Journal of Health Care Law and Policy

Volume 12 | Issue 1 Article 2

The Ethical Foundations of Consumer-Driven Health Care

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THE ETHICAL FOUNDATIONS OF CONSUMER-DRIVEN HEALTH CARE

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Among contemporary American academic health policy commentators,[1] foundation researchers,[2] and liberal think tank analysts,[3] the concept of consumer-driven (also known as consumer-directed) health care is a subject of great trepidation and loathing, akin to the ever-unpopular managed care scapegoat of around a decade ago.[4] In the case of consumer-driven health care (CDHC), these emotions of dread emanate from several sources. Some critics have a rather transparent political agenda,[5] fearing that any success of the CDHC approach would weaken the political support for a universal single-payer (i.e., federal

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1. *See generally* TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT (2007) (discussing the benefits and problems existing in consumer-driven health care programs).

2. *See, e.g.*, Sara R. Collins, *Consumer-Driven Health Care: Why It Won't Solve What Ails the United States Health System*, 28 J. LEGAL MED. 53, 54 (2007) (reflecting an Assistant Vice President of the Commonwealth Fund's skepticism about health savings accounts and high-deductible health plans).

3. *E.g.*, *Health Savings Accounts and High Deductible Health Insurance Plans: Implications for Those With High Medical Costs, the Low-Income, and the Uninsured: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Cong. 7 (2008), *available at* http://www.urban.org/UploadedPDF/901168_Blumberg_health_insurance.pdf (statement of Linda J. Blumberg, Ph.D., Principal Research Associate, The Urban Institute).

4. *See* Arnold J. Rosoff, *Consumer-Driven Health Care: Questions, Cautions, and an Inconvenient Truth*, 28 J. LEGAL MED. 11, 18 (2007). *See generally* JAN GREGOIRE COOMBS, THE RISE AND FALL OF HMOS: AN AMERICAN HEALTH CARE REVOLUTION 290 (2005) (discussing how concerns about rationing override the "desirable attributes that would make [HMOs] an appropriate vehicle for delivering health care").

5. Although these critics rarely explicitly acknowledge their political agenda, usually it is quite easy to identify.

> [Certain] proposals . . . in the House Ways and Means Committee to require government bureaucratic review and approval of each individual expense funded by a Health Savings Account are a transparent attempt to destroy such accounts. Perhaps what is really intolerable to these congressmen is the idea of Americans depending on their own choices and resources, rather than being forced to depend on politicians as their only source of medical care. That requires them to relentlessly oppose anything that makes health care affordable for most Americans as an obstacle to implementing politically-controlled medicine.

Richard E. Ralston, Letter to the Editor, *Don't Kill Health Savings Accounts With Regulation*, WALL ST. J., Apr. 25, 2008, at A14.

government) health care system;[6] others accept the theoretical plausibility of CDHC but lament that it just will not—indeed, cannot—work as theorized in actual practice,[7] and several base their objections on philosophical or religious concerns.[8] I accept as my task in this article the mounting of an attempt to respond to the value-based apprehensions of my colleagues, whose own views are set out elsewhere in this symposium issue,[9] and specifically to outline the main ethical framework undergirding and supporting the arguments of CDHC proponents in the United States today.[10]

I. DEFINING THE CDHC MODEL

To pursue its tripartite objectives of making high-quality health care more accessible to, and affordable by, more individuals, the CDHC model may take many different structural forms.[11] As I have explained elsewhere,

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6. *See generally* David U. Himmelstein et al., *Our Health Care System at the Crossroads: Single Payer or Market Reform?*, 84 ANNALS THORACIC SURGERY 1435, 1438–39 (2007) (arguing that the U.S. should adopt a National Health Insurance program rather than a Consumer Directed Health Care system). One devotee of federal government hegemony over the health care system, Professor Peter D. Jacobson, smugly (but, to his credit, candidly) suggests a perverse reason to (almost) support CDHC:

> A serious backlash to CDHC may be the best way to achieve some form of universal health care, which I favor. As a result, part of me wants to adopt CDHC because doing so will simply hasten the enactment of some form of universal health care or single-payer system. After the experiment with CDHC fails, as it inevitably will, the only reasonable alternative will lie with greater governmental involvement. Once the market solution is exposed, there will be no more excuses and no justifications for further delaying universal health care. To that extent, CDHC may be the necessary precursor to a more equitable health care delivery system.

Kristin Madison & Peter D. Jacobson, Debate, *Consumer-Directed Health Care*, 156 U. PA. L. REV. PENNUMBRA 107, 113, 116 (2007), http://www.pennumbra.com/debates/pdfs/CDHC.pdf. Professor Jacobson's notion might well be turned on its head. One might convincingly surmise that a short-term experiment with a single-payer system would inevitably, disastrously fail, driving the public to embrace more fully a CDHC approach, and to drag along recalcitrant academic antagonists of the competitive marketplace with them.

7. *See, e.g.*, Rosoff, *supra* note 4, at 31–33.

8. *See, e.g.*, Timothy Stoltzfus Jost, *Access to Health Care: Is Self-Help the Answer?*, 29 J. LEGAL MED. 23, 40 (2008) ("If you believe, as I do both on the basis of my faith and my experience, that many hard-working poor people have not gotten everything in life that they deserve and that blessings are meant to be shared, then, at least as to health care, solidarity-based sharing makes more sense [than CDHC].").

9. *See* Rebecca Elon, *The Ethics of Health Care Reform: Unintended Consequences of Payment Schemes and Regulatory Mandates*, 12 J. HEALTH CARE L. & POL'Y 63 (2009); Namrata Kotwani & Marion Danis, *Expanding the Current Health Care Reform Debate: Making the Case for Socio-Economic Interventions for Low Income Young Adults*, 12 J. HEALTH CARE L. & POL'Y 17 (2009).

10. *See infra* Part II.

11. *See* Marshall B. Kapp, *Consumer-Driven Health Care: Implications for the Physician/Patient Relationship*, PHAROS, Spring 2007, at 12, 12–13. *See generally* CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS (Regina E. Herzlinger ed., 2004) (explaining the theory and mechanics of the CDHC model and rebutting common criticisms).

> [t]he most usual version of the consumer-driven model contains three separate but related parts.
> 1. A high-deductible health insurance product [HDHP] purchased for the individual or dependents by either a person's employer or union, the government, or the individual. It protects the insured person against the risk of incurring catastrophic health care costs. These insurance policies may vary regarding provider networks, particular services included, benefit packages, and co-payment requirements.
> 2. An individually-managed, tax-exempt, interest-bearing HSA [Health Savings Account], usually used to pay for routine and preventive medical, dental, and vision services that cumulatively cost less than the deductible amount specified in the insurance contract. Unused finds may be rolled over into, and accumulated in, various kinds of investment vehicles.
> 3. The so-called gap or doughnut hole. This component becomes pertinent if an individual uses up all the funds in his or her HSA to pay for medical care and then has to use personal, after-tax income until expenses reach the deductible threshold and the insurance policy begins to pay out.[12]

II. ETHICAL UNDERPINNINGS

Despite the many efforts exerted thus far to demonize "the logic and behavior of HSA free-market economics,"[13] the CDHC approach to health care reform[14] is predicated on a legitimate set of ethical underpinnings.[15] This moral foundation contains both deontological and consequentialist (or teleological) components.[16]

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12. Kapp, *supra* note 11, at 13.

13. Halsted R. Holman, *Health Savings Accounts—The Avoidance of Solution*, PHAROS, Spring 2007, at 16, 16.

14. Across the political and ideological spectrum, there is broad consensus that the American health care system is in serious need of some kind(s) of change. *See, e.g.*, Am. Coll. of Physicians, *Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries*, 148 ANNALS INTERNAL MED. 55, 72 (2008).

> [T]he U.S. health care system is inefficient and inconsistent: Health care quality and access vary widely both [sic] geographically among populations, some services are overutilized, and costs are far in excess of those in other countries. Moreover, the United States ranks lower than other industrialized countries on many of the most important measures of health.

Id. The unanswered question is what direction change should take. *See* Laura Meckler, *Parties' Split Most Apparent on Health Care—Democrats, Republicans Differ Over Roles of Government and Market to Revamp System*, WALL ST. J., Apr. 19, 2008, at A4; Geoff Colvin, *Making Health-Care History*, FORTUNE, June 9, 2008, at 20.

15. *See infra* Part II.

16. *Id.*

a. Deontological Considerations

Deontological arguments are those that are based on ethical principles or norms.[17] In the United States, the primary ethical principle in the health policy arena is individual autonomy.[18] "The law and ethics of medicine are today dominated by one paradigm—the autonomy of the patient."[19] Although some academic commentators have begun to take aim at the viability of the autonomy concept,[20] it remains a vital force in legal and public policy formulation.[21] The attempt to provide consumers with a meaningful opportunity for self-determination regarding the financial parameters of their own health care is at the heart of the CDHC movement.[22]

CDHC begins with the unassailable premise that someone, at some point, needs to make decisions regarding the health care financial resources to be available to each person.[23] First, the health care system is plagued by inefficiency, ineffectiveness, and waste; unnecessary or otherwise inappropriate medical services should be eliminated (as should payment for those services) in the interests of both cost-containment (i.e., making health care more affordable) and improving quality.[24] However, even when our attention is restricted to only those health care interventions that hold some promise of producing benefits for a particular patient, difficult coverage choices (put most bluntly, rationing) sometimes must be made

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17. *See* H. TRISTRAM ENGLEHARDT, JR., THE FOUNDATIONS OF BIOETHICS 57 (2d ed. 1996) ("The deontologists will consider the right- and wrong-making characteristics of the actions involved in order to endorse [a] decision.").

18. CARL E. SCHNEIDER, THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS 3 (1998).

19. *Id.*

20. *See, e.g.*, George P. Smith, II, *The Vagaries of Informed Consent*, 1 IND. HEALTH L. REV. 109, 112, 126–27 (2004) (discussing the difficulties facing many individuals when attempting to make informed health care decisions because of poor decision-making skills, anxiety, lack of medical knowledge, or mental or physical impairment).

21. *See* SCHNEIDER, *supra* note 18, at 6 (discussing state and federal legislative efforts to enhance patient autonomy through advance directives).

22. *See* EDMUND F. HAISLMAIER, HERITAGE FOUND., HEALTH CARE REFORM: DESIGN PRINCIPLES FOR A PATIENT-CENTERED, CONSUMER-BASED MARKET 1–2 (2008), *available at* https://www.policyarchive.org/bitstream/handle/10207/13490/bg_2128.pdf?sequence=1.

23. *See* Kapp, *supra* note 11, at 15.

24. *See* Gerard F. Anderson & Kalipso Chalkidou, *Spending on Medical Care: More is Better?*, 299 JAMA 2444, 2445 (2008).

> Currently, the United States spends more than twice as much as most other industrialized countries on health care services, some regions of the United States spend twice as much as other regions of the country, and some institutions or clinicians are twice as expensive as others. In terms of outcomes and satisfaction, the United States may have reached the position of diminishing returns for spending on medical care.

Id.

because financial, as well as human[25] and material,[26] resources available for devotion to health care services ultimately are finite.[27] The limited economic capacity of any modern society, including the United States, to satisfy all medically valid demands has been recognized quietly for a considerable time,[28] but the acknowledgment of limited resources and the consequent need to make choices has become much more widespread and open recently.[29]

There are a number of potential candidates for the role of health care rationing agent[30]—the government,[31] insurers,[32] the community,[33] individual physicians at

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25. *See* Am. Coll. of Physicians, *supra* note 14, at 59 ("The United States is in the midst of a primary health care workforce crisis that is expected to worsen precipitously in the next decade.").

26. *See* Thomas H. Lee, *Rationing Influenza Vaccine*, 351 NEW ENG. J. MED. 2365, 2366 (2004). Thomas H. Lee writes regarding the shortages of material health care resources, noting that:

> With the flu-shot crisis, everyone—including the patients—knows that the shortage is not artificial. The problem is not some company's unwillingness to pay for care or society's reluctance to suffer a tax increase. Patients are not questioning physicians' financial motives. And most patients say they want their flu shots to be saved for patients who are sicker than they are.

Id.

27. *See* Marshall B. Kapp, *Health Care Rationing Affecting Older Persons: Rejected in Principle But Implemented in Fact*, 14 J. AGING & SOC. POL'Y 27, 28 (2002). *See generally* GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES (1978) (warning of the hazards of public involvement in rationing choices).

28. *See* CALABRESI & BOBBITT, *supra* note 27, at 186 (1978) (discussing the allocation of limited quantities of kidneys among transplant patients in the United States); DANIEL CALLAHAN, WHAT KIND OF LIFE? THE LIMITS OF MEDICAL PROGRESS 32 (1990).

29. *See* Am. Coll. of Physicians, *supra* note 14, at 63, 72.

> As a wealthy nation, the United States can devote a greater share of its national income on health care than can other countries. As wealth increases, individuals and society as a whole have greater means to purchase health care services, including services that in other countries might be considered discretionary or luxuries. . . . Although the United States produces and consumes more goods and services than any other country, resources still are limited and greater spending on health care will mean that less is available for other high-priority items, such as housing, education, and national defense, or will contribute to the escalation of the public debt.

Id. at 63.

30. *See* Brendan Miniter, *The Weekend Interview with Mark Sanford: South Carolina's Contender*, WALL ST. J., Apr. 19, 2008, at A11 ("[S]omeone is going to cap it [health care expenditures]. It's just a question of who is it going to be? A government bureaucrat? An HMO bureaucrat? Or is it going to be you? But it is going to be somebody, because we can't keep growing health care at double digits and expect to be competitive." (quoting South Carolina Governor Mark Sanford)).

31. *See* DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY 133–38 (1987) (advocating that the federal government ration health care for older adults by setting stricter limits on Medicare coverage).

32. *See* James E. Sabin & David Cochran, *Confronting Trade-Offs in Health Care: Harvard Pilgrim Health Care's Organizational Ethics Program*, 26 HEALTH AFF. 1129, 1129–30, 1133 (2007) (discussing how a group of health insurers rationed the distribution of Viagra and how health insurers often make tough allocation decisions).

the patient's bedside[34]—but each of these alternatives has been largely unappealing to a broad spectrum of the public and career policymakers.[35] Thus, if someone must perform the task of deciding how finite health care resources ought to be spent but the other alternatives are bad, proponents of CDHC contend the ethical principle of autonomy dictates that it ought to be the individual health care consumer who is afforded both the right and responsibility to make decisions about the allocation of limited health care dollars for his or her own health care services (i.e., what will be purchased and what will be foregone).[36] This ethical position promotes respect for individuals by economically empowering purchasers to be in control of their own respective health care programs, to the extent individuals can be in control in a real world of finite resources.[37]

The ethically and legally valid exercise of autonomy requires that a cognitively and emotionally capable decision-maker act voluntarily and on the basis of adequate information.[38] Critics of CDHC seek to infantilize people[39] by suggesting that health care is somehow so different (i.e., so much more inherently and irreducibly complex and confusing) than other sorts of consumer goods and services that decisions about how to spend one's own health care dollars are too inscrutable and emotionally charged for mere consumers themselves to possibly figure out.[40] In reality, though, it is highly debatable whether health care purchases are that much more fundamentally incomprehensible than other important decisions that consumers make every day about buying,[41] for example, real property, life and casualty insurance, financial investments, or automobiles. The fact that most individuals admittedly begin with a relatively low level of health literacy[42] in no

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33. *See* Lawrence Jacobs, *The Oregon Health Care Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL'Y & L. 161, 161–62 (1999) (describing Oregon's efforts to control Medicaid costs through rationing of services).

34. *See* Kapp, *supra* note 27, at 32.

35. HENRY J. AARON ET AL., CAN WE SAY NO? THE CHALLENGE OF RATIONING HEALTH CARE 131, 147–48 (2005).

36. *See* Marshall B. Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice*, 2 J. HEALTH & BIOMED. L. 1, 19 (2006).

37. *See id.*

38. *See* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMED. & BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: A REPORT ON THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 1–3 (1982).

39. *Cf.* Marshall B. Kapp, *Ninny Clients of the Nanny State? Selective Paternalism in Public Benefit Programs for Older Americans*, 6 GEO. J.L. & PUB. POL'Y 191, 191–92 (2008) (discussing how Social Security retirement and traditional Medicare programs infantilize older persons by presuming them incapable of exercising autonomy regarding their own income security or health care).

40. *See id.* at 208, 211; *see also* Mary Crossley, *Becoming Visible: The ADA's Impact on Health Care For Persons with Disabilities*, 52 ALA. L. REV. 51, 53 (2000) (discussing the argument that health care is a "special" good).

41. *See* Kapp, *supra* note 39, at 211–12.

42. *See* OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, DEP'T OF HEALTH & HUMAN SERVS., QUICK GUIDE TO HEALTH LITERACY 2.3 (2007) *available at* http://www.health.gov/

way negates their ability to become sufficiently educated to make ethically valid choices.[43]

A burgeoning array of information sources is constantly becoming publicly available to assist consumers to exercise autonomy in the health care marketplace.[44] Accessible "report cards" grading competing health plans on a comparative basis, for use by consumers, abound.[45] Certainly, a belief in the potential educability of consumers has taken hold in analogous areas.[46] For instance, the ethical and legal doctrine of informed consent applies with full force in the arena of clinical decision-making,[47] where there is a strong (albeit rebuttable) presumption that every adult patient is capable enough of understanding and manipulating often very complex medical information to make and express valid autonomous choices concerning specific diagnostic, therapeutic, and research interventions.[48] Similarly, it is widely contended in policy and practice circles that many older disabled persons and younger chronically disabled individuals are capable (with sufficient informational and administrative support) of personally deciding upon and directing even the most complicated aspects of their own home- and community-based long term care.[49] There is no meaningful distinction between medical informed consent, home- and community-based long term care, and similar situations in which consumer autonomy is honored and applauded, on the one hand, and the area of CDHC, on the other.[50]

The personal autonomy rationale for CDHC has been summed up best by George McGovern, a past populist candidate for President of the United States:[51]

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communication/literacy/quickguide/Quickguide.pdf (stating that only 12 percent of adults have proficient health literacy).

43. *See id.* at 2.4, 4.1–5.4 (explaining the ways in which health professionals and adult educators can more effectively convey health information to American adults).

44. *See, e.g.*, M. Gregg Bloche, *Consumer-Directed Health Care*, 355 NEW ENG. J. MED. 1756, 1756 (2006) (describing initiatives to provide clearer information about quality, price, and efficacy to health care consumers); Carolyn Clancy, U.S. Dep't of Health & Human Servs., Advice Columns, Navigating the Health Care System, http://www.ahrq.gov/consumer/cc.htm (last visited Apr. 8, 2009).

45. *See e.g.*, Nat'l Comm. for Quality Assurance, Report Cards, http://reportcard.ncqa.org/plan/external/Plansearch.aspx (last visited Apr. 8, 2009).

46. *See* Kapp, *supra* note 36, at 13.

47. *Id.*

48. *Id.* at 2, 10–11, 14.

49. *See* Carol J. Whitlatch, *Older Consumers and Decision Making: A Look at Family Caregivers and Care Receivers*, *in* CONSUMER VOICE AND CHOICES IN LONG-TERM CARE 3, 13–15 (Suzanne R. Kunkel & Valerie Wellin eds., 2006).

50. *See* Kapp, *supra* note 36, at 25 (explaining that the challenges facing autonomy proponents in the consumer-driven health care paradigm are not fundamentally distinguishable from the challenges facing patients in the clinical arena).

51. Edwin Harper, *The New Populism: Radicalizing the Middle*, TIME, Apr. 17, 1972, *available at* http://www.time.com/time/magazine/article/0,9171,944465,00.html.

> I've come to realize that protecting freedom of choice in our everyday lives is essential to maintaining a healthy civil society. Why do we think we are helping adult consumers by taking away their options? We don't take away cars because we don't like some people speeding. We allow state lotteries despite knowing some people are betting their grocery money. Everyone is exposed to economic risks of some kind. But we don't operate mindlessly in trying to smooth out every theoretical wrinkle in life. The nature of freedom of choice is that some people will misuse their responsibility and hurt themselves in the process. We should do our best to educate them, but without diminishing choice for everyone else.[52]

b. Consequentialist (Teleological) Considerations

"The consequentialists will analyze a particular bioethical case by considering the consequences that make it appropriate or inappropriate to embrace a particular decision."[53] There are several ways in which promotion of the CDHC model will contribute to ethically desirable outcomes or results.

First, making health care affordable for people is a laudable social or distributive justice goal.[54] None of the financing models with which we have experimented previously have been successful in containing the inexorable increase in health care costs.[55] CDHC, by contrast, has the potential to achieve a meaningful measure of cost containment.[56] An informed, economically empowered consumer is a better purchasing agent for his or her own health care than would be the government, a managed care organization, or health care providers, in at least two respects. Under CDHC, individuals have a personal incentive to shop around for the best value for their dollars, thus fostering price competition among providers who would need to vie for informed, cost-conscious customers to purchase their

52. George McGovern, *Freedom Means Responsibility*, WALL ST. J., Mar. 7, 2008, at A15.

53. ENGLEHARDT, *supra* note 17, at 56–57.

54. *See* Wendy K. Mariner, *Access to Health Care and Equal Protection of the Law: The Need for a New Heightened Scrutiny*, 12 AM. J.L. & MED. 345, 346–47, 372 (1986) (explaining the importance of access to health care in ensuring equality of opportunity).

55. *See, e.g.*, Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, at tbl.1 (2006), *available at* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf (indicating that national health expenditures have continued to increase every decade from 1960 until 2006).

56. *See* PAUL FRONSTIN & SARA R. COLLINS, EMPLOYEE BENEFIT RESEARCH INST., FINDINGS FROM THE 2007 EBRI/COMMONWEALTH FUND CONSUMERISM IN HEALTH SURVEY (2008), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_03-2008.pdf (explaining that consumer-driven plans encourage cost-conscious decision-making); Paul Fronstin & John MacDonald, *Consumer-Driven Health Plans: Are They Working?*, WALL ST. J., Apr. 22, 2008, at A17.

services in a vibrant free marketplace.[57] Competition would chisel away at current price barriers.[58] Moreover, because the individual consumer is economically encouraged (because it is his or her own money at risk) to reduce the overuse of health services whose necessity and value are questionable,[59] there is a reasonable chance to reduce much of the moral hazard, accounting for substantial waste and inefficiency, that occurs when, as now, consumers have an incentive to overuse expensive services because a third party is paying for those services.[60]

As expressed by one analyst:

> For all its [CDHC's] problems, at least it puts the consumer in charge. Would that create a world where we're forced to dicker with heart surgeons? No. It will create a world where health care is treated as the precious resource that it is, rather than a costless entitlement; where nationwide competition pushes down the price of catastrophic care and consumers focus their attention and budgets on what's really crucial to their health. That's an important first step. The price of health care is never going to get under control until patients get what they deserve: the right to be consumers too.[61]

Second, infusing the health care financing arena with economically empowered and motivated consumers as purchasers creates an incentive for health care providers to compete for patients on the basis of quality (as measured by patient outcomes that can be compared easily by informed consumers) and customer service.[62] Improving health care delivery, both in terms of clinical outcomes and customer satisfaction, serves the ethical goal of beneficence, or doing good for the patient.[63] Third, wider dissemination of the CDHC model holds the potential for promoting social or distributive justice by improving access to good

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57. *See* FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, chap. 5, at 28–30 (2004), *available at* http://www.usdoj.gov/atr/public/health_care/204694.pdf (explaining that a well-functioning market will maximize consumer welfare when consumers are able to make their own well-informed health care decisions and that price competition will usually lead to lower prices); Madison & Jacobson, *supra* note 6, at 108–10 (explaining that CDHC increases health care consumers' sensitivity to costs, which may create greater levels of competition and reduce health care expenditures overall).

58. *See* FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 57, at chap. 1, at 41–43.

59. *See* Madison & Jacobson, *supra* note 6, at 108–09.

60. *Id.* at 109 ("CDHC's first potential long-run effect is to change the way that people think about health care and health care coverage."). *But see* John A. Nyman, *Consumer-Driven Health Care: Moral Hazard, the Efficiency of Income Transfers, and Market Power*, 13 CONN. INS. L.J. 1, 2–3 (2006) (arguing against the view that CDHC will reduce prices by reducing moral hazard).

61. Shawn Tully, *Why McCain Has the Best Health-Care Plan*, FORTUNE, Mar. 17, 2008, at 143, 146.

62. *See* FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 57, at chap. 1, at 41–43; Madison & Jacobson, *supra* note 6, at 109–10.

63. *See* William G. Kelly, Comment, *Ericka and Myron: Canaries in the Mines*, 13 ALB. L.J. SCI. & TECH. 173, 189–90 (2002) (explaining that the principle of beneficence requires physicians "to help or at least to do no harm").

quality health care provided in a decent customer service environment for many people who lack such access today just because they are not economically empowered.[64] Individuals who are uninsured or underinsured often have little choice regarding where, when, and from whom they can receive their medical care, because providers are not competing for their business;[65] indeed, providers often do whatever they can to discourage access to their (unreimbursed or insufficiently reimbursed) services by the economically disadvantaged segment of the population.[66] A paradigm in which public support allows the presently uninsured and underinsured population to participate as economically empowered, "skin in the game" consumers in the health care marketplace makes members of that group desirable customers for profit-seeking health care providers.[67] Providers would have a financial incentive to make their services accessible to this previously shunned set of consumers.[68] Current inequities in health care access created by the existence of significant pockets of people lacking the economic power to demand easily available, high-quality, affordable health services could be reduced.

Another consequentialist underpinning of the CDHC paradigm is the Rule of Second Best. This Rule basically means that, although everyone has a different favorite solution, they almost all can agree on the second best alternative.[69] Historically, the United States has experimented in some depth with various public and private command-and-control mechanisms of health care financing in which the major decisions about health care coverage have been made by parties other than the consumer: unmanaged fee-for-service,[70] central health planning,[71] and

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64. *See* Madison & Jacobson, *supra* note 6, at 116 ("To be sure, market competition is generally good at reducing costs and improving quality. . . . For those who believe that excessive costs and poor quality are the most glaring health care failures, CDHC could be a viable option."). Professor Jacobson goes on, however, to express skepticism about the plausibility that reducing costs will lead to enhanced access without governmental intervention. *Id.*

65. *See* Barry R. Furrow, *Access to Health Care and Political Ideology: Wouldn't You Really Rather Have a Pony?*, 29 W. NEW ENG. L. REV. 405, 406 (2007) (noting that the poor and uninsured must rely on the charity of providers as "health care beggars").

66. *See* Hoangmai H. Pham et al., *Financial Pressures Spur Physician Entrepreneurialism*, HEALTH AFF., Mar.–Apr. 2004, at 70, 76 (describing physicians' efforts to avoid low-income patients by refusing to take new patients admitted through the emergency room).

67. *See* HAISLMAIER, *supra* note 22, at 1–2. Even in the absence of new government support for the uninsured and underinsured, those groups will likely still benefit indirectly under a predominantly CDHC regime. "Building a framework for disseminating information about health care prices could help not only HDHP/HAS participants, but also the uninsured and anyone else financing their own care, particularly if CDHC promotes price competition." Madison & Jacobson, *supra* note 6, at 112; *see also* CONSUMER-DRIVEN HEALTH CARE, *supra* note 11, at 200 ("Consumers who allocate funds they view as theirs now have 'skin in the game.'").

68. *See* HAISLMAIER, *supra* note 22, at 3, 7–8.

69. EZEKIEL J. EMANUEL, HEALTHCARE, GUARANTEED: A SIMPLE, SECURE SOLUTION FOR AMERICA 174–75 (2008).

70. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., YOUR GUIDE TO MEDICARE PRIVATE FEE-FOR-SERVICE PLANS 1, 7 (2007), *available at*

managed care.[72] None of these systems have come remotely close to producing widespread, ongoing public or academic satisfaction with the value tradeoffs made by the parties who controlled spending choices.[73] The unmet challenge is illustrated by the following two quotations. "The fundamental problem arises because of a cost-coverage trade-off. Without controlling health care costs, any attempt at universal coverage will be transient."[74] "The current rate of increase in societal resources devoted to health care is widely thought to be unsustainable. . . . But setting limits on expenditures of *shared* societal resources is ethically required for sustainability [of the health care system]."[75] There is an urgent need for further experimentation in the quest for improved quality, affordability, and access,[76] and the burden of proof at this point ought to rest on the proponents of paternalistic approaches rather than the advocates of strategies that maximize consumer autonomy. The individual consumer may not be the perfect ethical risk manager—some may make bad decisions—but may well be the best alternative for the job.

III. KNOCKING DOWN THE STRAWPEOPLE

Even the staunchest opponents of CDHC (which is to say, the staunchest proponents of a federal government-qua-single payer health care financing regime) reluctantly admit, "Whether CDHC will benefit or harm individual enrollees is an empirical question that has not yet been answered."[77] This lack of evidence,

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http://www.medicare.gov/Publications/Pubs/pdf/10144.pdf (explaining that Medicare Private Fee-for-Service Plans must only cover what Medicare deems to be "medically necessary services" and that not all providers accept the plan's payment terms); *see also* David M. Eddy, *Balancing Cost and Quality In Fee-For Service Versus Managed Care*, HEALTH AFF., May–June 1997, at 162, 163–64 (explaining differences between fee-for-service and managed care); Pamela Signorello, *The Failure of the ADA—Achieving Parity With Respect to Mental and Physical Health Care Coverage in the Private Employment Realm*, 10 CORNELL J.L. & PUB. POL'Y 349, 376–77 (2001) (citing the fall of "unmanaged fee-for-service").

71. Darwin Palmiere, *Types of Planning in the Health Care System*, 62 AM. J. PUB. HEALTH 1112, 1114 (1972).

72. Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 121 (2005).

73. *See* Kapp, *supra* note 11, at 12; *see also* Mark A. Levine et al., *Improving Access to Health Care: A Consensus Ethical Framework to Guide Proposals for Reform*, HASTINGS CENTER REP., Sept.–Oct. 2007, at 14, 17–18 (describing the problems and shortfalls of various ethical and financial tradeoffs in the American system of health care delivery).

74. Ezekiel J. Emanuel, *The Cost-Coverage Trade-off: "It's Health Care Costs, Stupid"*, 299 JAMA 947, 947 (2008); *see also* Mark Schlesinger & Jacob S. Hacker, *Secret Weapon: The "New" Medicare as a Route to Health Care Security*, 32 J. HEALTH POL. POL'Y & L. 247, 248 (2007) (discussing how the evolving Medicare program, a private/public hybrid, may serve as a bridge to universal health insurance coverage in the United States).

75. Levine et al., *supra* note 73, at 17.

76. *See, e.g.*, Charles Kenney, Op-Ed., *Finally, A Little Optimism In Healthcare*, BOSTON GLOBE, Jul. 30, 2008, at A13 (discussing the decline in health care quality in the United States and the current need for easier access to medical care).

77. Madison & Jacobson, *supra* note 6, at 113–14, 120.

however, has in no way inhibited critics of consumer control from suggesting a parade of horrible results that would be visited upon the United States if CDHC took hold more strongly.[78] To the extent that critics can get away with portraying an extreme libertarian version of CDHC,[79] it certainly is possible that some of the critics' fears might be realized. But, a less extreme and more compassionate version of CDHC is considerably more likely,[80] and under such a moderated approach the worst horribles paraded by CDHC critics become more like strawpeople to be knocked down.

a. CDHC Ignores the Poor

Social Darwinists[81] would leave people to sink or swim with the vagaries of life's health lottery and not be concerned about the inability of the poor to participate in and reap benefit from society's health care delivery opportunities.[82] However, the overwhelming majority of CDHC advocates do not fall into that philosophical category.[83] There is nothing at all inconsistent between CDHC and a strong sense of social responsibility and equity (not to be confused with equality in the sense of mandated uniformity).[84] The absence of monolithic control by a government bureaucracy does not have to equal an absence of public subsidization of participation by the poor in the private system. On the contrary, unlike current and proposed health care financing systems that patronize poor people by using the blunt force of law to deprive them of any meaningful control over the details of their own health care,[85] CDHC is fully compatible with an agenda of leveraging private interests with public dollars by empowering the poor to direct their own

78. *See* Amy Feldman & Peter Carbonara, *Are You Ready to Own Your Health Care?*, MONEY, Nov. 2004, at 135, 136 (noting that critics of CDHC contend that CDHC would leave the poor with little or no significant health care and would leave employees with a greater share of health care costs).

79. *See, e.g.*, RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 18–23 (1997).

80. *See* Meredith Rosenthal & Arnold Milstein, *Consumer-Driven Plans: What's Offered? Who Chooses?*, 39 HEALTH SERVICES RES. 1055, 1068–69 (2004) (explaining the market approval of moderate forms of CDHCs that "emphasize consumerism").

81. *See generally* RICHARD HOFSTADTER, SOCIAL DARWINISM IN AMERICAN THOUGHT (1969) (discussing the lack of concern for the poor under Social Darwinism).

82. *See* William R. Patterson, *The Greatest Good for the Most Fit? John Stuart Mill, Thomas Henry Huxley, and Social Darwinism*, 36 J. SOC. PHIL. 72, 72–73 (2005).

83. *See* Katherine Baicker et al., *Lowering the Barriers to Consumer-Directed Health Care: Responding to Concerns*, 26 HEALTH AFF. 1328, 1330 (2007) (explaining that due to tax advantages, a CDHC plan attracts and is available to both low- and high-income individuals).

84. *See* Madison & Jacobson, *supra* note 6, at 121 (arguing that, though CDHC has the potential to decrease public support for equity programs such as universal health care, this will likely never happen).

85. *See* David R. Riemer, *Follow the Money: The Impact of Consumer Choice and Economic Incentives on Conflict Resolution in Health Care*, 29 HAMLINE J. PUB. L. & POL'Y 423, 429–32 (2008).

health care delivery with the benign help of progressive tax credits[86] and taxpayer-supported vouchers or cash, in the same way that we use the governmental Food Stamp program to entitle needy people to privately control their own nutrition agendas.[87] In both CDHC and the Food Stamp program, compassionate but intelligent policymaking would utilize public dollars to purchase private control—hence, a sense of dignity and respect—for those who would otherwise be financially excluded from the benefits of consumer direction because lack of finances made them supplicants of the mandatory government bureaucracy.[88]

b. CDHC Means No Consumer Protection

Similarly, the claims of CDHC critics that this approach to health care financing leaves vulnerable consumers unprotected against the perceived evils of deregulation of the health care financing system[89] are ill-founded. On the contrary, responsible proponents of CDHC would agree with Mark Hall and Carl Schneider that "regulating markets and protecting consumers is a standard part of law's agenda. Law specifically ameliorates the harshness of applying commercial law to medical contracts in multiple ways"[90] and that "[g]ood private law is crucial to good markets, to ensuring that fair contracts are fairly enforced."[91]

First, a consumer empowerment regime, properly implemented so that the marketplace works as expected, will require more, not less, consumer protection regulation regarding such matters as guaranteed information availability,[92] prohibitions on fraudulent business practices,[93] and restraints on competitive conduct that restrains competition.[94] Thus, CDHC would not entail deregulation at

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86. *See* M. Gregg Bloche, *Consumer-Directed Health Care and the Disadvantaged*, 26 HEALTH AFF. 1315, 1323 (2007) (suggesting progressive tax subsidies as a method to increase CDHC's impact on the economically disadvantaged); *see also* Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J.L. & MED. 395, 396, 406 (2005) (noting the existence of state tax subsidies for Health Savings Accounts).

87. 7 U.S.C. § 2011 (2006); *see also* David A. Super, *Are Rights Efficient? Challenging the Managerial Critique of Individual Rights*, 93 CAL. L. REV. 1051, 1056–58 (2005) ("[B]oth critics and defenders of individual rights have seriously underestimated the contributions a[n individual] rights-based system can make to the efficiency and effectiveness of governmental activities.").

88. *See* Rosoff, *supra* note 4, at 13, 21.

89. *See* Madison & Jacobson, *supra* note 6, at 109.

90. Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 670 (2008).

91. *Id.* at 671; *see also* Riemer, *supra* note 85, at 442–43 (arguing that, in a consumer-driven regime, disputes between patients and providers are less likely to arise in the first place).

92. *See* Rosoff, *supra* note 4, at 23, 30 (discussing the need for "information-forcing strategies" to ensure that consumers have sufficient information to make health care decisions in a CDHC system).

93. *See* Jost & Hall, *supra* note 86, at 402, 407, 410, 416 (explaining possible fraudulent practices in CDHC).

94. *See* FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 57, chap. 2, at 3, 15–17 (explaining that many health care regulations limit physician competition); *id.* at chap. 8, at 3–4, 6–9 (describing the anti-competitive tendencies of the health insurance market).

all, but rather the pursuit of different, smarter forms of regulation than the blunt objects that the current regulatory regime employs to bludgeon participants into rough compliance.[95]

> Second, as Hall and Schneider have noted, the legal system has powers to protect patients when providers abuse their contractual power. Happily, courts command several doctrines for supervising contracts. Courts can (1) fill in missing contract terms or declare contracts void for vagueness, (2) amend or refuse to enforce unconscionable contracts, and (3) evaluate the fairness of fiduciaries' behavior.[96]

Furthermore, as a matter of consumer protection, under CDHC the states or federal government would closely prescribe and oversee the practices of the health insurance industry regarding the marketing, sale, and implementation of CDHC-related insurance products.[97] This regulatory opportunity would basically be lost under the single payer (i.e., federal government) models advocated by most of the critics of CDHC.[98]

c. CDHC Lets Employers "Off the Hook"

A third strawperson interjected by CDHC opponents is the erroneous claim that the CDHC paradigm is somehow incompatible with the involvement of employers as financial subsidizers of health insurance for their present and former workers and those workers' dependents.[99] Contrary to that claim, this paradigm presents no impediment to employers paying in whole or part for the HDHP premiums covering present and former workers and those workers' dependents or

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95. *See* Timothy Stolzfus Jost & Ezekiel J. Emanuel, *Legal Reforms Necessary to Promote Delivery System Innovation*, 299 JAMA 2561, 2561 (2008) (discussing the unintended but deleterious impact on delivery system innovation exerted by the current regulatory system).

96. Hall & Schneider, *supra* note 90, at 671.

97. *See generally* Jost & Hall, *supra* note 86, at 407–17 (discussing the need for health insurance regulation in a CDHC system).

98. *See* KAO-PING CHUA & FLAVIO CASOY, AM. MED. STUDENT ASS'N, SINGLE PAYER 101, at 9 (2008), *available at* http://www.amsa.org/uhc/SinglePayer101.pdf (explaining how a single payer system requires less regulation of physicians).

99. Jon R. Gabel et al., *Employers' Contradictory Views About Consumer-Driven Health Care: Results From A National Survey*, HEALTH AFF., Apr. 21, 2004, http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.210v1/DC1. The proposition that employers still ought to be involved as subsidizers of health care for their employees and dependents is itself a controversial one. *See* NAT'L BUSINESS GROUP ON HEALTH, OPPOSING AN EMPLOYER MANDATE, http://www.businessgrouphealth.org/pdfs/Opposing%20an%20Employer%20Mandate.pdf (last visited Apr. 13, 2009). *Cf.* Jane Zhang, *Lawsuits Test Disabilities Act—Two Cases Cite Little-Known Protections for People Who Aren't Disabled but Care for Those Who Are*, WALL ST. J., June 4, 2008, at D1 (discussing several pending lawsuits filed under the "association discrimination" provision of the Americans With Disabilities Act against employers who allegedly fired workers because of the medical costs generated by family members). Ms. Zhang's article illustrates a problem that would cease to exist if health care coverage were a matter of individual consumer choice instead of being yoked to a specific job or employer.

funding present employees' Health Reimbursement Arrangements (HRAs).[100] In fact, the prospect of achieving substantial systemic cost savings as an outcome of moving the workforce and dependents more to CDHC may actually make employers more amenable to contributing to health insurance coverage than they are today,[101] given that presently uncontrollable health care inflation discourages increasing numbers of employers from subsidizing workers' health care more generously.[102]

CONCLUSION

Despite numerous boasts to the contrary,[103] no individual or group—either internationally or within the United States—has yet produced the definitive, comprehensive "answer" to the challenge of achieving the ideal combination of health care quality, affordability, and accessibility.[104] Thus, sincere seekers of the most reasonable trade-offs among these three components must be open to all ideas, avoiding ideological closed-mindedness that would preclude the consideration of potentially useful approaches to the conundrum. Reflexively drawing false and inflexible adversarial dichotomies between "privatization" and "commodification" of health care, on one side, and an abstract deification of "social solidarity," on the other,[105] are foolish when virtually all reasonable observers of

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100. NAT'L CTR. FOR POLICY ANALYSIS, CONSUMER DRIVEN HEALTH CARE, http://cdhc.ncpa.org/learn/hra (last visited Apr. 13, 2009).

> An HRA can be offered in conjunction with a high-deductible health plan, and is funded by the employer for each participating employee. It pays for eligible health care expenses typically covered under the medical plan. Unused funds can be carried over to the next year to cover future health care expenses, an incentive to employees to use their personal HRA wisely. If funds are exhausted, the employee is responsible for satisfying the remaining deductible before the plan begins to pay. If the employee changes jobs, the money stays with the employer.

Id.

101. *See* Rosoff, *supra* note 4, at 14–15 ("[A]s much or more than anything else, what is driving the [CDHC] movement is employers' desire to limit their exposure to and responsibility for health care costs increases.").

102. *See, e.g.*, Paul Fronstin & Stephen Blakely, *Is the Tipping Point in Health Benefits Near?*, WALL ST. J., Apr. 22, 2008, at A16 ("[L]arge employers all think that small employers might be on the verge of taking such action [as dropping health benefits]."); Steve Jacob, *Health Benefits Making Employers Sick*, AUGUSTA CHRON. (Ga.), May 10, 2008, at A7 (addressing the cost-inspired trend of businesses substantially reducing health insurance benefits).

103. *See, e.g.*, EMANUEL, *supra* note 69, at 81–82; LAURENCE J. KOTLIKOFF, THE HEALTHCARE FIX: UNIVERSAL INSURANCE FOR ALL AMERICANS 92 (2007).

104. *See* Kapp, *supra* note 11, at 12.

105. *See* CATO INST., CATO HANDBOOK FOR CONGRESS: POLICY RECOMMENDATIONS FOR THE 108TH CONGRESS 283–94 (2003) *available at* http://www.cato.org/pubs/handbook/hb108/hb108-27.pdf (discussing the "privatization" of health care); George France, *The Form and Context of Federalism: Meanings for Health Care Financing*, 33 J. HEALTH POL. POL'Y & L. 649, 665 (2008) (defining "social solidarity" in the health care setting); *see generally* CONSUMING HEALTH: THE COMMODIFICATION OF

and participants in the health care financing and delivery enterprise acknowledge that some combination of public and private responsibility is both unavoidable and desirable.[106]

The CDHC model is properly "on the table" as one alternative in contemporary American health policy formulation. In the absence of dazzling success being radiated by other attempts to improve the health care financing and delivery situation,[107] CDHC deserves a fair trial and evaluation. The ethical foundation undergirding this approach is sound.[108] It may be great intellectual sport for critics to caricature market-based endeavors in the health care sphere, but demonization exercises that summarily reject policy proposals simply because they fail critics' liberal litmus tests[109] are likely to serve payers, providers, and actual or potential consumers of health services quite poorly.

HEALTH CARE (Saras Henderson & Alan Peterson eds., 2002) (discussing the theoretical underpinnings of consumerism in health care and manifestations of consumerism in the health care marketplace).

106. *See generally* ROSEMARY STEVENS, THE PUBLIC-PRIVATE HEALTH CARE STATE: ESSAYS ON THE HISTORY OF AMERICAN HEALTH CARE POLICY (2007) (outlining the history of public/private partnerships in American health care).

107. *See* Rosoff, *supra* note 4, at 19 ("[B]ecause nothing else has worked to control escalating health care costs, we might as well give CDHC a shot—a 'last ditch' effort, if you will.").

108. *See supra* Part II.

109. *E.g.*, Paul Krugman, Op-Ed., *Voodoo Health Economics*, N.Y. TIMES, Apr. 4, 2008, at A23.