Consumer-Directed Health Care And The Courts: Let The Buyer (And Seller) Beware

Even if litigation generally supports consumer-directed care, neither physicians nor insurers will emerge as clear winners.

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ABSTRACT: In consumer-directed health care, patients will be expected to exert greater control over their spending decisions than before. As consumer-directed care gains market acceptance, courts will inevitably be involved in resolving challenges to the new arrangements. We anticipate that courts will be generally favorable toward consumer-directed care, but the new legal doctrine will not uniformly favor medical professionals and insurers. The information demands inherent in consumer-directed care will present particular legal challenges to physicians and insurers. Even as courts provide flexibility to reflect the new market realities, they will closely monitor how consumer-directed care is implemented. [Health Affairs 26, no. 3 (2007): 704–714; 10.1377/hlthaff.26.3.704]

Consumer-directed health care is becoming an increasingly important feature of the U.S. health care delivery system. In this model, patients will be expected to exert greater control over their health care spending decisions than before. There is no agreed-upon definition of consumer-directed health care; the core components are high-deductible health plans (HDHPs), usually paired with tax-favored health savings accounts (HSAs). Whatever the exact combination chosen, the essential feature is to shift risk away from the employer or health insurer to the patient. Its proponents argue that a market-driven system will result in lower costs and increased quality of care.

In contrast to the health care delivery models that preceded consumer-directed care, first fee-for-service (FFS) and then managed care, patients will take increasing responsibility for what treatment to seek and how much treatment to receive. Shifting the risk of health care choices to patients has the potential to fundamentally transform health care into a market commodity and to change the nature of what differentiates health care from other goods and services. Since transformative changes in social and economic arrangements often lead to litigation, we can

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anticipate that the courts will be deeply involved in resolving challenges to how these new products are implemented.3

As consumer-directed care gains market acceptance, the overriding conceptual issue in the expected litigation will be to decide who bears the burden of an adverse event. Underlying this consideration is whether the differences between previous eras and the current one, especially shifting risks to patients, have legal significance that will shape the development of legal doctrine. As litigation develops, some general issues likely to dominate are the following: Will courts alter (and lessen) legal accountability standards for medical professionals and institutions, or will they provide additional protections for patients? Will courts shift legal accountability toward contract standards or even reconsider the legal standard of care for medical liability? Will defenses that have not been available in medical liability cases become more prevalent? And how will the availability of cost and quality information affect litigation?

In this paper we consider what differentiates consumer-directed health care from previous health care financing arrangements, what the legal significance of those differences is, how litigation challenging consumer-directed care might emerge, and what the judicial responses to those challenges might be. Of necessity, we focus on themes and possibilities in developing new legal doctrine and discuss the issues in broad strokes.3 Because there are no judicial opinions to analyze and because consumer-directed products will continue to evolve, this account is prospective. We conclude with a discussion of the policy implications.

Standard Legal Doctrine Before Consumer-Directed Care

The judicial response to consumer-directed care will not occur in a vacuum. Rather, it will emerge from rules developed in the FFS and managed care eras. In the FFS era, physicians dominated medical care, and courts deferred to their judgment. When market dominance shifted to managed care, the courts largely upheld managed care organizations’ (MCOs’) cost containment initiatives and facilitated the new market arrangements. Fears about the courts’ willingness to impede cost containment strategies never materialized.4 The deference to changing market arrangements in litigation predating consumer-directed care suggests that the judicial environment might be conducive to changes favoring defendants.

For historical reasons, medical liability differs from determining liability in other areas. In medical liability litigation, courts defer to the medical profession to set the standard of care based on what is customary and usual practice, as established through physician testimony and medical treatises. The same level of care must be provided to all patients, regardless of resource constraints (often referred to as the unitary standard of care). In determining common-law negligence for everything other than medical liability, courts more explicitly weigh the benefit of the conduct against the risks.5 Courts have consistently held that contractual arrangements can neither alter nor substitute for medical liability claims. Even
though patients lose the majority of medical liability cases, they are able to sue for damages in state courts. In contrast, challenges to insurance denials for benefit coverage are usually decided under contract law.

Equally important, courts in the managed care era have relied on the Employee Retirement Income Security Act’s (ERISA’s) preemption provision to limit MCOs’ liability. (ERISA preempts state laws, including personal injury claims, that relate to an employee benefit plan. In this context, preemption means that state courts cannot decide the litigation.) Despite often egregious facts, ERISA has compelled judges to limit patients’ access to sue in state courts.

**Consumer-Directed Care—Changes With Legal Significance**

Two broad conceptual changes are likely to dominate how litigation concerning consumer-directed care is framed. In shifting the risk to patients, consumer-directed care changes the nature of the physician encounter, emphasizing patients’ preferences as opposed to professional control over health care spending. It also alters the perception that health care is different from other market commodities, allowing defendants to raise new defenses to liability claims.

Each of these changes suggests new legal issues that will vary by stakeholder. Presumably, HSA holders will become more sensitive to the costs of seeking treatment and will have an increased interest in knowing the prices of services when making important health care decisions. This represents a major break from the traditional physician-patient relationship, where patients reflexively follow physicians’ recommendations. If patients use their autonomy to decide on a course of treatment different from that recommended by their physician or even to forgo care (perhaps considering the costs to be too high), who bears the risk of harm resulting from a patient’s erroneous decision—the patient or the physician?

Consumer-directed care also raises questions about the cost of various clinical options and whether insurers will accept medical expenses as meeting the insurance deductible. With this sensitivity to costs, disputes might arise over the amount of billed services, whether billed by the physician or the hospital. If charges for medical treatment are not considered reasonable costs under the consumer’s HSA or HDHP, they might not be fully reimbursable, which will lead to disputes.

Finally, the information needed to fulfill the objectives of consumer-directed care exposes insurers, and possibly physicians, to additional demands not faced in previous eras. This is one of the key changes that will shape litigation concerning consumer-directed care. Consumer-directed care is premised, to a greater extent than before, on patients’ ability to obtain adequate information. Indeed, information asymmetries that have constrained the shift to a market-based health care system in the past are now magnified.

Consequently, litigation in the new era is likely to differ from that seen previously in two ways. One is that the underlying conceptual reliance on medical lia-
bility as a quality control mechanism might be challenged. The other is that defenses that have largely been unavailable in health care litigation will reemerge. Whether changes in legal doctrine evolve slowly or change more dramatically will be a function of how aggressively defense attorneys attack earlier doctrine and on judicial receptivity to a market-driven health care system.

**How Cases Might Arise**

The movement to a market-based system is likely to generate new forms of litigation. The following scenarios present different forms of litigation and different vulnerabilities than occurred during the shift to managed care.

Assume a hypothetical consumer-directed care case where a patient presents with head pain. The physician might now explain that the patient has low- and high-cost alternatives. An x-ray will cost $50, while the recommended treatment, a computed tomography (CT) scan, will cost $500. Suppose the patient rejects the recommendation because the CT scan costs too much, but the x-ray does not detect a tumor (which the CT scan would have) that goes untreated. Another scenario is that a primary care physician (PCP) refers a patient to a specialist, but the patient balks because of the cost and uncertainty of whether the referral will count toward the deductible. Suppose the PCP then treats the patient but fails to detect a cancer that the specialist most likely would have seen.

These two scenarios also suggest how litigation against insurers might emerge. Suppose the patient agrees to see the specialist. For consumer-directed care to achieve its anticipated objectives, providing patients with adequate cost and quality information is essential. But the way information is provided and then used could expose insurers to litigation. For example, suppose quality ratings are posted on an insurer's Web site and a patient selects the specialist based on this information. What happens if either the information is not up to date and the posted quality rating no longer reflects actual performance, or important data are missing? Under either scenario above, a patient may sue if the insurer subsequently rejects the deductible expense as not medically necessary.

**Litigation against physicians.** For physicians, consumer-directed care does not change the responsibility to meet the skill and knowledge aspects of the legal standard of care. What changes is the role that costs play in treatment recommendations and whether contractual arrangements for a lower standard of care would be upheld. At issue will be judicial willingness to adopt a liability standard consonant with shifting the risk to the patient. Instead of the unitary standard of care regardless of resource constraints, consumer-directed care focuses on the patient's willingness and ability to pay—resource constraints ignored in most previous medical liability decisions. With consumer-directed care, patients' preferences are central, not physicians' technical skills. Thus, those preferences may force physicians to consider costs in treatment recommendations by providing care they believe to be suboptimal or that differs from care generally provided to fully insured patients.
Currently, physicians would be vulnerable to liability for an adverse outcome attributable to ordering the suboptimal treatment. But with consumer-directed care, physicians will be able to raise traditional defenses that have rarely been invoked under the existing medical liability standard. Physicians may stress assumption of risk in lawsuits where the patient alleges that physicians should have provided a higher level of service. Assumption of risk is the deliberate and voluntary choice to assume a known risk. If the focus with consumer-directed care is on patients’ preferences and the patient makes a cost-based decision to accept a lower level of care, then the physician can argue that he or she does not have a duty to provide more care than the patient is willing to finance. As long as the physician has explained the options, once the patient abjures the CT scan in favor of an x-ray, the patient cannot hold the physician liable for an adverse event based on the patient’s choice. The patient has assumed the risk that the lower-cost option might produce a worse outcome.

The physician might also allege comparative negligence as a defense and argue that the patient, by accepting a lower level of care, is partially at fault for any injury that resulted from the agreed-upon treatment. Comparative negligence is a defense that reduces a plaintiff’s recovery proportionally to the plaintiff’s degree of fault in causing the damage. If the physician can show that the patient was partially at fault, then any damage award is reduced by that proportion.

Physicians could also attempt to avoid liability by having patients enter into explicit contractual relationships to waive liability or reduce the standard of care. These contracts are unlikely to be upheld. Courts have consistently rejected efforts to permit the contractual exclusion of liability. Instead, courts are more likely to uphold contracts requiring mediation or arbitration of liability claims.

In sum, it seems likely that legal doctrine will evolve in ways that permit physicians to take costs into account without vulnerability to medical liability. Nevertheless, two caveats are in order. First, courts could rule that physicians have a duty to maintain the unitary standard of care regardless of patients’ choices. Similarly, courts could rule that physicians owe fiduciary duties to patients that supersede consumer-directed health care products. Physicians hold a fiduciary relationship of trust with the patient and must act in the patient’s best interest. Although legal doctrine in this area has been limited, courts might be particularly amenable to breach-of-fiduciary-duty claims where there is an actual conflict of interest between serving the physician’s own financial interests and serving the interests of the patient in minimizing the costs of treatment.

Shifting the risk to patients may present some problems regarding physicians’ informed-consent obligations. For a number of reasons, courts might be more stringent in ensuring that physicians adequately inform patients about the risks of selecting less costly alternatives. Even though jury verdicts in informed-consent cases have tended to be low, courts might rely on informed-consent doctrine to ensure that patients’ choices are adequately understood. In this sense, consumer-
directed care increases the burden on physicians (and insurers) to provide full information, including the costs of various treatment alternatives, to allow the patient to determine which course of treatment to pursue.

This is not a trivial burden. Assuming that courts will hold patients to decisions (even if poor in hindsight) refusing treatment recommendations because the value does not justify the cost, it will be incumbent upon physicians to encourage the discussion about costs. The problem is not the physician's ability to do so; rather, the problem is a time constraint. At a time when the current primary care encounter averages about fifteen minutes, full explanation of the more complex issues at stake would expand the encounter well beyond those bounds.

Yet providing adequate information will be necessary for the physician to use assumption of risk as a defense. The patient's resource decision must be based on understanding the risks and benefits of the choices. In litigation alleging failure to provide informed consent, courts will analyze the health care encounter to determine if the necessary information was conveyed before the patient made the decision. Physicians must disclose information about the need for treatment, the risks of lower-cost alternatives or of refusing treatment altogether because of costs, and the medically reasonable alternatives.13

Litigation against health insurers. Market proponents have criticized the judicial tendency to ignore insurance benefit limits in favor of expanded coverage. Whether or not that critique is valid, it seems unlikely to be replicated under consumer-directed care. Some litigation against insurers will challenge either benefit denials that would otherwise meet the deductible or how reasonable charges are determined. Over time, however, the more important litigation for the overall success of consumer-directed care will involve the dissemination of information. Consumer-directed care can achieve its objectives only if cost and quality information is accurate and easily available to patients. But in providing this information, insurers might open themselves to increasing judicial scrutiny.

Health insurers are likely to pursue contractual defenses that were not pertinent in previous insurance disputes. Insurers might argue that the choice of insurance plans depends on patients' preferences. Therefore, the concept of “caveat emptor” (let the buyer beware) should be a sound defense to a patient's complaint that the insurer did not provide state-of-the-art medical benefits. In all other markets, caveat emptor is a standard defense. Since consumer-directed care resembles any other contractual arrangement, the same defenses should be available.

For example, health insurers might make analogies to cases involving challenges to insurance benefit denials. In these cases, courts have interpreted the contract to determine whether the insurer clearly and unambiguously excluded coverage for experimental treatment. These determinations are usually retrospective coverage denials based on the contractual definition of medical necessity. Insurers might argue that certain spending under HSAs, perhaps for obesity treatment or cosmetic surgery, either is not a covered benefit or is not medically necessary and
will therefore not be counted as meeting the deductible. But as Mark Hall contends, it is unlikely that consumer-directed care represents any change in how courts will review medical-necessity determinations. Indeed, the tortured history of medical-necessity litigation is likely to remain tortured.

An area where health insurers have been vulnerable is in bad-faith insurance denial cases (a frivolous or unfounded refusal to pay for the benefits). Arguably, since the patient selects the appropriate benefit level in consumer-directed care, insurers are less likely to be subject to punitive damages for such denials.

If physicians face an added burden for informed consent in consumer-directed care, insurers face huge challenges and considerable vulnerability in managing the flow of information on which that model depends. Although insurers are not likely to be guarantors of the information provided, courts will carefully scrutinize patients’ decisions based on reasonable reliance on the accuracy and currency of the data. This is one area where consumer-directed care will expose insurers to new liability litigation. In fact, insurers will likely bear the burden of demonstrating transparency—that the information is complete, accurate, and up to date. If patients are expected to make choices about the value of treatment options relative to costs, including choosing high-quality providers, the institutions providing data will face litigation for any harm resulting from deficient information. Patients will have a strong claim that they justifiably and detrimentally relied on the insurer’s information.

For insurers, the shift to contract could result in legal doctrine that amounts to “beware what you ask for.” To protect patients, courts could stringently hold insurers to the information provided, verging on strict liability. If the information is not current or a reasonable patient could not easily interpret it, the insurer will be held responsible for errors and resulting harm. Courts could also rely on the doctrine of contra proferentum (where any ambiguity is resolved against the drafter of the contract) to mitigate the potential harshness of consumer-directed care.

If all else fails, insurers might be able to rely on ERISA preemption to avoid liability. To the extent that consumer-directed care is still tied to employer-sponsored health plans, ERISA preemption remains valid. What will be interesting to follow is whether, as consumer-directed care evolves, the employer plays a reduced role in selecting high-deductible plans. The more detached consumer-directed care is from employer control, the more attenuated ERISA preemption becomes. This would be an ironic result, since proponents of a market-driven health care system have steadfastly defended ERISA preemption as necessary for health care to become a market good.

The Courts And Public Policy

Historically, courts have deferred to the marketplace in establishing legal doctrine during times of changing social and economic arrangements, and there is little reason to expect a different result now. The most likely result is to observe in-
cremental change in legal doctrine, mainly the acceptance of defenses such as assumption of the risk and caveat emptor. Courts will be receptive to consumer-directed care and will not impede its diffusion. Yet even if the litigation generally supports consumer-directed care, neither physicians nor health insurers will emerge as clear winners. Each will gain some protection against liability, but each will be exposed to potential liability in implementing consumer-directed care.

- Altering the legal standard of care. For many health law scholars and health care stakeholders, a key objective of consumer-directed care is to alter both the health care marketplace and the role of legal oversight. Since consumer-directed care looks like any other marketplace commodity, as opposed to a product that reflects health care’s inherent differences from other market goods, the liability standard should be changed to reflect its specific cost considerations and the expectation that physicians will be making different risk-benefit trade-offs than before.

To its proponents, consumer-directed care offers the best opportunity so far to encourage judges to replace the current negligence standard with contractual principles. Doing so would permit physicians to alter the standard of care through contract. Despite proponents’ optimism, it is unlikely that courts will do so in the short term. Instead, an incremental gain is likely to be the incorporation of cost and resource constraints into setting the legal standard of care.

For many years, scholars have debated whether and how to incorporate cost constraints into the legal standard of care. Until now, only a few courts have done so. In Hall v. Hilbun, the court distinguished technical skills and knowledge, which should not vary across professionals, from resource availability, which varies greatly across institutions. Under this standard, a physician practicing in a rural area would not be faulted for failing to use a CT scan if the equipment was not reasonably available. The expansion of consumer-directed care and more explicit use of costs in medical decision making make it likely that courts will begin to factor resource constraints in setting the legal standard of care in medical liability cases. Following this reasoning, a court could reject physician liability when a patient chooses less resource-intensive care.

- Contract versus medical liability. One reason to be skeptical that contract will supplant medical liability is that the current standard is more than 150 years old. Even in its modern incarnation during the FFS era, it has long been the principal way the courts monitor the quality of care. It is easy to imagine that judges will be skeptical of shifting to contract because of concerns that patients will lack judicial redress when harmed through medical negligence. But considering the judicial response to ERISA preemption challenges, where judges sometimes bemoaned their own rulings but nevertheless largely upheld ERISA preemption doctrine, judicial sympathy is by no means assured.

Where the shift in risk is likely to result in legal doctrine more amenable to contract proponents is that we expect courts to be receptive to defenses more prevalent in other areas of the law, especially assumption of the risk and caveat emptor.
Even if these defenses will not fully mitigate liability exposure, they certainly move toward a judicial environment that is friendlier to a contract-based health system. Insurers would attack the underlying notion that health care differs from other goods and services and stress the dominance of contractual arrangements in the health care market and the support for contract among policymakers.

- **Trade-offs for physicians and insurers.** As such, legal doctrine surrounding consumer-directed care would represent trade-offs for both physicians and insurers. In return for strong new defenses to liability litigation, physicians might lose the expert-determined standard of care. From physicians’ perspective, this means that standard liability defenses would play a more prominent role, and economic considerations, balancing risk and benefits, would drive the liability determination. For insurers, a similar trade-off would permit enhanced contractual defenses at the potential expense of greater responsibility for ensuring the transparency, accuracy, and completeness of information provided to patients. Development of legal doctrine along these lines for consumer-directed care would achieve some of the goals of market proponents: ending the deference to physicians in setting the standard of care and being receptive to more robust contractual defenses.

**Health Policy Implications**

- **Adequate disclosure of information.** The key policy issue is how to ensure adequate disclosure of information to facilitate consumers’ decision making. Until now, health insurance has not been a model of clarity, transparency, or full disclosure. If consumers do not understand fully the nature and consequences of the choices they are expected to make, it seems unlikely that consumer-directed care will attain the market acceptance its proponents anticipate. Regulation through information disclosure is central to properly functioning markets in many areas, including environmental protection, securities transactions, and pharmaceuticals.18

To be sure, holding an insurer legally responsible for inadequate information could result in the provision of less information. But patients must be able to rely on the information if health care delivery is moving toward a market-based system. Therefore, state insurance regulators, perhaps in conjunction with industry-sponsored guidelines, will need to develop standards for what information should be disclosed, along with format and appropriate reading levels expected.19

- **New locus of patient protections.** A second policy issue will be to recognize that policymakers cannot rely on the courts to protect patients from their medical choices. Policymakers will need to address any market deficiencies in the operation of consumer-directed care. For example, it could exacerbate existing disparities in access and clinical outcomes.20 Likewise, patient protections might be needed to avoid deceptive marketing practices. Although state consumer protection laws have played only a peripheral role in health care to date, they might become a more prominent mechanism for redressing marketing and information deficiencies.

- **Need for “regulatory pluralism.”** Third, consumer-directed care presents an
opportunity to rationalize the regulatory structure along the lines that Michelle Mello and colleagues have suggested.\textsuperscript{21} They argue for regulatory pluralism that would attempt to more coherently align public regulation, industry self-regulation and accreditation entities, and legal system oversight. For consumer-directed care, the balance between state regulation of insurance products and industry self-regulation should be reexamined.

- **New role for state-mandated review of coverage denials.** Fourth, state-mandated external review processes for insurance coverage denials, particularly retrospective denials under the deductible, will play an important role in mediating claims where the cost of litigating the denial would exceed the amount of the deductible. Effective and timely external review can facilitate the acceptance of consumer-directed care among consumers and mitigate the need for litigation.

A less desirable option is to establish specialized health courts. These courts have worked well in certain areas, especially with drug cases, but fragmenting the judicial system along social policy lines might not be manageable. More importantly, the analogous use of binding arbitration in securities cases has been heavily criticized for bias against consumers. That said, demonstrations are worth pursuing for cases that would otherwise be too costly to litigate, such as spending under the insurance deductible or medical liability cases with limited damages.\textsuperscript{22}

Two conflicting impulses will shape the judicial response to consumer-directed health care. One is the courts' traditional deference to market arrangements. The other is potential judicial reluctance to view health care as just another market commodity. At a minimum, courts are unlikely to impede the expansion of consumer-directed care and might even facilitate its development. If previous analyses that in health care the courts support the market winner are correct, then there will at least be incremental change in judicial opinions, with the possibility of more radical change. With each shift toward health care as a market commodity, the argument that health care is different is less tenable. Eventually, the new market realities will be reflected in judicial opinions. The more health care resembles any other commodity, the more the courts will treat it as such. Judges might therefore be more amenable to dramatic changes in current legal doctrine than many observers anticipate.

Yet the changes might not entirely favor physicians or health insurers. To be sure, physicians will have more defenses to liability claims but will have the added burden of greater informed-consent requirements. Health insurers will also have expanded defenses but can anticipate greater responsibility for providing accurate and timely information. In either event, health law is entering a dynamic phase that could look very different than it has in the past. Much depends on whether consumer-directed care actually gains the level of acceptance in the marketplace that it has among policymakers. When that happens, the litigation could get very interesting.
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NOTES
6. Because of difficulty in obtaining accurate pricing and quality information, litigation over reasonable charges is likely. Space constraints limit full discussion. See Morreim, “High-Deductible Health Plans.”
7. Because consumer-directed care represents a move away from employer-sponsored health insurance, we anticipate that employers will not face meaningful consumer-directed health care litigation.
8. See, for example, Washington State Medical Association v. Regence BlueShield (Wash. Super. Ct., no. 06-2-30665-1SEA, 2006).
10. A related defense would be contributory negligence. If the patient has contributed to the injury, most states allow a reduction in damages (comparative negligence), although contributory negligence would bar any recovery in a few states.
11. This is known as a nondelegable duty (it cannot be altered through a contract). See, for example, Pope v. Winter Park Healthcare Group Ltd., 2006 Fla. App. LEXIS 16605 (Fla. 5th DCA, 2006).
12. Morreim, “High-Deductible Health Plans.”
13. Ibid.
17. 466 So.2d. 856 (Miss. 1985).
19. See Jost and Hall, “The Role of State Regulation.”