How Congress plans to increase the cost of medical insurance and punish those who can least afford it

# Treatment Decisions: Tort or Contract?

By Paul H. Rubin

An issue that must be resolved under any health insurance policy is the locus of decisions on treatment. There will be times when a patient may want some treatment that the insurance company (hmo) will not want to provide. There may be other situations when a decision must be made about the amount to spend on care; two issues that come to mind are treatment at the end of life and amount of treatment for premature newborns. There are essentially two ways of making such decisions. They can be made *ex ante* through contract, or *ex post* through tort law. That is, it is possible to specify in advance what sort of payments will be provided through a contract between the patient and the hmo, or it is possible to wait until after some illness occurs and some treatment decision is made and then use tort law (or its variant, malpractice law) to decide whether the treatment offered was adequate.

The basic issue is this: a person in a healthy state can determine how much money he wants to spend on medical care if he should become ill; that is an *ex ante* decision. However, once the person becomes ill, he will want to spend more than he agreed to when healthy. That is because, when healthy, he did not know from what illnesses he might suffer, but once he has the additional information, he will desire increased spending. In order to contain medical costs to approximately the amount that consumers desire to spend, it is necessary to devise some method of deciding how much to spend in the event of illness. On the other hand, the hmo cannot unilaterally make the decision either. The hmo has received a payment from the consumer, and, just as the consumer desires to spend more in the event of illness than he initially contracted for, so the hmo has an incentive to spend less than it initially promised.

That is where the issue of the exact form of law that will govern the decision becomes relevant. Under contract law, the parties (consumer, hmo) specify in advance the nature of care and also the penalties for violation of the contract. Under tort law (or its variants, product liability and malpractice), the decision is made after treatment is offered and is based on a jury's second-guessing the medical decisions made. There are also fundamental differences between the remedies available under each body of law, as discussed below.

The argument of this paper is that contract law is preferable to the alternatives. In making the argument, I will first discuss the institutional background of the legal issues involved. I will then discuss contract and tort law. The last section is a conclusion.

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## Some Institutional Background: Contracts vs. Torts

parties can have two types of legal relationship with each other. They can engage in a voluntary mutual exchange or they can be legal "strangers." Parties to an agreement for one to buy a car from another are engaged in a mutual exchange, with the terms of the exchange mutually agreed upon. Parties to an accident involving two cars that crash into each other at a stoplight are strangers; they have not agreed to the terms of the interaction.

This distinction has long been important in the law. Parties to an agreement—buyers and sellers, employers and employees, doctors and patients—have been able to agree to the terms of their transaction. Their agreement includes terms such as price and quantity, product characteristics, and delivery date. But it has sometimes also included terms allocating the costs if the agreement should for some reason go wrong, such as warranty terms or penalty clauses for improper or incomplete performance. That is a desirable feature of contracts if we believe in free markets because it allows the parties to the agreement to establish whatever terms they find most useful.

Some examples: if a product is not of the promised quality, who has the duty to inspect and make a claim? What happens if the product turns out to be defective? What if some event makes delivery impossible? All of these terms and countless others are part of the law of contracts, and parties are able to freely bargain for whatever terms they find mutually desirable. Of course, the allocation of liability will also affect the price of the product. The point is that the party who can most effectively bear the associated risk will assume that risk because it will increase the gains to both parties from the contract. That is, the total cost of the product (price plus the real cost of any liability) will be lowest if the efficient party bears the costs.

As George Priest has shown, consumer product warranties have exactly this structure. Those elements of the product whose life is determined by the consumer (for example, the finish on the door of a refrigerator) are the responsibility of the consumer; those elements whose life is determined by the manufacturer (for example, the compressor of the refrigerator) are covered by the manufacturer. These arrangements reduce the total cost of the product (where cost includes repair and maintenance) and therefore result in the most efficient contract.

Such contracts also disallow what are called "consequential damages"—damages that are a result of product failure in addition to the cost of the product or repairs. For example, while the manufacturer would fix the compressor of a refrigerator, it would not pay for any spoiled food. The explanation is that it is easier and cheaper for the consumer to find another way to preserve the food than for the manufacturer to do so; moreover, the amount of loss suffered by a consumer is highly variable and therefore difficult for the manufacturer to insure against. If the manufacturer accepted the responsibility, the price of the product would have to increase by more than the cost to consumers of taking care. That will be the form contracts take in a market economy because the parties jointly gain the most from it, and the total cost of the product (including the price and the costs of precautions and repairs) will be lowest.

Until about 1960, the same theory applied to harms caused by consumer products as well. Manufacturers would fix or replace defective products, but they would not be liable for injuries associated with such products. However, beginning in about 1960, "product liability" became a principle of our legal system. Under the product liability rule manufacturers are liable for harms to consumers caused by defective products (with a very expansive definition of "defective"). Although the interests of lawyers were well served by that change in legal liability, the change was fundamentally inefficient and not in the interests of consumers.

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## Some Institutional Background: ERISA and HMOs

because of a legal quirk, insurance paid for and organized by employers is not subject to the same liability as other goods and services: such insurance is covered under erisa, the federal pension law, which exempts employers from such liability. Thus medical insurance is currently one of the products supplied under the most favorable market conditions because buyers and sellers are free to agree on terms. However, that may be subject to change.

One major policy question currently being debated is whether malpractice liability under tort law should apply to managed care offered by employers. Currently under erisa, such hmos are exempt from malpractice liability. There are several proposals that would extend malpractice by allowing patients to sue an hmo itself under tort law if they believe that the hmo or a physician employed by the hmo has harmed them or has unreasonably refused them some treatment. The proposals would also open to liability the employer who chose the hmo, unless the employer gives up any effort to monitor the hmo and

thus control costs. The proposals are flawed and would ultimately harm consumers, particularly low-income consumers. They would also lead to smaller enrollments in hmos, and those who would be excluded would be the poorer members of society. Many employers would cease offering health care benefits if these proposals passed.

It is quite surprising that such a policy is being seriously debated. Most studies of medical malpractice as it currently exists find that it is generally an unsuccessful policy as applied. In the United States, we already spend 1.4 percent more of gnp on the legal liability system than the average amount spent by oecd countries. Physicians are generally opposed to expanding the scope of malpractice for themselves, although many physician groups favor the proposals. Because of the failings of the malpractice system, malpractice reform and other types of tort reform have been adopted at both the state and federal levels, although there is much political debate about the best way to undertake such reforms. Malpractice liability is one element responsible for increasing the cost of medical care in the United States relative to other countries. Given that the U.S. system as it currently exists is so flawed and harmful, it is surprising that there is such demand for increasing its scope.

There are several important facts to keep in mind in evaluating the plans. First, it is ultimately patients and consumers who pay for health care. Even though the employer might write the checks, insurance costs are part of wages and therefore are ultimately paid by workers. Any rules increasing the costs of offering health insurance by hmos will be paid for in higher premiums or lower wages for workers. Second, in evaluating the plans, it is important to remember that payments will be made through the tort system, which generates costs (in the form of legal fees) of about 50¢ to $1.00 for every dollar that is transferred and which has other inefficiencies as well, as discussed below. Consumers also ultimately pay legal costs—both their own legal costs (usually paid as a percentage of any recovery) and the costs to the insurance company (paid through higher premiums for insurance.) Third, the rules governing hmos are ultimately contractual: representatives of covered persons and the medical plans negotiate them. Thus, if there is anything that existing plans do not cover that would be in the interest of patients, there is no reason the plans could not be modified to include such coverage with no need for a government mandate. Finally, proposed modifications of insurance plans would serve to benefit richer workers at the expense of poorer consumers, raising substantial issues of equity.

## HMOs Are Currently Pure Contracts

the first important point to note is that hmos are based on voluntary contracts. In most cases, employers choose medical insurance policies paid for (on paper) jointly by the employer and the worker. The employer has a strong incentive to choose an efficient plan—one that provides all cost-justified care and no more—because workers value medical insurance as part of their wages

and inefficient insurance will be viewed and treated as a reduction in wages. The employer generally hires a benefits manager or other professional with an interest in maximizing worker benefits for the amount spent. Any hmo that routinely denied efficient care would lose business from those informed buyers. There are also independent agencies certifying the quality of hmos.

It is also true that provision of medical care through voluntary contract has certain efficiency and other desirable properties. Primarily, it allows people to decide how much they want to spend on medical care as opposed to alternatives. While it may appear that one "needs" a certain amount of care depending on one's health, such is not the case. For many or perhaps most conditions, there are alternative amounts of medical care available, each with different resource costs. One major example is the amount of care to be given at the end of life. Some persons may want all possible efforts taken to keep them alive; others may prefer to end life sooner. But one input into this decision should be the cost. It may cost hundreds of thousands of dollars to prolong life for a relatively short time. Some persons may be willing to spend such an amount—either directly or in terms of higher insurance premiums for a policy that will provide such care. If someone has such preferences, then there is no reason not to allow the spending. On the other hand, if another person does not want to spend such an amount, he should not be forced to do so, nor should he be forced to pay for those who do. Allowing contractual freedom is the best way to make such decisions. If we do not allow free contract, then either the government or medical professionals will make decisions that are best left to the individual patient.

Cost tradeoffs in medical care are ubiquitous. Examples: Some drugs may produce fewer nonthreatening side effects or come in more convenient dosage forms but cost more. Some medical procedures or remedies may be purely comfort-enhancing or cosmetic. One example is medicine aimed at removing toenail fungus, an unsightly and uncomfortable malady but not in any sense threatening. Another widely publicized issue is payment for potency treatments. Still another is fertility treatment. The length of a stay in hospital following a procedure is another debated issue. A simple issue is the wait from the onset of symptoms of what may be an illness until treatment; sometimes symptoms will disappear with no treatment after some time, but a shorter wait will add to medical costs. Copayments are an efficient way of optimizing this decision. One important point to note is that consumers have the option of paying for courses of treatment that may not be covered by insurance themselves.

There are also incentives for hmos to provide the optimal level of quality of care. Richard L. Huber, the ceo of Aetna, discusses the competitive pressure on hmos to provide quality. He indicates that there is a private, nonprofit accrediting agency, the National Committee for Quality Assurance, that monitors hmo quality. Employers consider the evaluation received by an hmo in deciding whether to use it. hmos therefore find it competitively necessary to receive the agency's accreditation. Thomas M. Burton also discusses hmos' efforts to improve quality in response to demands from customers. He indicates that hmos often find it valuable to improve the quality of care offered by physicians.

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This incentive for efficiency has several implications. First, no hmo will offer benefits that are more costly than their value to consumers. That is, benefits will be cost-justified. If a given benefit costs on average $100 per year per employee but is valued at only $75, that is equivalent to a $25 pay reduction for the employee. A rational employer will not want to offer such benefits because the effect would be to reduce the supply of workers and essentially require the employer to pay more money for his work force. On the other hand, the employer will offer all cost-justified benefits because they will reduce his costs of hiring workers. That is, if an employer can offer a benefit for $75 that is worth $100 to workers (perhaps because of economies associated with large-scale purchase) then it is in the employer's interest to offer that benefit since it acts as an increase in real wages for workers. In other words, an employer will strive to offer exactly that set of benefits that provides the greatest benefits to workers, because it is in the interest of the employer to do so.

Contractual freedom also can be used to determine the penalties for contractual violation. That is, the contract itself can indicate the nature of the liability of an hmo for failing to provide the level of care for which a patient contracted. Such a breach may be in the form of a failure to provide certain services that are in fact cost-justified. If policies providing for increased liability were worthwhile, then some hmos would offer them (at a price premium) and some firms or consumers would buy them, without the need for a law. Rather, hmo contracts provide for other remedies—usually, that the treatment be provided. But they do not include tort liability.

The fact that no one *does* offer this form of protection in a free market should be sufficient evidence that the benefits cost more than they are worth. Moreover, the costs would not be trivial. One estimate is that imposition of liability on hmos would increase costs by between 2.7

percent and 8.6 percent. Another estimate is that removing the exemption would increase costs by 1.4 percent, but it argues that liability already costs hmos about 2 percent of revenues. In either case, patients' insurance costs would increase. One result of the increase would be that more consumers would choose not to carry insurance at all, so that one effect of the reforms would be to reduce the number of insureds. Indeed, estimates are that the number of insured persons would decrease by 500,000 to 1,800,000 as a result of subjecting hmos to malpractice liability, because at least some consumers would not find the added insurance worth its cost and would choose not to purchase it. In general they would be low-income consumers. Such reductions are already occurring in part as a result of cost increases mandated by law. Although liability is not an issue, there is evidence that states that impose more requirements on hmos have lower levels of insurance coverage than other states.

The fact that medical insurance is generally offered with employment because of the tax treatment has some disadvantages. A given firm will offer one policy or at most a few policies. But workers may differ in their preferences. Some workers will prefer more insurance or more benefits than are available, even at a higher price; such workers may be a source of political pressure for increased regulation of hmos, and they may be among those unhappy with current policies. (Additional pressure comes from physicians who are trying to use the law to improve the terms on which they deal with hmos.) But there are other workers who decide not to purchase health insurance even under current terms; indeed, it is estimated that six million workers (mainly low wage and young workers) are offered health insurance but decide not to purchase it. If the law mandates more benefits, then the number will increase.

There are yet other methods of determining treatment options. Some states have adopted a policy of "external review," a system in which a panel of physicians reviews an hmo decision regarding treatment and may order a change or reimbursement. Such plans could be adopted voluntarily by hmos or they could be mandated by the government. In either case, they are clearly preferable to the use of the tort system, as explained in the next section.

## What Benefits Would Tort Payments Provide?

under the tort or malpractice system, a consumer denied care could sue the hmo and be paid damages. To see whether additional liability is worthwhile, we may ask whether consumers would find the benefits of liability worth the costs that the benefits would impose on them. There are four classes of damage payments a consumer might collect if an hmo engaged in some improper behavior that harmed him and if the employer or the hmo were liable under tort or malpractice law. Analysis shows that none of the damage payments generate benefits that are worth their costs. That explains why imposition of liability would lead to a reduction in insurance coverage: many would not find the increased benefits worth the amount they would be forced to pay for them. (Moreover, because employers might become liable for malfeasance of hmos, imposition of liability might cause many employers to stop offering plans to workers, again reducing the number of insured consumers.)

*Medical costs.* The first class of damages is additional medical costs that might be incurred because of faulty behavior on the part of the hmo. But liability is not needed to cover this class of costs. The hmo is already liable for all medical expenses of its members and will remain liable anyway. Additional legal liability is not needed for this part of damages and will provide no benefits. However, it may add substantially to costs because injured consumers would have incentives to overstate their medical costs in the event of liability, in part because other elements of payment (e.g., "pain and suffering") are often related to medical costs. Moreover, if the medical care were offered outside the hmo itself, then it would probably be more expensive.

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*Lost earnings.* If the hmo misbehavior causes a patient to be sick longer than he would have been without the misbehavior, then the patient will lose wages. In the extreme, if the patient dies, then his family will lose his future earnings. Such events are unfortunate or even tragic. They may also be financially costly. But the hmo is not the proper insurer of this class of losses. If consumers want such insurance, then they should and do buy it directly in the form of lost wage, disability, or life insurance; it is much cheaper to buy such insurance directly as "first party" insurance than to buy it indirectly as "third party" insurance from a health insurer through the tort system. If life and disability insurance is bundled with medical insurance and operated through the tort system, then the "load" in the form of legal fees is about 50 percent; for direct insurance, the administrative costs are 5 percent to 10 percent or less. Therefore, it is cheaper for consumers to buy direct insurance and not to buy insurance through the tort system. Besides, even in today's world, events leading to tort liability are rare, and so consumers already have such insurance if they find it valuable.

Other inefficiencies and inequities arise from using the

tort system for compensation for lost wages. If a person purchases life or disability insurance directly, then the premium is tailored to his likely costs. A high-earning person who wants a large policy will pay more, and conversely for a low-earning person desiring a smaller policy. But the tort system cannot tailor premiums in that way. If the same hmo covers both the high earner and the low earner and the hmo is liable, then it must charge both enrollees the same premium for the implicit life and disability insurance bundled with the medical insurance, because both pay the same amount for the medical insurance. It is as if premiums for $300,000 and $50,000 life insurance were equal, and all insureds had to pay the same amount independent of the amount of coverage. This is inequitable (regressive in this case) in that it transfers money from poorer persons, who will collect less if harmed, to richer persons, who will collect more. It is also inefficient because one result will be to make health insurance itself relatively more costly and less desirable for poorer people, and thus lead to reduced insurance coverage.

*Pain and suffing.* The third class of damage payments is for what are called "nonpecuniary" losses, generally characterized as pain and suffering in the legal system. It is quite true that patients are not normally insured against nonpecuniary losses, and so if the hmo is not liable there will generally be no compensation for them. No direct insurance policy covers this class of loss, but tort damages commonly do pay them. But the ability to receive payments for nonpecuniary losses is not a benefit to consumers; it is a cost. The reason insurance does not commonly cover them is that consumers are not willing to pay the cost of the coverage, even given the small loads commonly associated with direct insurance. (The theory of rational insurance can explain that reluctance.)

But if consumers are not willing to pay voluntarily for direct insurance against pain and suffering, why should they benefit if they are forced to buy the same insurance as part of their medical payments? The answer is that they would not benefit. By forcing payments for nonpecuniary losses on consumers as part of medical insurance, we would not be creating a net benefit for them.

*Punitive damages.* The final class of damage payments that would be opened up if hmos were liable through tort is punitive damages. The purpose of punitive damages is to provide incentives to avoid excessively harmful behavior. By their nature, punitive damages are not aimed at compensation but at deterrence. But there are already adequate incentives for hmos not to behave improperly, as discussed above. The ability of injured consumers to collect punitive damages would increase costs of medical insurance but provide no additional benefits.

## Conclusion

increasing tort liability for hmos would benefit the plaintiff's bar, but would provide no net benefits to consumers. Many workers—primarily low-income workers—already choose not to purchase medical insurance. To the extent that there are weaknesses in market provision of health care, it is generally agreed that they deal with the way in which the market treats low-income workers and others. But proposals to require additional benefits through law, and particularly proposals to require tort liability, have the effect of exactly harming the poor and reducing their access to insurance. They do so by requiring poorer consumers to subsidize insurance for richer consumers and by increasing the price of medical insurance so that fewer low-income workers will find the insurance worth purchasing. Thus, in terms of standard economic efficiency arguments or in terms of arguments involving equity, the proposed policies make little sense.

## Readings


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