "cause" an increase in tort claims. By contrast, persons filing for health insurance do not usually need or seek the services of a lawyer.

⁶⁴ S. 1757, 103d Cong., 1st Sess. § 1135(a) (1993).

⁶⁵ Hilary Stout, *Freedom to Choose a Doctor is Dwindling, Even Before Reforms*, WALL ST. J., Feb. 10, 1994, at A1.

⁶⁶ *Id.*

⁶⁷ An article in USA Today, describing "the health-care system of the future," indicates that only "an affluent elite" will take advantage of fee-for-service plans. Managed care will be the "Chevy" of health care, and fee-for-service the "Cadillac." Bill Montague, *Patients Find Control Over Care Eroding*, USA TODAY, Apr. 13, 1994, at 1A, 2A.

Second, my treatment of the attitudes of judges and juries has assumed that with about half the problem of the economic costs of accidents solved by a national health care program, judges and juries will feel significantly less inclined to tinker with tort law to protect victims from serious accident losses. The contrary possibility is that the adoption of such a program would reinforce a public ethic in favor of socializing accident losses. If that ethic *is* so reinforced, then juries and judges might become even more inclined to manipulate tort law to socialize the income losses that accidents would continue to bring about.⁶⁸ While acknowledging this possibility, I still regard my assumption as correct. Some supportive evidence comes from the legal systems in England, Canada, Germany, and Japan. By 1960, these countries had all adopted programs of national health insurance. Yet as judges in those countries' have subsequently gone about the business of fashioning tort doctrine, they seem to have given little weight to the loss-spreading rationale for liability.⁶⁹

In any event, what my analysis above has predicted is a smaller number of lawsuits relative to the underlying number of injuries. Is there any reason to believe that a national health care program would increase the accident rate? Two possibilities should be noted here. One concerns the subsidy that a national health care program might provide to injurers; the other, the subsidy that the program would confer on accident victims. The former subsidy might increase the rate of tortious conduct; the latter subsidy might increase the amount of risky and careless conduct engaged in by potential accident victims.

Injurers would receive a subsidy if a national health care program leads to the outright abrogation of the collateral source rule. While basic economic theory predicts that such a reversal would significantly increase the number of tortious accidents, the accuracy of such predictions should be reviewed in a realistic and perhaps skeptical way.⁷⁰ To recap the analysis developed in Part I above,⁷¹ policymakers should abrogate the rule outright only if a realistic review finds that this abrogation would not result in a significant increase in the accident rate. Should such a review conclude that there *would* be a meaningful in-

⁶⁸ Public approval of the loss distribution ethic may well have influenced judges and juries during the late 1960s and 1970s. Schwartz, *supra* note 61, at 635-38. My sense, however, is that judges and juries are no longer as susceptible as they once were. *Id.* at 683-702.

⁶⁹ I rely here on the review of these countries' tort opinions that I undertook in preparing an earlier article. See Schwartz, *supra* note 28.

In all of these countries, tort cases are decided by judges rather than juries. Therefore, none of these countries' experiences can provide evidence of how the adoption of a national health care program affects the attitude of juries.

⁷⁰ See *supra* text accompanying note 33.

⁷¹ See *supra* text accompanying notes 32-41.

crease, then policymakers, rather than simply repealing the rule, should replace it with subrogation.

A national health care program could subsidize accident *victims* by offering its insurance benefits even to those who engage in high-risk activities (such as motorcycling) and even to those who, while engaging in ordinary activities, display a clear lack of care (such as jaywalking, driving while intoxicated, or standing on the unstable top rung of a ladder).⁷² In affording first-party health insurance to all accident victims, a national program would evidently make no effort to experience-rate the price of insurance to account for the victims' risky or careless behavior.⁷³ Accordingly, economic theory predicts that such a program would increase the rate of risky or careless conduct by potential victims and hence increase the number of accidents.⁷⁴ To be sure, this federal subsidy would go only so far: accident victims would continue to face uninsured income losses, pain and suffering, and the risk of death. Moreover, the economic analysis may lack realism in the very high degree of "rationality" it imputes to the conduct of potential accident victims.⁷⁵

Still, even if the economists' concerns are exaggerated, the problem's core is certainly worth worrying about.⁷⁶ One response would be to impose fees on high-risk activities. Current proposals to boost the cigarette tax can be interpreted in this light. Another response would be to strengthen the regulatory controls that protect people from unduly exposing themselves to risk. Examples include regulations that prohibit jaywalking and require the wearing of seatbelts and

⁷² Of course, over 85% of Americans currently have some health insurance, and about 65% have adequate health insurance. See *supra* text accompanying note 18. The assessment in the text therefore depends on the extent to which a national program would broaden insurance coverage.

⁷³ In 1987, George Priest praised first-party insurance for the way in which it efficiently segregates insureds into discrete risk pools. See George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1539-50 (1987). In truth, in light of Medicare, Medicaid, and employer-provided group health plans, it is doubtful that first-party health insurance as of 1987 deserved this praise. At any rate, a national health care program would make no effort to establish subcategories of insureds for purposes of fixing the price of insurance coverage. Such a program would adopt, as a matter of principle, the practice of community rating. See Robert Pear, *Pooling Risks and Sharing Costs in Effort to Gain Stable Insurance Rates*, N.Y. TIMES, May 22, 1994, at 22.

⁷⁴ See Jon D. Hanson & Kyle D. Logue, *The First-Party Insurance Externality: An Economic Justification for Enterprise Liability*, 76 CORNELL L. REV. 129, 167-68 (1990) (arguing that standardized premiums in first-party insurance sharply reduce potential victims' incentives to exercise care and make prudent choices).

⁷⁵ See Gary T. Schwartz, *Contributory and Comparative Negligence: A Reappraisal*, 87 YALE L.J. 697, 713-21 (1978).

⁷⁶ A significant number of persons who receive benefits under New Zealand's accident compensation plan have suffered injuries while riding motorcycles or playing rugby. Sir Geoffrey Palmer, *The New Zealand Experience*, 15 U. HAW. L. REV. 604, 642-43 (1993). Undeniably, the New Zealand program subsidizes motorcycling and rugby, two very high-risk activities.

safety helmets. With the burden of medical care having been dramatically socialized, the objection that these regulations are unduly paternalistic would diminish in force.

III

THE CHANGING ECONOMIC AND LEGAL ENVIRONMENT FOR MEDICAL MALPRACTICE

Parts I and II of this Article have considered the ways in which a national health care program could affect the entire tort system. The Article now focuses on the medical malpractice portion of the tort system. I shall not attempt to assess the particular restrictions on malpractice claims that various congressional proposals would impose: regulation of the contingent fee, periodic payments at the request of either party, certificate-of-merit requirements, mediation and other forms of alternative dispute resolution, and caps on pain-and-suffering damages.⁷⁷ These are the familiar staples of state malpractice reform statutes, and have been adequately discussed in other commentary. Rather, my objective is to analyze how a national health care program might contribute to the economic and legal environment within which instances of medical malpractice (and also defensive medicine) occur.

A. Fee-For-Service Insurance and the Problem of Overutilization

Developing this analysis calls for the perspective of recent history. In 1940 only ten percent of Americans were covered by health insurance.⁷⁸ Most of the technology that is characteristic of modern medicine had not yet been developed; in this sense, there often was not all that much doctors could do for their patients.⁷⁹ In considering expensive diagnostic tests or treatments, doctors would have considered the fact that their patients would pay for these services. When doctors did recommend a test or procedure, patients might decline on grounds that it would cost too much.⁸⁰ For whatever combination of reasons, the annual per capita expenditure on health care in 1940

⁷⁷ All but the last of these were included in the Clinton plan. S. 1757, 103d Cong., 1st Sess. §§ 5301-06 (1993). The bill developed by the Senate Finance Committee would have placed a \$250,000 ceiling on pain-and-suffering awards. See Bob Herbert, *Punishing the Victims*, N.Y. TIMES, Aug. 10, 1994, at A15.

⁷⁸ Burton A. Weisbrod, *The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care & Cost Containment*, 29 J. ECON. LIT. 523, 523 (1991).

⁷⁹ E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1726 (1987) ("Prior to World War II, physicians had few interventions, costly or otherwise, to offer patients.").

⁸⁰ Note, however, one famous nineteenth-century malpractice case which suggested that a physician, having accepted a low-wealth individual as a patient, might be required to provide without charge those medical services which the patient turns out to need. *Becker v. Janinski*, 15 N.Y.S. 675, 677 (C.P. 1891):

was very low. As late as 1950, this expenditure was only \$332. Having increased to \$482 by 1960, it then leaped to \$891 in 1970, \$1291 in 1980, and \$2105 in 1991.⁸¹

After World War II there was huge growth in private health insurance, typically provided by employers operating under the spur of a federal tax subsidy. Moreover, in the mid-1960s Congress created the Medicare and Medicaid programs, providing health insurance for older Americans and low-income Americans on welfare. Most of this insurance was on a simple fee-for-service basis. Health insurers would routinely pay for the reasonable cost of whatever services doctors deemed appropriate for their patients.

Especially since fee-for-service arrangements remain an important part of today's health care system, it is useful to assess the incentives these arrangements provide to doctors and patients. Consider a diagnostic test or a treatment procedure that is quite expensive but which nevertheless provides the patient with a possible benefit. In one out of every 200 cases, for example, it renders possible a diagnosis that would elude a less expensive test; or in one of 100 cases it improves the patient's health in a way that a less expensive procedure would not. Both this diagnostic test and this method of treatment, while certainly costly, provide the patient with a small but positive expected value.⁸² Operating under fee-for-service, the physician would be inclined to order the test or treatment. The physician's inclination is in large part due to his sense of his patient's best interests. The test is possibly advantageous; and its cost is no problem for the patient, who is adequately covered by insurance. For that matter, the cost is no problem for the doctor, since it will be borne not by him but by a third-party health insurer. The doctor might feel there is no particular reason to give serious consideration to the economic interests of the insurance company. This is a prime example of what economists call "moral hazard":⁸³ the doctor and the patient can agree on tests and treatments that benefit the patient while exporting the relevant costs to a third party who is uninvolved in the decisionmaking.

Indeed, the doctor-patient relationship turns out to provide an interesting set of added dimensions to the moral hazard problem.

Whether the patient be a pauper or a millionaire, . . . the physician owes him precisely the same measure of duty, and the same degree of skill and care. . . . [The physician] cannot defeat a suit of malpractice . . . upon the principle that the skill and care required of a physician are proportioned to his expectation of pecuniary recompense.

⁸¹ These expenditures are all expressed in 1983 dollars. U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, HEALTH UNITED STATES 1992, at tbl. 114 (1993). In nominal dollars, the per capita expenditure in 1950 was \$80; in 1991, \$2868.

⁸² This is the economist's term, as employed in Weisbrod, *supra* note 78, at 527.

⁸³ See Mark V. Pauly, *Overinsurance and Public Provision of Insurance: The Role of Moral Hazard and Adverse Selection*, 88 Q. J. ECON. 44 (1974).

Under fee-for-service, the doctor can easily conclude that it is morally inappropriate for him to take the insurer's interests into account. As a conscientious doctor, his duty runs to the patient alone; according to the traditional understanding, the doctor is a "fiduciary" for the patient.⁸⁴ One doctor has set forth a conventional understanding of his role: "[A]s a physician, I have been taught throughout my professional career that I had an absolute obligation to my patients to provide them with the highest quality medical care within my reach, almost without regard to cost."⁸⁵ This, indeed, is the doctor's "professional imperative."⁸⁶

Moreover, if providing costly services to the patient gives the patient some expected value, then providing those services is also within the economic self-interest of the doctor. Doctors can charge their patients' health insurers, often with a substantial markup, for those tests and procedures that doctors provide within their own offices. Lab tests are "a great source of income [for doctors]. You can significantly increase your average bill per patient."⁸⁷ Blood-cholesterol tests, for example, cost a doctor about \$2, but the doctor can bill the health insurer within a range from \$8 to \$22.⁸⁸ To be sure, perhaps only a small percentage of doctors order tests for the explicit purpose of increasing their income. Yet as Gregg Easterbrook points out, "every doctor knows at some subconscious level that additional procedures are financially beneficial—and human nature dictates that what is in the back of the mind can be as influential as what is in the front."⁸⁹

In short, under conventional fee-for-service insurance doctors' sense of their fiduciary obligation is reinforced by the doctors' economic self-interest, creating powerful incentives to order tests and conduct procedures whose expected health value (while positive) is less than their economic cost.

⁸⁴ See *Tracy v. Merrell Dow Pharmaceuticals, Inc.*, 569 N.E.2d 875, 879 (Ohio 1991); Arnold S. Relman, M.D., *What Market Values Are Doing to Medicine*, ATLANTIC, Mar. 1992, at 99, 100, 106.

⁸⁵ Phillip Caper, M.D., *The Meaning of Quality in Medical Care*, 291 NEW ENG. J. MED. 1136, 1136 (1974).

Another doctor has expressed his sense of his obligation as follows:

[P]hysicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations. In caring for an individual patient, the doctor must act solely as that patient's advocate, against the apparent interests of society as a whole, if necessary.

Norman G. Levinsky, M.D., *The Doctor's Master*, 311 NEW ENG. J. MED. 1573, 1573 (1984).

⁸⁶ Jan Blustein & Theodore R. Marmor, *Cutting Waste by Making Rules: Promises, Pitfalls, and Realistic Prospects*, 140 U. PA. L. REV. 1543, 1563 (1992).

⁸⁷ Glen Ruffenach, *Medical Tests Go Under the Microscope*, WALL ST. J., Feb. 7, 1989, at B1 (quoting the president of a medical consulting firm).

⁸⁸ *Id.*

⁸⁹ Gregg Easterbrook, *The Revolution in Medicine*, NEWSWEEK, Jan. 26, 1987, at 40, 49. According to one hospital president, "[t]he incentives were to keep people in the hospital, to perform more tests and procedures, to increase costs." *Id.* at 43.

With this in mind, we can consider the general standards of malpractice liability. The malpractice concept is typically seen as the doctrine of negligence as applied to physicians; furthermore, the negligence doctrine itself is often understood in the cost-benefit terms of the Learned Hand formula.⁹⁰ In fact, however, the primary interpretation of the malpractice doctrine is not the cost-benefit test but rather the content of professional customs and standards. The doctor who complies with professional customs cannot be found guilty of malpractice; the doctor who departs from custom can easily be held liable. It is commonly suggested that the professional custom standard may well operate at a lower level than the cost-benefit standard; accordingly, the former standard is seen as providing a liability shelter for the doctor who could properly be found negligent if the latter standard were applied.⁹¹

I support here a contrary interpretation.⁹² In an environment of unregulated fee-for-service insurance, the common and customary practices among physicians can easily become *more* protective of patients and *less* attentive to economic costs than those practices that would be called for by the Learned Hand test. Take a set of X-rays that provide a diagnostic benefit, but so infrequently as to inadequately justify the X-rays' monetary costs. The doctor who fails to order these X-rays may be complying with the Learned Hand test for nonnegligence. Yet in a fee-for-service setting, the incentives operating on doctors could easily result in such X-rays becoming a standard practice.⁹³ Once this happens, the "professional" malpractice standard sets itself at a level that is "higher" than the cost-benefit standard. Accordingly, doctors who decline to order such X-rays would be exposing themselves to malpractice claims. Their interest in preventing those claims gives them yet another reason to order the X-rays, even though the economic analyst might deride the X-rays as excessive defensive medicine.

⁹⁰ *United States v. Carroll Towing Co.*, 159 F.2d 169, 173 (2d Cir. 1947) (conduct is negligent if magnitude of risk exceeds cost of risk prevention).

⁹¹ See, e.g., PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* 19-21 (1991).

⁹² For an earlier suggestion of this, see Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 *DUKE L.J.* 1375, 1394-95.

⁹³ During this period dominated by fee-for-service insurance, there was a massive flow of new technology into the medical system. The availability of new technology certainly contributed to the remarkable increase in per capita medical costs. More precisely, new technology interacted with the incentives afforded by fee-for-service insurance to provide a mechanism whereby new technology would be promptly adopted by the medical community. In this way fee-for-service arrangements increased the extent to which new technology raised the overall cost of medical services. Moreover, since firms engaging in R&D certainly took potential profits into account, the unregulated fee-for-service system provided an encouragement for the development of new medical technology. See Weisbrod, *supra* note 78, at 528. This seems like one advantage of that unregulated system.

B. Modern Arrangements and the Possible Problem of Underutilization

What has happened, then, to the practice of medicine since the mid-1970s? The relevant changes can easily be seen as a response to the problems of cost overruns which by the mid-1970s had become quite noticeable. Fee-for-service insurance programs remain; but they now are subject to various forms of cost containment, including utilization review as a condition for initiating or continuing various treatments.⁹⁴ Moreover, new institutions have emerged that rearrange the relationship between insurers and doctors. Several of these fall within the category of health maintenance organization. HMOs receive insurance premiums at the beginning of the year in exchange for promising to provide medical services during the year. In a "staff model" HMO, the HMO hires its own physicians, who provide medical services as salaried employees. In a "group model" HMO, the HMO contracts with a physician practice group, which provides medical services. In an "independent physician association (IPA) model" HMO, the HMO contracts with a considerable number of physicians who have their own offices.

Another new institution is the preferred provider organization (PPO). A PPO somewhat resembles an IPA-model HMO. Commonly administered by an insurance company, the PPO enters into contracts with a network of doctors and hospitals. By promising to deliver a flow of patients, the PPO can secure their services at discounted prices.⁹⁵

⁹⁴ These reviews are most common for hospitalization and surgery. Utilization review is also often required for certain particularly expensive procedures such as CAT-scans and magnetic resonance imaging. Elisabeth Rosenthal, *Insurers Second-Guess Doctors, Provoking Debate Over Savings*, N.Y. TIMES, Jan. 24, 1993, at A1, A22. A fee-for-service plan offered to UCLA employees requires the insurer's precertification for a list of approximately a dozen tests and treatments, including gastroscopy, colonoscopy, speech therapy, and physical therapy.

Within the Medicare program, a prospective payment system has been in effect since 1983 as a way of paying hospitals. The patient's medical problem is classified within a particular "diagnostic related group" (DRG); the hospital's fee is then the fee associated with that DRG. LOUISE B. RUSSELL, *MEDICARE'S NEW HOSPITAL PAYMENT SYSTEM: IS IT WORKING?* 9 (1989). Also, physicians participating in Medicare face a system of retrospective reviews for the services they provide. If such a review finds that the service was not medically necessary, then the doctor is denied payment. Robert A. Rosenblatt, *Study Finds More Medicare Claims in Southland Rejected*, L.A. TIMES, Mar. 29, 1994, at A3, A16.

⁹⁵ There are also many health plans that provide various kinds of "hybrids." UCLA, for example, offers a hybrid plan that includes both HMO and fee-for-service. The premium that UCLA and the employee pay is primarily in exchange for the HMO's basic services. But the employee remains free to consult a doctor outside of the HMO. An employee who does so pays a larger portion of that doctor's fee than would be called for in the typical fee-for-service plan. Patients like myself find hybrid plans attractive because these plans enable patients to escape the psychological claustrophobia of confining themselves in advance to the list of the particular doctors employed by the HMO. But the

During the last twenty years, then, the institutional arrangements for the delivery of medical care have become diverse. The number of patients in fee-for-service plans has decreased, and those plans are now subject to significant cost controls. As late as 1975, only 6.5 million Americans were enrolled in HMOs,⁹⁶ and PPOs did not yet exist. However, between 1985 and 1991 the number of persons in either HMOs or PPOs increased from twenty-five million to ninety million.⁹⁷ By 1993, forty-two percent of the employees working for large companies were signed up in fee-for-service plans, but twenty-six percent were enrolled in HMOs, twenty-two percent in PPOs, and ten percent in hybrid plans.⁹⁸

Malpractice law is often concerned with the care or skill employed by doctors as they deliver particular medical services. There is no particular reason for believing that the ongoing shift in institutional arrangements is exerting any detrimental effects on the levels of care and skill that doctors exercise. Accordingly, the discussion below does not profess any particular relevance to the malpractice doctrine in these applications.

Malpractice law, however, is also concerned with the medical services—those tests and treatments—that doctors choose to deliver. The revised arrangements do dramatically alter the incentives for furnishing a variety of those services. Under unregulated fee-for-service, the relevant decisions were made by doctors, who could perceive a variety of reasons for ordering plenty of tests and procedures. Yet once a fee-for-service insurance company establishes a cost-containment program of utilization reviews, the company is in a good position to withhold utilization approvals so as to enhance its end-of-year net revenues. PPOs likewise engage in utilization reviews. In addition, the PPO, in reviewing its list of preferred providers, has an incentive to remove from this list those doctors whose tests and services exceed financial targets. PPOs act on the basis of this incentive. Doctors who order large numbers of expensive tests can find themselves “purged” from PPOs.⁹⁹ Insurers assert that their right to “select and ‘de-select’ doctors is at the heart of their ability to develop networks that provide high-quality, cost-effective care.”¹⁰⁰ Unfortunately, doctors who deal with PPOs frequently perceive that “high quality” is not the primary

convenience of remaining within the HMO, in combination with the high cost of going outside, means that most patients remain in the HMO for almost all their medical needs.

⁹⁶ Bovbjerg, *supra* note 92, at 1394 n.59.

⁹⁷ Ron Winslow & Edward Felsenthal, *Physicians Fight Back as Insurers Cut Them from Health Networks*, WALL ST. J., Dec. 30, 1993, at A1.

⁹⁸ See Milt Freudenheim, *H.M.O.'s That Offer a Choice Are Gaining in Popularity*, N.Y. TIMES, Feb. 7, 1994, at A1. For additional data, see Montague, *supra* note 67, at 2A.

⁹⁹ Winslow & Felsenthal, *supra* note 97, at A5.

¹⁰⁰ *Id.*

criterion: according to the general counsel of the American Medical Association, "if you are a cheap doctor, you are going to be in the [PPO] plan, whether you are good or bad."¹⁰¹ To the extent that this AMA spokesman is professing to describe all PPOs, he is obviously overgeneralizing. Still, he has correctly identified an incentive that naturally operates on PPOs.

HMOs operate under somewhat similar incentives. Having received premiums at the beginning of the year, the HMO has an obvious reason to hold down the volume of services it delivers during the year.¹⁰² In response to this incentive, HMOs commonly establish systems of utilization review. Yet these reviews typically reach only a small fraction of the decisions rendered by the HMO's treating physicians. These physicians' understanding of their own "professional imperative"¹⁰³ might discourage them from conserving on tests and treatments.¹⁰⁴ For that matter, a commonplace observation within the academic literature is that "agents" do not always behave in ways that promote the interests of their "principals."¹⁰⁵ It is not surprising, then, that HMOs have developed a variety of techniques to encourage physicians to conserve.¹⁰⁶ Many HMO primary-care physicians are

¹⁰¹ *Id.*

¹⁰² Since this subpart of my Article will identify problems associated with HMOs, it should be noted here that HMOs can also improve the quality of care. There can be coordination advantages when medical services are provided by a physician group. Also, groups of physicians can better engage in peer review. In addition, HMOs have a basic economic interest in persuading their patients to give up unhealthy practices such as smoking and overeating. Ron Winslow, *An HMO Tries Talking Members into Healthy Habits*, WALL ST. J., Apr. 6, 1994, at B1.

¹⁰³ See *supra* text accompanying notes 85-86.

¹⁰⁴ Generational factors are influential here. The older generation of physicians is most likely to feel the force of this professional imperative. Younger physicians have entered the profession during the era of cost controls, and are much less likely to find these controls offensive. George Anders, *Changes in Medicine Widen the Usual Gap Among Practitioners*, WALL ST. J., June 20, 1994, at A1.

¹⁰⁵ See, e.g., WILLIAM A. KLEIN & JOHN C. COFFEE, JR., *BUSINESS ORGANIZATION AND FINANCE* 31-44 (5th ed. 1993).

¹⁰⁶ The following discussion draws on Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743 (1987); Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86 (1989); Alan L. Hillman et al., *Contractual Arrangements Between HMOs and Primary Care Physicians: Three-Tiered HMOs and Risk Pools*, 30 MED. CARE 136 (1992); W.P. Welch, *The New Structure of Individual Practice Associations*, 12 J. HEALTH POL., POL'Y & L. 723, 724 (1987); W.P. Welch et al., *Toward New Typologies for HMOs*, 68 MILBANK Q. 221 (1990).

What about the fee-for-service insurance company which establishes a cost-containment program? In fact, fee-for-service insurers have often adopted procedures that establish the "independence" of physician consultants who render the cost containment decisions on behalf of the insurers themselves. Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1670 (1992). HMOs, however, have declined to adopt such "procedural safeguards." *Id.* at 1683 n.169. See the story of the *Fox* case, as discussed below in the text accompanying notes 136-41.

paid on a "capitation" basis.¹⁰⁷ That is, for a given time period they receive a fixed sum for each of their enrolled patients. Accordingly, every service the physician provides to a patient (including referrals to specialists) reduces the net revenue left to the physician at the end of the time period. Alternatively, physicians are paid an annual salary. But a significant fraction of that salary—often twenty percent—is withheld until the end of the year; whether this withhold is then turned over to the doctor depends on whether the doctor's service costs remain below a pre-established target.¹⁰⁸ Under other arrangements, the doctor is given a bonus if her aggregate service costs during the year are less than the pre-established figure. For doctors subject to such withholds and bonuses, their annual income within a considerable middle range is unaffected by the treatment choices they make. Still, at the bottom and the top, the regime of withholds and bonuses means that each service the doctor provides comes out of her own pocket.

On other occasions the capitation payment, or the system of withholds and bonuses, is addressed not to the individual physician but rather to physician groups. This shift in focus obviously reduces the extent to which the payment system is likely to affect the choices physicians render. Still, depending on the number of physicians in the group and the degree of their interaction, physicians can establish informal standards. As one physician in a group-model HMO recently indicated, "we don't get paid if we go over budget."¹⁰⁹ He also described discussions held among the physicians within his group to establish informal norms or practices. In line with one of those norms, the HMO's physicians insist that emotionally depressed patients take Prozac for six weeks before the physician is willing to give serious consideration to referring the patient out for psychotherapy. In line with another norm, the HMO's physicians attempt to dissuade their under-fifty women patients from insisting on mammograms. Accordingly, "our mammogram rate is about as low as you can get."¹¹⁰

The trend toward cost containment, and especially towards HMOs and HMO-dominated hybrids, would clearly be reinforced, and would almost certainly be accelerated, by the national health care plans recently considered by Congress.¹¹¹ Both the Cooper plan and

¹⁰⁷ Welch et al., *supra* note 106, at 224-25.

¹⁰⁸ *Id.* at 126-27.

¹⁰⁹ Robert Brook, M.D., Remarks at the Rand Corporation Seminar on the Legal Implications of Health Care Reform (Feb. 25, 1994).

¹¹⁰ *Id.*

¹¹¹ One recent article points out that "health system reform legislation" could "greatly increase incentives" facing patients in a way that would "speed enrollment shifts from indemnity insurance to HMO plans." Robert H. Miller & Harold J. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1518 (1994).

the Chaffee plan would have rendered nonincludible as employee income only the employer-provided health insurance premium needed to purchase the least expensive health-insurance plan locally available¹¹²—which almost certainly would be an HMO. The Clinton bill would have required each local health plan to offer an HMO option, a fee-for-service option, and a hybrid option.¹¹³ Yet the fee-for-service option would have made the patient pay a higher annual deductible, a higher per visit cost-sharing fee, and probably a higher annual premium.¹¹⁴ Accordingly, the vast majority of persons would have predictably elected the HMO, or some hybrid primarily featuring an HMO.

The good news about HMOs and utilization review programs is that they can do a much better job than unregulated fee-for-service in avoiding the costs of excessive defensive medicine. Indeed, the HMOs' ability to inhibit excessive defensive medicine is a primary reason public policy has favored their formation.¹¹⁵ By combining the provision of insurance and the furnishing of services within the same organization, HMOs are in a good position to solve the problem of moral hazard. The bad news is that the incentives operating on HMOs and cost-containment programs can go too far,¹¹⁶ facilitating a significant number of incidents of medical malpractice, at least when malpractice is itself defined in conventional Learned Hand cost-

¹¹² Hilary Stout, *Freedom to Choose a Doctor is Dwindling, Even Before Reforms*, WALL ST. J., Feb. 10, 1994, at A1, A6.

¹¹³ S. 1757, 103d Cong., 1st Sess. § 1131 (1993). On hybrids, see *supra* note 95.

¹¹⁴ The Clinton bill would have required the employer to pay at least 80% of the aggregate of the health insurance premiums for all its employees. *Id.* § 6131(b)(1)(A). But the employer's share of the employee's particular health insurance plan could have varied depending on which plan the employee chose. Most observers assumed that the employer would have ended up paying more than 80% for the HMO and less than 80% for fee-for-service. One health care analyst, for example, estimated that the employer would have paid the entire premium for an HMO but less than half the premium of a fee-for-service plan. Montague, *supra* note 67, at 2A (citing Tom Beauregard, with Hewitt Associates, a consulting firm).

¹¹⁵ "The presence of [financial] risk [borne by the HMO] creates the incentives for cost containment that have made HMOs so attractive to policy makers." Harold S. Luft, *Assessing the Evidence of HMO Performance*, 58 MILBANK HEALTH & SOC'Y 501, 504 (1980). The balance of the empirical evidence gathered to date shows that HMOs somewhat reduce hospital admission rates, clearly shorten the duration of hospital stays, and result in a lower rate of utilization of expensive tests and procedures. Miller & Luft, *supra* note 111, at 1514-15. Yet the studies reaching these findings are generally not able to distinguish between cost-effective reductions in utilization and reductions that might count as malpractice. Indeed, what evidence there is suggests that the overall quality of care in HMOs is roughly equivalent to the quality found in more traditional medicine. *Id.* at 1516.

¹¹⁶ Oregon's new health plan relies on monthly capitation payments to physicians for low-income patients. According to one Oregon internist, "[t]he problem with old fee-for-service medicine was that the incentive was to do more. The problem with capitation . . . is that the incentive is to do less." Marilyn Chase, *Rationed Health Care Helps Oregon's Poor, But Real Test Is Ahead*, WALL ST. J., Mar. 22, 1994, at A1, A8 (quoting Dr. Gregg Coodley).

benefit terms.¹¹⁷ Indeed, during the 1994 Congressional debates, “lawmakers [tried] to outdo one another with horror stories about” HMOs that “skimp on care to save money.”¹¹⁸

Note, however, that the bad news evaluation rendered above relied primarily on the *short-term* incentives that operate on health maintenance organizations and cost containment programs. That evaluation should now be broadened to take into account *medium-* and *long-term* incentives that might offset the effects of the basic short-term incentives. To appreciate the medium-term incentive, consider the HMO that is thinking about cutting costs by withholding reasonable tests and treatments. If it chooses this course, some of its patients' diseases will worsen before they finally demand attention. The HMO's contract will then impose on the HMO the burden of providing the medical treatments which these advanced diseases require.¹¹⁹ In general, the HMO's perception of its eventual contractual responsibilities clearly gives it a medium-term incentive to avoid undue economies in its original provision of tests and treatments.¹²⁰

The long-term incentive relates to the external market for HMOs. Consider the HMO that has already received its annual premium and therefore has an immediate incentive to practice parsimony in the furnishing of medical services. This parsimony can easily result in patient dissatisfaction. If patients sign up directly with HMOs, at the end of the policy year they can vote with their feet and decline to renew their relationship with the HMO. Under the various proposals for national health care plans, the contract with the HMO may be entered into not by patients themselves but rather by employers or health alliances. Yet if employees convey to their employers their dissatisfaction with the HMO, or if citizens convey their dissatisfaction to their health alliances, the employer and the health alliance will be less willing to renew their arrangement with the HMO at the end of the policy year. The market can therefore serve to discourage HMOs from delivering substandard medical care.

¹¹⁷ See Hillman's conclusion that “[c]ertain financial incentives, especially when used in combination, suggest conflicts of interest that may influence physicians' behavior and adversely affect the quality of care.” Hillman, *supra* note 106, at 1743. For a discussion of how many “modern IPAs give physicians an incentive to underutilize,” see Welch, *supra* note 106, at 735.

¹¹⁸ Robert Pear, *Once in Forefront, H.M.O.'s Lose Their Luster in Health Debate*, N.Y. TIMES, Aug. 23, 1994, at A12. Bills introduced in the House and Senate therefore would have placed particular restrictions on HMO's methods of operation.

¹¹⁹ For example, the cost-containment decision to discharge a patient prematurely can end up imposing costs on the health insurer once complications develop, requiring the rehospitalization of the patient and eventual surgery. See *infra* text accompanying notes 129-32 (discussing a case with these facts).

¹²⁰ See Michael W. Weinstein, *The Freedom to Choose Doctors: What Freedom?*, N.Y. TIMES MAG., Mar. 27, 1994, at 64, 65.

HMOs thus face both a medium-term contract incentive and a long-term market incentive that can counter the basic short-term tendency towards underutilization. Unfortunately, however, these incentives by no means eliminate the tendency. As for the medium-term incentive, the HMO's contractual liability extends *only* to the costs of medical care. The HMO is not liable for income losses that the patient might incur on account of his disease or for his nonmonetary costs, such as pain and suffering and lost enjoyments. Since the health care costs of diseases may be no more than twenty-five percent of their entire costs, the HMO contract goes only part way toward cost internalization. Furthermore, consider the patient who might suffer the harm of death if the HMO originally provides him with inadequate tests or services.¹²¹ Death is a particularly adverse result which, far from expanding the HMO's obligation to provide subsequent medical treatments, eliminates that obligation altogether. When treating a patient with a disease that will probably but not certainly prove fatal,¹²² the very high cost of treatment may give the HMO an incentive to prematurely abandon the possibility of survival.¹²³ In addition, consider the HMO that is thinking of skimping on such preventive measures as vaccinations for children, or full diagnostic work-ups for infants exhibiting signs of developmental problems. The diseases and problems which these vaccinations prevent might well afflict patients years later. The HMO that fails to provide such a vaccination or work-up might readily assume that it will no longer be responsible when the problem finally materializes.¹²⁴ The very circumstance of patient mobility that provides some credibility for the long-term market incentive reduces the value of the medium-term contract incentive.

¹²¹ Consider the facts in the case discussed *infra* text accompanying notes 133-35.

¹²² Consider the facts in the case discussed *infra* text accompanying notes 136-41.

¹²³ Of course, in these cases the HMO's ability to avoid apparently excessive expenditures also acquires a special relevance. A high fraction of all Medicare costs is incurred in the last half-year before death. See Hilary Stout, *Clinton's Health Plan Must Face Huge Costs of a Person's Last Days*, WALL ST. J., Apr. 22, 1993, at A9.

¹²⁴ See Weisbrod, *supra* note 78, at 542 n.38. For discussion of the apparent inadequacy of the services provided by HMOs to children with possible developmental problems, see Elizabeth J. Jameson & Elizabeth Wehr, *Drafting National Health Care Reform Legislation to Protect the Health Interests of Children*, 5 STAN. L. & POL'Y REV. 152, 161-63 (1993). Recent studies suggest that some HMOs are doing an inadequate job in providing childhood vaccinations. See Jonathan E. Fielding et al., *Immunization Status of Children of Employees in a Large Corporation*, 271 JAMA 525, 527-28 (1994); Thomas Schlenker & Kathleen Fessler, *Measles in Milwaukee*, WISCONSIN MED. J., July 1990, at 403; David Wood et al., *Access to Infant Immunizations for Poor Inter-City Families: What Is the Impact of Managed Care?*, 5 J. HEALTH CARE FOR THE POOR & UNDERSERVED 112 (1994). Note, however, that the last two of these studies focus on Medicaid HMOs. The low reimbursement rate offered by Medicaid, and the high turnover rate among patients enrolled in Medicaid HMOs, may explain some of those studies' results.

As for the long-term incentive, a basic problem is that patients, lacking information, may not be able to observe or assess the quality of the care they receive.¹²⁵ In addition, patients, having established relationships with one set of doctors, can find it very disruptive to shift to another set; this disruption obviously impairs consumer mobility. Certainly an employer, having affiliated itself with a particular HMO, will encounter resistance from many of its employees if it considers shifting to another HMO. Furthermore, there are bound to be what economists call "imperfections" in the process by which patients transmit their dissatisfactions to employers and health alliances and in which employers and health alliances then bargain with patients' interests in mind.¹²⁶ Even now, there is anecdotal evidence that when employers shop for HMOs they place far more weight on the cost of the HMO than on the quality of the services the HMO undertakes to deliver.¹²⁷

The analysis developed up to this point can now be restated. The basic economic structure of HMOs gives them a basic short-term incentive to practice conservation and even parsimony in their delivery of medical services. Moreover, the arrangements that HMOs work out with their affiliated physicians tend to align those physicians' incentives with the incentives of the HMOs themselves. The good result is the HMO's ability to reduce excessive defensive medicine. The bad result is a tendency for physicians to practice the kind of underutilization that the law would deem malpractice. While medium-term and long-term incentives also operate on HMOs, they go only part way toward solving the underutilization problem created by the short-term incentives.¹²⁸

¹²⁵ See Weisbrod, *supra* note 78, at 541. Of course, if the market could be fully trusted, there would be little need for the malpractice action even in its traditional setting. Since patients can refuse to consult those physicians with a propensity for malpractice, the market can provide physicians with appropriate incentives to avoid malpractice. Even the basics of malpractice law, then, rest on the implicit premise that patients lack the information or the bargaining ability to render effective this market mechanism. To be sure, employers or health alliances might be able to gather information or to bargain with sophistication in a way that would improve the functioning of the market for medical services.

¹²⁶ Indeed, the health alliances that the Clinton bill sought to create would have been monopolies entrenched by federal law and assigned a multitude of tasks, capable of exerting conflicting pressures.

¹²⁷ See Ron Winslow, *In Health Care, Low Cost Beats High Quality*, WALL ST. J., Jan. 18, 1994, at B1, B12.

¹²⁸ At the very least, one can easily predict that on some occasions, HMOs—if only on account of imperfect management—will succumb to their short-term incentive and deliver an inadequate level of medical services. When this happens, the malpractice action, if available, can provide a corrective-justice remedy to the patient who has been shabbily treated.

C. The Tort Suit As a Solution to the Prospective of Underutilization: The Southern California Trilogy

Given all of this, courts are likely to turn to the malpractice tort to discourage inadequate care by HMOs and cost-containment decision-makers. If my own region—southern California—has recently engrossed the nation with an amazing combination of riots, fires, earthquakes, floods, terrible crimes, and melodramatic criminal trials, it has also provided the three most important cases dealing with the possible malpractice liability of organizations that engage in medical cost-containment efforts. The first of the three was the 1986 case *Wickliffe v. State of California*.¹²⁹ The plaintiff in *Wickliffe* was a Medi-Cal patient who was hospitalized for surgery on her leg. During treatment, her doctor sought authorization from Medi-Cal for an additional eight days of hospitalization. Medi-Cal, with a board-certified surgeon serving as its consultant, authorized payment for only four additional days. Because of this, her treating physician discharged her from the hospital once these four days had elapsed. After her discharge, complications developed. Because of these complications, she was re-hospitalized, and eventually her leg was amputated. Alleging that this amputation was caused by her early release from the hospital, she brought suit against Medi-Cal. The court of appeal found that the four-day discharge in fact met the pertinent standard of care: hence the position taken by Medi-Cal was not improper or negligent.¹³⁰ But the court went out of its way to emphasize in dictum the potential liability of cost-containment programs. "It is essential that [such programs] not be permitted to corrupt medical judgment."¹³¹ The patient "who requires treatment and who is harmed when care which should have been provided is not provided should recover . . . from all those responsible . . . , including, when appropriate, health care payors."¹³²

In 1990 came *Wilson v. Blue Cross of Southern California*.¹³³ Here a patient was hospitalized for major depression. Though his treating physician believed that four weeks of hospitalization was necessary, Blue Cross refused to authorize payment for more than ten days.

¹²⁹ 228 Cal. Rptr. 661 republished at 239 Cal. Rptr. 810 (Ct. App.), *rev. granted*, 727 P.2d 753 (Cal. 1986), *dismissed, remanded and ordered published*, 741 P.2d 613 (Cal. 1987).

¹³⁰ 239 Cal. Rptr. at 818-19.

¹³¹ *Id.* at 820.

¹³² *Id.* at 819.

¹³³ 271 Cal. Rptr. 876 (Ct. App. 1990). A case with facts considerably resembling *Wilson* is *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992). In *Corcoran*, however, the employer's health plan was self-insured, and the court found that the patient's malpractice claim against the plan's cost-containment administrators was preempted by ERISA. The ERISA preemption problem is discussed in William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Diagnosis*, 26 TORT & INS. L.J. 451, 485-92 (1991).

Since the patient and his family could not afford to pay for future inpatient care, he was discharged after ten days.¹³⁴ Not long thereafter, he committed suicide. In the wrongful death action brought by his family against Blue Cross, the court of appeal, setting aside a summary judgment for the defendant, ruled that the action could proceed to trial. The court squarely rejected the idea that any "important public policy" in favor of utilization review should restrict the scope of liability.¹³⁵

The third case, *Fox v. Health Net*, went to trial in December 1993.¹³⁶ Nelene Fox, enrolled in the Health Net HMO, was suffering from advanced breast cancer. After she had been evaluated by a Health Net oncologist,¹³⁷ she was referred to specialists at the University of Southern California Medical Center, who thought that she was an appropriate candidate for a bone-marrow transplant. However, the HMO's associate medical director, in charge of the HMO's utilization review program decided not to approve the transplant. This decision-maker almost certainly took into account the \$150,000 cost of the transplant procedure. Fox family members, however, were eager for the transplant, and were eventually able to raise the funds to finance the procedure themselves. The August, 1992 transplant may well have been successful in extending Nelene Fox's life by a few months and in providing her with additional quality time with her family. Even so, she died of cancer in April, 1993. Before her death, she and her husband filed suit against Health Net, alleging the tortious infliction of emotional distress; her brother was the family's lawyer in this suit.

¹³⁴ Because of the patient's limited financial resources, the court was able to conclude that Blue Cross's refusal to pay for further hospitalization was in a sufficiently meaningful sense a "cause" of the discharge. *Wilson*, 271 Cal. Rptr. at 883. The *Fox* case, discussed below in text accompanying notes 136-41, suggests how complicated the causation issue can get. For an interesting recent discussion of causation, see Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1328 (1994).

¹³⁵ *Wilson*, 271 Cal. Rptr. at 884.

What is here set forth is a somewhat simplified account of *Wilson*. The health insurance contract in that case seemed to say that the contract covered hospitalization whenever the insured's physician decided that hospitalization was necessary. *Id.* at 880. Accordingly, the very creation of the cost-containment program that enabled the insurer to reject the physician's recommendation could be regarded as a breach of contract. *Id.* at 881. Indeed, this contract argument in *Wilson* tended to subordinate the wrongful-death negligence argument that my text here emphasizes.

¹³⁶ The following paragraph draws on Erik Eckholm, *\$89 Million Awarded Against Family Who Sued H.M.O.*, N.Y. TIMES, Dec. 30, 1993, at A1; Tom Gorman, *Jury Adds \$77 Million Against HMO that Denied Coverage*, L.A. TIMES, Dec. 29, 1993, at A3; Telephone Interview with Mark Hiepler (plaintiffs' counsel), Feb. 17, 1994; Telephone Interview with Lyle Swallow (defense counsel), Feb. 23, 1994.

Not surprisingly, the accounts of the evidence that I have received from opposing counsel differ in important respects; and I have not attempted to resolve those differences.

¹³⁷ Opposing counsel have provided me with quite different accounts of the substance of this oncologist's evaluation.

The suit went to trial after her death.¹³⁸ In December, 1993, the jury awarded \$12 million in compensatory damages, and an additional \$77 million in punitive damages.

While bone-marrow transplants are effective in dealing with certain cancers such as leukemia, their efficacy in cases of advanced breast cancer is currently uncertain (and under study by the federal government).¹³⁹ The transplant procedure, as noted above, is quite expensive. Also, it requires a considerable period of hospitalization and carries a five percent risk of death. While Mrs. Fox's contract specified that Health Net would not provide her with "experimental" treatments, it also indicated that bone-marrow transplants were "covered services."¹⁴⁰ As for the Health Net associate medical director, he was eligible for an annual bonus geared to the company's overall profitability. Plaintiffs' evidence tended to identify an additional bonus, tailored to the associate medical director's success in "optimizing" medical care within the particular provider group. However, the defendant's evidence tended to show that this second bonus, while proposed, had never been implemented.¹⁴¹

In assessing the significance of this trio of cases, one can employ the facts in *Wickline*, in which the patient's physician wanted eight days of hospitalization, and Medi-Cal approved only four. These facts are especially useful, since hospitalization days play a large role in the overall costs that a health plan incurs. Assume now that the cost-beneficial period of hospitalization would be six days. Traditional fee-for-service might result in eight days of hospitalization, thereby producing excessive defensive medicine. On its facts, then, *Wickline* shows how such a program can be successful in achieving a desirable cost-containment goal. Yet the momentum of cost containment on HMO decisionmaking might result in the further reduction of the patient's

¹³⁸ The medical evidence available to the plaintiffs' attorney did not indicate that the delay in the transplant was the probable cause of her death. Accordingly, the lawsuit did not include a wrongful death claim.

¹³⁹ See Eckholm, *supra* note 136, at 57.

¹⁴⁰ Defense counsel reconciles these two clauses by suggesting that the contract guarantees bone-marrow transplants when they are medically appropriate (for example, in a leukemia case) but not when they are medically uncertain (as with advanced breast cancer).

The plaintiffs' evidence in *Fox* showed that Health Net had provided bone-marrow transplants to two other patients. Health Net offered explanations as to why these two patients were atypical. The jury's punitive damage award suggests that the jury rejected these explanations and perceived that the HMO had treated Mrs. Fox in a disfavored way. A recent survey finds a lack of uniformity in how insurance companies treat patients who seek bone-marrow transplants. See 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). Not only were there variations among different insurers, but the same insurance company would often treat its own insureds in nonuniform ways.

¹⁴¹ It is unclear how the jury resolved this conflict in the evidence.

hospital stay from six days down to four. This is a result that looks like malpractice. Given its facts, *Wilson* suggests how cost-containment reviews might be the source of malpractice. In a society, then, which increasingly relies on cost containment and HMOs, the malpractice tort as affirmed by the *Wickline* dictum acquires an important new function—offsetting the incentives for malpractice that these institutional arrangements seem capable of providing.

The counter incentives provided by these cases are already affecting the behavior of health-care institutions. HMOs are responding to decisions such as *Fox* by making certain tests and procedures more readily available.¹⁴² However, even if one appreciates that cases like *Wilson* and *Fox* provide a *possible* solution to the problem with cost-containment programs, one may wonder whether they provide an *intelligent* solution. Malpractice litigation, even in its ordinary contexts, inspires concerns about the competence of the jury to render intelligent decisions on malpractice issues. The problem of jury competence looms especially large as one considers the new responsibility that is assigned to the jury by the *Wickline* dictum. For that matter, if the actual goal of cost-containment programs is to properly balance the health benefits of medical services and the costs associated with those services, a special problem is that juries have often proved hostile to the core public-policy idea that high monetary costs can justify a reduction in health or safety.¹⁴³

Fox itself provides an interesting illustration of the range of problems. From what an outsider can tell,¹⁴⁴ the jury in *Fox* might have reached the right result in finding liability. But it also is possible that the jury erred in an emotional way in imposing liability for compensatory and especially punitive damages.¹⁴⁵ At the very least, when cases like *Wilson* and *Fox* go to juries, there is considerable uncertainty as to jury verdicts. This uncertainty can perplex defendants who want to account for the prospect of liability, and can lead to a variety of undesirable behavioral responses.¹⁴⁶

¹⁴² See George Anders, *More Insurers Pay for Care That's in Trials*, WALL ST. J., Feb. 15, 1994, at B1, B6; Gina Kolata, *Patients' Lawyers Lead Insurers to Pay for Unproven Treatments*, N.Y. TIMES, Mar. 28, 1994, at A1, A11; Thomas H. Maugh II, *Costly New Treatments Put Insurers in Quandary*, L.A. TIMES, Mar. 28, 1994, at A1, A20.

¹⁴³ See Gary T. Schwartz, *The Myth of the Ford Pinto Case*, 43 RUTGERS L. REV. 1013, 1035-47 (1991) (describing "basic public beliefs").

¹⁴⁴ See *supra* note 136.

¹⁴⁵ The *Fox* case was settled by the parties in early April 1994, at a time when posttrial motions were still pending. The amount of the settlement was not announced. See *Law Note*, WALL ST. J., Apr. 7, 1994, at B5.

¹⁴⁶ For careful consideration of the impact on defendants of uncertain liability rules, see John E. Calfee & Richard Craswell, *Some Effects of Uncertainty on Compliance with Legal Standards*, 70 VA. L. REV. 965 (1984); Mark F. Grady, *A New Positive Economic Theory of Negligence*, 92 YALE L.J. 799 (1983).

D. Contract Law and Federal Law

Part C has suggested that a national care health program, by encouraging cost containment programs and HMOs, might well encourage courts to turn to the malpractice tort to discourage what courts would perceive as incentives for the provision of inadequate care. That Part then went on to consider whether the malpractice action is selective enough and intelligent enough to get this job done well. Let me now extend my analysis by showing how the legal formats of HMOs and a national health care program can eclipse or subordinate the patient's malpractice claim. Indeed, a national program could easily lead to the federalization of a body of law that until now has been exclusively under the domain of the state malpractice tort.

One alternative remedy stems from the contractual relationship between the HMO and the patient (or the employer or health alliance that represents the patient). The underlying contract might well limit the HMO's obligations. Assume, for example, that the contract specifies that the HMO will provide no more than twenty sessions of psychotherapy per year;¹⁴⁷ assume further that a patient alleges that the termination of psychotherapy after twenty sessions was unreasonable in a Learned Hand sense and caused him to suffer the harm of intense emotional distress. This tort claim would fail: the limitations built into the HMO's contractual commitment would confine the reach of the findings that a malpractice jury might otherwise render. On the other hand, the HMO contract might affirmatively specify that certain health services—for example, particular vaccinations—will be provided by the HMO. If the HMO then fails to do so, the patient has a breach-of-contract claim that would largely subordinate whatever malpractice claim she might have. Recall that in the *Fox* case, the plaintiffs relied in part on the contract language suggesting that Health Net would pay for bone-marrow transplants.¹⁴⁸

Furthermore, the HMO contract typically contains certain general terms to describe the services provided by the HMO. For example, the HMO might commit itself to affording all services that are "medically necessary."¹⁴⁹ Assume that the HMO declines to provide mammograms to patients under fifty, that this disinclination prevents

¹⁴⁷ This is the condition in the contract that the Kaiser-Permanente HMO offers to UCLA employees. See KAISER-PERMANENTE, YOUR HEALTH PLAN IN DETAIL 6 (1993). The contract also excludes "experimental or investigative services" and provides a paragraph-long definition. *Id.* at 44-45. If it were clear that a breast cancer treatment such as a bone-marrow transplant is experimental, then the HMO would be free of liability in a case such as *Fox*.

¹⁴⁸ See *supra* text accompanying note 140.

¹⁴⁹ This is the general language in the program that Health Net offers UCLA employees. HEALTH NET, DISCLOSURE FORM PLAN D2, at 3 (1993). On the meaning of this lan-

the HMO from detecting a forty-seven-year-old patient's breast cancer, and that the failure to promptly diagnose the cancer results in the patient's death. The patient may possibly have a claim against the HMO for malpractice, but the patient can also argue that the HMO has breached its contract. Next assume that the HMO obstetrician declines to perform a caesarian section for a patient who is beginning a difficult delivery, and that the infant emerges with a birth defect that a caesarian might have prevented. This patient can sue the HMO physician for his own malpractice; but it is possible that she can also sue the HMO, alleging breach of contract. In a society of HMOs, then, contract claims can combine with and possibly subordinate tort claims.

To be sure, the contract claim in question, like the tort claim, would arise under state law and would be primarily litigated in state courts. Furthermore, the American legal tradition has been to subordinate contract standards to tort standards when patients sue because of the adverse results of medical care. The law, for example, has disfavored patients' claims that the doctor has violated a promise to cure.¹⁵⁰ State courts probably would rely on this legal tradition when they consider the patient's claim against the HMO. Accordingly, the HMO's contractual obligation to provide "medically necessary" services would be interpreted in light of the physician's own tort obligation to provide reasonable and customary care in treating her patients. Indeed, the general language in one HMO contract I have consulted obliges the HMO to provide those procedures that are "generally and customarily provided to patients residing in the Service Area."¹⁵¹ This contract norm is drafted in a way that renders it a precise equivalent of the traditional malpractice norm. In all, then, when patients suing HMOs rely on both a common-law malpractice theory and a contract theory that depends on the general language in the HMO's disclosure form, the malpractice theory is likely to dominate the resolution of their suits.

Consider now how the situation would change if a national health care program is adopted. Most of the bills that Congress recently considered insisted on some "standard benefit package" of health insurance coverage.¹⁵² Accordingly, once a national program is approved,

guage in standard fee-for-service health insurance contracts, *see infra* text accompanying note 155.

¹⁵⁰ *See Sullivan v. O'Connor*, 296 N.E.2d 183, 186 (Mass. 1973) (requiring "clear" proof of the existence of such a promise).

¹⁵¹ KAISER-PERMANENTE, *supra* note 147, at 36.

¹⁵² There is a unitary one-size-fits-all quality to these standard benefit packages. I am therefore puzzled by the suggestion of Professors Henderson and Siliciano that the adoption of a national health care program would lead to greater diversity in the health service packages offered to various groups. *See James A. Henderson, Jr. & John A. Siliciano, Univer-*

the dimensions of HMO's obligations will be largely controlled by federal statutory requirements. Some of the bills recently considered by Congress went into considerable detail in their definitions of coverage. If any program that Congress finally approves mandates certain vaccinations, then an HMO that fails to provide such a vaccination would violate its federally imposed obligation, and would apparently bear liability for whatever harms result. Yet, if the specifics of the federal statute could create liability, they could limit liability as well. The Clinton bill, for example, would have expected HMOs to provide mammograms only to women over the age of fifty.¹⁵³ Had this bill been enacted, the HMO that failed to provide a mammogram to its forty-seven-year-old patient would probably be shielded from liability when the absence of a mammogram prevents it from detecting the patient's breast cancer.

Moreover, most of the bills Congress recently considered employed certain general terms in expressing the scope of mandated benefits. "Medically necessary" was a term commonly utilized; the Clinton bill itself would have required health plans to provide all services that are "medically necessary or appropriate."¹⁵⁴ The language of "medically necessary" is currently common in health insurance contracts, and "medically necessary" is often interpreted broadly as meaning "medically appropriate" rather than "medically imperative."¹⁵⁵ But in dealing with health insurance contracts, courts have found this concept difficult to understand. They have divided, for example, on its application to treatments such as bone-marrow transplants.¹⁵⁶ Moreover, judicial opinions have failed to clarify the extent to which economic costs are a relevant or important variable in understanding a "medical necessity" clause. Unfortunately, none of the bills considered by Congress provided any real definition of the "medically necessary" concept. Since the meaning of the concept seems essential in

sal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice, 79 CORNELL L. REV. 1382 (1994). *But see supra* note 67 and accompanying text.

¹⁵³ S. 1757, 103d Cong., 1st Sess. § 1114(h)(2)(B) (1993).

¹⁵⁴ *Id.* § 1141(a).

¹⁵⁵ *See* Hall & Anderson, *supra* note 106, at 1646 n.27. In the context of fee-for-service health insurance, the "medically necessary" standard comes in at the *second* level of decisionmaking. At the *first* level, the patient's physician decides on whether the patient should receive a particular medical service. Only after the physician has determined what services should be offered does the insurer review those determinations under a "medically necessary" standard for purposes of reimbursement. In the context of a national health program, "medically necessary" assumes a more central role: it becomes the criterion for determining what services should originally be provided by physicians.

¹⁵⁶ *Id.* at 1637-40.

any assessment of either the efficiency or the justice¹⁵⁷ of the various bills, the absence of a definition is unfortunate.¹⁵⁸

Under the Clinton bill, decisions as to what services are “medically necessary or appropriate” would initially have been rendered by the physicians and the managers of health plans. But when a recurring issue arises, the bill would have assigned to the National Health Board the authority to determine whether a particular service is “medically necessary or appropriate.”¹⁵⁹ Such an administrative agency could, for example, decide under what circumstances bone-marrow transplants are medically necessary or appropriate.¹⁶⁰ Moreover, in the course of deciding the bone-marrow transplant issue, the agency might articulate some general definition of the “medically necessary or appropriate” concept. Under the *Chevron* doctrine,¹⁶¹ federal courts would be required to defer to the agency’s interpretation of the admittedly ambiguous statutory term, so long as that interpretation is “reasonable.” Once a regulation has been adopted and judicially affirmed, the legal system would no longer need to rely on individual damage actions such as *Fox* to assess the acceptability of withholding a bone-marrow transplant.

Furthermore, even if the medical service denied by the patient’s health plan had not yet been considered by the agency, the Clinton bill sought to provide administrative procedures by which patients could complain about the health plan’s decision.¹⁶² These procedures were elaborate—indeed, so elaborate that when the bill was introduced industry lawyers complained that health plans would be unduly pressured to provide excessive services.¹⁶³ At any rate, the availability of a complaint procedure, enabling the patient prospectively to demand medical services, can serve as an alternative to tort

¹⁵⁷ See Ronald Dworkin, *Will Clinton’s Plan Be Fair?*, N.Y. REV. OF BOOKS, Jan. 13, 1994, at 20, 22.

¹⁵⁸ This absence was no doubt strategic; drafters of each bill probably perceived that any effort to provide a definition would prove excessively divisive among the groups they hoped to enlist in a coalition supporting the bill.

¹⁵⁹ S. 1757, 103d Cong., 1st Sess. § 1141(a)(2) (1993).

¹⁶⁰ See Dworkin, *supra* note 157. The Board would have rendered such decisions through regulations. S. 1757, 103d Cong., 1st Sess. § 1154 (1993). The bill was silent as to the procedures accompanying regulation drafting. Accordingly, these procedures—including an eventual right of judicial review—would evidently have been determined by the Administrative Procedure Act, and its particular requirements for informal rule making. 5 U.S.C. § 553 (1988).

¹⁶¹ *Chevron, U.S.A., Inc. v. Natural Resources Defense Counsel, Inc.*, 467 U.S. 837, 893-44 (1984).

¹⁶² S. 1757, 103d Cong., 1st Sess. §§ 5201-14 (1993) (outlining the procedures for submitting claims and filing grievances).

¹⁶³ Robert Macauley, Jr., *Clinton’s Proposed Amendments to ERISA Threaten to Undo the Cost-Containment Gains Achieved Under Managed Care*, NAT’L L.J., Jan. 31, 1994, at 29.

cases such as *Wickline* and *Wilson*, in which patients seek retrospective damages for harm caused by the withholding of medical services.

Yet as extensive as the claims procedures in a national health care program might be, certain practical conditions must be satisfied before the procedures can be utilized. One condition relates to timing. Take the doctor who decides (perhaps unwisely) not to perform a caesarian section for a pregnant woman who is beginning a difficult birth process. This woman obviously has no time to file a claim or grievance seeking a caesarian. The second condition concerns patient knowledge. Before filing a claim, the patient would need to know that there is some possibly beneficial medical service she is not receiving. In some cases, as in *Fox*, the patient will learn of the service being withheld. But in other cases, the patient may lack this knowledge.¹⁶⁴ If, for example, an HMO simply tells a patient that four days of hospitalization is enough, she might be unaware of the extent to which she would benefit by six or eight days. Moreover, the informed-consent doctrine, as currently interpreted, does not obligate the doctor to advise his patients of the services that he is *not* providing, and what all their pros and cons might be.¹⁶⁵

Consider now the ophthalmologist who does not include a pressure test in a routine eye exam.¹⁶⁶ As a result, his patient's glaucoma escapes detection.¹⁶⁷ Assume further that the administrative agency has not yet issued regulations on whether the pressure test is "medically necessary," and that the circumstances surrounding the physician's omission did not provide the patient with a realistic opportunity to file a statutory "claim." If the patient wants to sue after-the-fact for damages suffered, what legal theories are available to her? Presumably she can file a state-law malpractice action against the physician and (depending on vicarious liability doctrines) against the HMO as well. But can the patient, in bringing suit against the HMO, rely on her allegation of the HMO's violation of the federal "medically necessary" requirement? Whether the federal program authorizes a federal-law cause of action against the HMO for failing to afford a "medically necessary" service would of course depend on the exact language of the

¹⁶⁴ Glenn Ruffenbach, *Medicine: Debate Grows Over Rationing Medical Care*, WALL ST. J., Mar. 27, 1990, at B1.

¹⁶⁵ See, e.g., *Parris v. Sands*, 25 Cal. Rptr. 2d 800 (Ct. App. 1993). But these cases might well be reconsidered as courts perceive *both* that cost containment is the basis for the doctor's disinclination *and* that only by providing patients with information will patients be able to take advantage of the national program's claims procedure. For a debate among scholars, compare Mark A. Hall, *Informed Consent to Rationing Decisions*, 71 MILBANK Q. 645 (1993) with Paul S. Appelbaum, *Must We Forgo Informed Consent to Control Health Care Costs? A Response to Mark A. Hall*, 71 MILBANK Q. 669 (1993).

¹⁶⁶ See *Helling v. Carey*, 519 P.2d 981 (Wash. 1974).

¹⁶⁷ Routine eye exams, though often excluded from private health insurance, would have been covered by the Clinton bill. S. 1757, 103d Cong., 1st Sess. § 1125 (1993).

federal statute. In any event, the federal "medically necessary" standard would become a key feature in the patient's own contract with the HMO. Therefore, the patient can probably invoke "medically necessary" in suing the HMO for breach of contract under state law. To be sure, this suit would bristle with complications. Does the suit "arise under federal law" so as to confer original jurisdiction on federal courts?¹⁶⁸ If so, does that federal court have pendent jurisdiction¹⁶⁹ over the patient's state-law malpractice claim against the particular physician?

Yet whether the physician's combination of claims is litigated in federal court or state court, one point is clear enough. The federal character of the "medically necessary" issue in the plaintiff's claim means that state malpractice law would lose its primacy in determining what services doctors are obliged to provide to their patients. Assume that the failure to provide a pressure test does *not* depart from professional custom and hence does not count as malpractice under state law. Even so, if federal law is interpreted as regarding the pressure test as "medically necessary," the patient's suit would evidently be a winner.¹⁷⁰ Given its federal character, state courts would be unable to merge the "medically necessary" issue into the state's own malpractice standard. Accordingly, once a national health care plan is adopted, many of the lawsuits that now proceed as state-law malpractice actions will become lawsuits dominated by federal statutory standards. Whether a glaucoma pressure test should be included in routine eye exams is a question that until now has been resolved by state-court judges and juries.¹⁷¹ Yet under a national program, this question would instead be decided by the United States Supreme Court.¹⁷²

CONCLUSION

The basic findings and suggestions of this Article can here be summarized. The Clinton bill would have taken the important step of

¹⁶⁸ See *Merrell-Dow Pharmaceuticals v. Thompson*, 478 U.S. 804 (1986) (state-law cause of action that incorporates federal standard does not arise under federal law).

¹⁶⁹ See CHARLES A. WRIGHT, *LAW OF FEDERAL COURTS* 103-09 (4th ed. 1983) (discussing pendent jurisdiction).

¹⁷⁰ What if the HMO *does* provide the patient with all services that are "medically necessary" in the federal-law sense? Would full compliance with the federal standard prevent a jury from concluding as a matter of state malpractice law that there are additional services the doctor should have provided? The answer to this question would depend on the proper interpretation of the precise statutory language.

¹⁷¹ See, e.g., *Helling v. Carey*, 519 P.2d 981 (Wash. 1974).

¹⁷² Recurring and important issues might eventually be addressed by an agency regulation. Once such a regulation is promulgated, federal courts, as a matter of judicial review, would subject this regulation to a hard look. See *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins.*, 463 U.S. 29 (1983) (adopting the "hard look" approach).

reversing the collateral source rule in medical malpractice cases. Moreover, if adopted, a national health care program might well lead to the repeal of the collateral source rule in all tort cases, at least in its application to health insurance. The rule makes the most sense when insurance is uncommon, is the product of individual choice, and is paid for out of the individual's own pocketbook. If health insurance becomes universal, mandated by government, and financed in significant part by government, the rule would lose its commonsense fairness basis. To be sure, one alternative to the outright abrogation of the rule would be to recognize subrogation rights for health insurers against tortfeasors. Whether subrogation makes sense depends on a difficult comparison of the overhead entailed by subrogation and the deterrence it could provide.

Any repeal of the collateral source rule as applied to health care benefits would significantly reduce the size of tort awards. Also, a national program, reimbursing for medical expenses, would reduce victims' practical need to turn to the tort system to secure compensation. In light of this, the adoption of such a program would probably turn out to restrain the number of tort claims filed. Moreover, such a program would assure juries and judges that accident victims are free of the burden of heavy medical bills. Given this assurance, the program would somewhat reduce the proplaintiff bias of juries and dampen the liability-expanding ardor of appellate judges.

Such a program would also reinforce and accelerate the revolution that American medicine has recently been undergoing. That revolution seems capable of reducing the amount of inappropriate defensive medicine. It likewise should be able to lower the malpractice standard of care from the unduly lofty level it evidently has attained during the moderu era. At the same time, the new arrangements this revolution is bringing about give health care providers temptations for underutilization in the provision of tests and procedures. Courts are likely to turn to the malpractice action as a device for resisting these temptations. But the malpractice action may be too blunt an instrument to perform well in this regard. In any event, a national health care program would threaten the future of the traditional malpractice tort in its application to the tests and procedures that doctors provide. Under such a program, controversies concerning the provision of appropriate tests and procedures would increasingly be governed by federal statutory and regulatory standards.

The public debate about the tort aspects of health care reform has mainly concerned the restrictions that various plans would explicitly place on malpractice claims.¹⁷³ My conclusion here is that this

¹⁷³ See, e.g., Herbert, *supra* note 77; George McGovern, *A Sneak Attack on Malpractice Reform*, WALL ST. J., Aug. 11, 1994, at A12.

debate has been shortsighted, inasmuch as it has failed to identify and deal with the wide variety of ways in which a national health care program could significantly affect the entire tort system, especially its malpractice component. Few of these consequences can be regarded as having been intended by the authors and sponsors of the various plans. Yet the law of unintended consequences is quite familiar. In any event, many of those consequences are at least foreseeable; and this Article can be understood as an exercise in foresight.

As such, the Article has been primarily positive rather than normative. But at times it has included normative elements. For example, its perception that a national health care program would likely displace the collateral source rule derives from its assessment that the program's insurance benefits would be understood as not complying with the assumptions about collateral sources that provide the rule with its basic appeal. Similarly, its suggestion that judges will assign a new function to the malpractice tort is based on its understanding that modern arrangements for the delivery of medical services pose a real problem, and that judges will hence turn to the malpractice tort as a possible solution to that problem. Yet its concern for the imprecision of the malpractice doctrine has led the Article to cast doubt on the wisdom of that solution.