

Choosing Affordable Health Insurance

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ABSTRACT

The Affordable Care Act (“ACA”) made health insurance accessible to many. Yet unaffordable insurance still abounds. This Article proposes a strategy for improving affordability that enables health insurance purchasers to choose, within reasonable limits, which treatments their insurance covers.

After critiquing recently proposed strategies for improving affordability and reviewing past legal scholarship on content choice in health insurance, this Article introduces the “Affordable Choices” framework. This framework regulates choice in four ways. First, health plans should only exclude treatments whose merits are subject to reasonable disagreement among patients and physicians. Second, plans should appeal to purchasers’ health-related values—values about the sort of life they want to live—rather than predictions about their health status. Third, plans should include interventions like vaccines that protect others from harm. Fourth, excluded interventions should be those costly enough that exclusion meaningfully shifts affordability. This Article will then discuss potential plan offerings, such as “international reference coverage” based on national plans in other developed countries like Canada or the United Kingdom, and discuss what legal reforms—if any—would be needed in order to offer Affordable Choices plans as part of ACA exchanges, employer-provided insurance, Medicare, or Medicaid.

This Article then considers legal and ethical objections that ill people, plan purchasers, society, or providers might advance. It first addresses the objection that Affordable Choices plans will unfairly raise health insurance costs for less healthy people and argues that requiring plans to appeal to health-related values rather than health status expectations will help to avoid this problem. It then explains how the Affordable Choices framework can be structured to protect purchasers from misprediction or choice overload.

Turning to objections from society, this Article explains how choice about the content of insurance is compatible with solidarity among insured patients, albeit liberal solidarity (focused on the framework that enables choice for all) rather than communitarian solidarity (focused on the substantive content of individuals’ choices). It also explains how Affordable Choices plans can be compatible with state requirements regarding specific benefits and with an-

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tidiscrimination law. Last, it explains why participation in Affordable Choices plans accords, rather than conflicts, with providers' legal obligations and ethical duties, and argues that providers are not only permitted but ethically encouraged to protect patients from financial hardship.

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INTRODUCTION

The Affordable Care Act (“ACA”)¹ made insurance accessible to many. Yet unaffordable insurance still abounds: a couple in Missouri pays nearly \$17,000 in yearly premiums with a \$4,500 deductible;² a Pennsylvania real estate agent pays over \$9,000 with a \$4,000 deductible;³ and when premiums reached nearly \$20,000 with a deductible of \$7,500, a pair of early retirees decided not to get health insurance at all.⁴

These costly plans most commonly confront older individual marketplace buyers whose income is too high for them to receive subsidies.⁵ But rising premiums and out-of-pocket costs also bedevil buyers

¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

² Steven Findlay, *Rising Health Insurance Costs Frighten Some Early Retirees*, KAISER HEALTH NEWS (Nov. 1, 2017), <https://khn.org/news/rising-health-insurance-costs-frighten-some-early-retirees/> [<https://perma.cc/D6W5-9LUG>]. An insurance deductible is the amount of money that an insured patient has to pay out of pocket before insurance begins to cover costs. U.S. DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS 1, <https://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf> [<https://perma.cc/XG83-TF25>].

³ Steven Findlay, *Health Insurance Costs Crushing Many People Who Don’t Get Federal Subsidies*, KAISER HEALTH NEWS (Dec. 14, 2018), <https://khn.org/news/health-insurance-costs-crushing-many-people-who-dont-get-federal-subsidies/> [<https://perma.cc/5ZJT-4SLB>].

⁴ Julie Rovner, *Steep Premiums Challenge People Who Buy Health Insurance Without Subsidies*, NPR (Oct. 7, 2017, 7:00 AM), <https://www.npr.org/sections/health-shots/2017/10/07/555957419/steep-premiums-challenge-people-who-buy-health-insurance-without-subsidies> [<https://perma.cc/B48E-QZCV>].

⁵ See Govind Persad, *Expensive Patients, Fair Sharing, and the Future of Health Care Reform*, 69 EMORY L.J. (forthcoming 2020) (manuscript at 25), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3584782 [<https://perma.cc/QR24-67DK>]; Jonathan Cohn, *An Iowa Teenager Didn’t Wreck His State’s Health Care Market. Here’s Who Did*, HUFFINGTON POST (Oct. 29, 2017, 3:00 PM), https://www.huffingtonpost.com/entry/iowa-teenager-obamacare-scapegoat_us_59f4715de4b077d8dfc9dd70 [<https://perma.cc/TA7C-ZS5U>].

with employer-based insurance,⁶ which has served to fuel backlash against the ACA more generally. Many strategies to rein in costs only produce new problems. “Copper plans” reduce up-front premiums but increase already high out-of-pocket costs.⁷ Plans without preexisting condition protections save money for the currently healthy, but only by undermining access for the sick.⁸ And subsidizing the purchase of costly insurance can improve affordability for purchasers, but worsens it for society.⁹

This Article proposes improving affordability through choice. People typically have a choice among different goods and services, even for essentials like housing and food. House hunters, for instance, can select the home that best fits their values and needs, or can choose to rent or buy. Insurance purchasers have similar reasons for wanting to customize the content of their insurance benefits. One important value that choice could help realize is *affordability*: savings from limiting benefits could lower premiums, deductibles, or copayments. Another is *autonomy*: choice enables insurance purchasers to select access to treatments that accord with their values and forgo access to treatments that do not.

That health insurance, unlike housing, involves risk pooling might seem to preclude content choice. If one person purchases a home with stairs, for instance, that does not make a step-free home unaffordable for a neighbor with a mobility impairment. But the ability to purchase a plan without coverage for mobility impairments could make plans that include such coverage unaffordable for that neighbor, who is now unable to pool risk. Some reject choice as infeasible for this reason.¹⁰ This Article draws a different conclusion. Because insurance involves risk pooling, insurance content must be more tightly regulated than home design. But it does not render choice over the content of insurance infeasible or inevitably unfair. While the cost of some medical treatments must be borne in common, the cost of others can be an appropriate object for choice, even if permitting choice lowers insur-

⁶ SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, HEALTH INSURANCE COVERAGE EIGHT YEARS AFTER THE ACA 6 (2019), https://www.commonwealthfund.org/sites/default/files/2019-08/Collins_hlt_ins_coverage_8_years_after_ACA_2018_biennial_survey_sb_v2.pdf [<https://perma.cc/2SMC-YLEN>] (observing that “the greatest growth in the number of underinsured adults is occurring among those in employer health plans”).

⁷ See *infra* Section I.A.

⁸ See *infra* Section I.B.

⁹ See *infra* Section I.C.

¹⁰ See, e.g., NICHOLAS BAGLEY ET AL., CORRECTING SIGNALS FOR INNOVATION IN HEALTH CARE 8–9 (2015), https://www.hamiltonproject.org/assets/files/correcting_signals_for_innovation_in_health_care_bagley.pdf [<https://perma.cc/64C4-966A>].

ance costs for some and raises them for others. Choice about the content of health insurance can be fair when it reflects a purchaser's health-related *values*—values about what sort of life is best—rather than factual predictions about future health *status*. An example of this contrast is the difference between a preference not to receive costly, life extending treatments if one develops dementia, and a belief that one is unlikely to develop dementia.

Both choice and its absence have been perennially controversial in health reform debates. Health insurance designs that emphasize choice, exemplified by early 2000s “consumer-directed health care,” have been criticized for inappropriately allowing market principles to colonize health care.¹¹ Yet proposals to reduce or eliminate choice, such as the rise of restrictive managed care in the 1990s or more recent concerns that ACA plans limit choice of providers, have prompted strong public backlash.¹² This Article recognizes the down-sides of choice, including the tension between choice and solidarity and the psychological burden that options can impose on decisionmakers.¹³ But it also recognizes the value of choice to affordability and to non-economic values like autonomy and dignity. Choice about the content of health insurance, compared to a one-size-fits-all regime, enables people to direct their health spending toward achieving outcomes they value. It also respects dignity and promotes autonomy by allowing people to shape their lives according to their commitments.

Section I.A of this Article reviews the problem of affordability in American health insurance and critiques some existing proposals that aim to improve affordability. Section I.B then critically examines past discussions of content choice in health insurance by law and health policy scholars.

Part II introduces the “Affordable Choices” framework for content choice in health insurance. Section II.A identifies principles for designing Affordable Choices plans. These plans should be broadly appealing, rather than attractive only to people who expect their fu-

¹¹ E.g., Kristin Madison & Peter D. Jacobson, *Consumer-Directed Health Care Debate*, 156 U. PA. L. REV. PENNUMBRA 107, 115 (2007) (section by Prof. Jacobson) (criticizing consumer-directed health care for “transforming health care into just another market commodity”).

¹² See Theodore R. Marmor & Gary J. McKissick, *Medicare's Future: Fact, Fiction and Folly*, 26 AM. J.L. & MED. 225, 241 (2000) (“The evidence of a backlash against managed care reflects considerable frustration with constraints on patient choice.”); Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. (forthcoming 2019) (manuscript at 7–8) (on file with Faculty Scholarship at Penn Law) (describing backlash against ACA's disruptive effects on provider choice).

¹³ See *infra* Section IV.D.

ture health status to deviate from the norm, and should include interventions (like vaccines and prenatal care) that have large positive consequences for society. Interventions excluded should only be those that are subject to reasonable disagreement among patients and physicians and are costly enough for exclusion to meaningfully shift affordability. Section II.B explains the categories of potential Affordable Choices offerings, including “international reference coverage” plans based on the sets of interventions offered in other developed countries like Canada or the United Kingdom. Section II.C describes the logistics of offering an Affordable Choices plan on an ACA exchange. Section II.D discusses what legal changes, if any, would be needed in order to offer Affordable Choices plans in various settings, including exchanges, employer-provided plans, Medicare, and Medicaid.

Parts III, IV, V, and VI consider potential obstacles to the Affordable Choices framework that ill people, plan purchasers, society, or providers might raise. Part III focuses on the ethical objection that content choice will unfairly raise health insurance costs for less healthy people by fragmenting the risk pool and the legal objection that Affordable Choices plans are unlawfully discriminatory. Part IV addresses the concern that the availability of Affordable Choices plans would be psychologically burdensome or produce bad outcomes because buyers will mispredict their future values and needs. Part V answers the objection that choice undermines social solidarity by proposing an ideal of liberal solidarity compatible with choice. Part VI discusses and rebuts two objections that health care providers might raise—that Affordable Choices plans require them to abandon their duty to do what is medically best for patients and that they expose providers to the risk of malpractice liability.

This Article’s proposal is compatible with other efforts to improve health insurance access, affordability, and quality. Some have proposed improving affordability by targeting excessive pricing.¹⁴ Others have suggested measures to reduce the monopoly power of large providers such as hospitals.¹⁵ Still others have proposed efforts to reduce unnecessary treatment.¹⁶ Politicians have suggested expanding access to Medicare and Medicaid or replacing private insur-

¹⁴ E.g., Gerard F. Anderson et al., *It’s Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt*, 38 HEALTH AFF. 87, 89 (2019).

¹⁵ E.g., Thomas L. Greaney, *Coping with Concentration*, 36 HEALTH AFF. 1564, 1568 (2017).

¹⁶ E.g., SHANNON BROWNLEE, *OVERTREATED* (2007).

ance entirely with public insurance.¹⁷ As Part II explains, even a move to exclusively public insurance is compatible with offering content choice as part of an insurance package.

Recent developments around health insurance have improved prospects for the type of content choice this Article proposes. There is increasing bipartisan willingness to borrow from other countries' strategies for stemming health care costs.¹⁸ This makes Section II.B's proposal for international reference coverage more compelling. Meanwhile, although "copper plans" will likely be ineffective, their bipartisan popularity suggests the potential appeal of offering lower and more predictable costs in exchange for a more restricted menu of treatments.¹⁹ And whether the ACA survives or is ultimately replaced by something else, widespread uncertainty and dissatisfaction around current health insurance arrangements may make a new option more appealing.

I. ADDRESSING THE AFFORDABILITY PROBLEM

Before the ACA, Americans had a difficult time accessing affordable health insurance, especially in the individual market.²⁰ Affordability was a particular problem for people who had previously suffered illnesses: For them, insurance was often prohibitively expensive or excluded treatment for preexisting illnesses.²¹ Insured patients who became ill were refused plan renewal or were kicked off their plans.²² Although "cheap" insurance was available via short-term plans or via "mini-med" plans that capped insurance benefits at less

¹⁷ Compare *Medicare-for-All and Public Plan Proposals*, KAISER FAM. FOUND. (May 15, 2019), <https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/> [<https://perma.cc/CF2R-EU4P>].

¹⁸ See Billy Wynne & Alyssa Llamas, *New Legislation to Control Drug Prices: How Do House and Senate Bills Compare? An Update*, COMMONWEALTH FUND (Jan. 9, 2020), <https://www.commonwealthfund.org/blog/2020/new-legislation-control-drug-prices-how-do-house-and-senate-bills-compare-update> [<https://perma.cc/PBN5-3R9D>] (discussing the use of international price comparisons in the House's Elijah E. Cummings Lower Drug Costs Now Act and in a proposed rule issued in 2018 by the Center for Medicare and Medicaid Services).

¹⁹ See *infra* Section I.A.

²⁰ John Aloysius Cogan Jr., *Does Small Group Health Insurance Deliver Group Benefits? An Argument in Favor of Allowing the Small Group Market to Die*, 93 WASH. L. REV. 1121, 1161 (2018); Brendan S. Maher, *Unlocking Exchanges*, 24 CONN. INS. L.J. 125, 144 (2017); Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Healthcare Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 176 (2011).

²¹ Maher, *supra* note 20, at 144.

²² See Monahan & Schwarcz, *supra* note 20, at 136 ("Those who did acquire coverage were subject to preexisting condition exclusions and the prospect of rescissions.").

than \$10,000,²³ affordable insurance that covered preexisting conditions was not. Insurance purchasers with illnesses faced the choice between cheap junk plans, prohibitively expensive plans, and uninsurance.

The ACA addressed these problems by requiring all insurers selling individual market plans to cover willing buyers regardless of preexisting conditions, and to cover a broad set of essential health benefits.²⁴ The ACA also limited insurers' ability to vary premiums by health status. Higher or lower rates were only permitted, at regulated percentages, for specific factors such as tobacco use and wellness program participation.²⁵

The ACA succeeded in providing more Americans with comprehensive health insurance.²⁶ But the plans offered on the ACA's individual marketplaces also tended to have high premiums. To improve affordability, the ACA subsidized both premiums and out-of-pocket costs for lower-income households enrolled in marketplace plans.²⁷ But individual market customers who were ineligible for these subsidies faced high premiums, deductibles, and copayments.²⁸ Middle-aged and older patients in the individual market faced the highest premiums, especially in states where individual markets were small or populated by particularly costly patients.²⁹ Buyers whose premiums exceed a specified percent of their income were exempted from the ACA's individual mandate, but this still left them exposed to the unbounded financial risk of uninsurance.³⁰ These high premiums for middle-income buyers engendered substantial backlash against the ACA.³¹ These problems have prompted efforts to improve the af-

²³ See Troy J. Oechsner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241, 306, 308 (2011).

²⁴ Maher, *supra* note 20, at 145.

²⁵ *Id.*

²⁶ COLLINS ET AL., *supra* note 6, at 3.

²⁷ Maher, *supra* note 20, at 146.

²⁸ See Rachel Fehr et al., *How Affordable Are 2019 ACA Premiums for Middle-Income People?*, KAISER FAM. FOUND. (Mar. 5, 2019), <https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people/> [<https://perma.cc/9WP4-72KA>].

²⁹ See Persad, *supra* note 5 (manuscript at 25); Cohn, *supra* note 5.

³⁰ Amy B. Monahan, *On Subsidies and Mandates: A Regulatory Critique of ACA*, 36 J. CORP. L. 781, 791 (2011) ("This group is a middle income group; they are not poor enough to qualify for a subsidy, but not well-off enough to be penalized for failing to purchase coverage."). The individual mandate has since been eliminated. See Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017).

³¹ See Samuel R. Bagenstos, *Disability, Universalism, Social Rights, and Citizenship*, 39

fordability of insurance plans under the ACA. The remainder of this Part reviews and critiques existing proposals for improving insurance affordability in order to motivate the potential attractiveness of the Affordable Choices proposal.

A. *Copper Plans*

In response to affordability concerns, politicians (both Democratic and Republican) and trade groups (such as America's Health Insurance Plans) have proposed "copper plans," which are insurance plans with lower premiums than those currently offered in the individual marketplace.³² Copper plans, however, also have lower actuarial value in the form of higher deductibles or copayments.³³

Some have defended copper plans on the basis that the ACA "forces some people to get more insurance than they want."³⁴ But copper plans do not protect people from having to buy more than they want; they simply allow purchasers to gamble on whether they will have to pay for health care. Although copper plan purchasers save money upfront by paying lower premiums, they face higher deductibles and copayments when they eventually get sick and require medical care.³⁵ Copper plans—whose deductibles exceed those of current bronze plans while covering the same interventions as current gold

CARDOZO L. REV. 413, 437 (2017); Joan C. Williams, *What So Many People Don't Get About the U.S. Working Class*, HARV. BUS. REV. (Nov. 10, 2016), <https://hbr.org/2016/11/what-so-many-people-dont-get-about-the-u-s-working-class> [<https://perma.cc/A43Z-W5JU>]; Abby Goodnough, *As Some Got Free Health Care, Gwen Got Squeezed: An Obamacare Dilemma*, N.Y. TIMES (Feb. 19, 2018), <https://www.nytimes.com/2018/02/19/health/obamacare-premiums-medicaid.html> [<https://perma.cc/5M97-X9KE>].

³² E.g., Deborah B. Gardner, *Dismantle or Improve Obamacare? Nurses Must Take Action*, 32 NURSING ECON. 323, 325 (2014) ("Republicans want to introduce a new metal level—*copper*, which would cover about 50% of medical bills.").

³³ E.g., David Anderson, *Why Current Copper Plan Proposals Won't Work*, HEALTH AFF. (Aug. 9, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180803.744146/full/> [<https://perma.cc/W8NT-Q8J5>] ("In 2013, Senator Mark Begich (D-AK) was a lead proponent of offering 50 percent actuarial value plans. A 50 percent actuarial value copper plan in 2019 would likely have a deductible and maximum out of pocket of \$12,000 to \$13,000."); Alexander Bolton, *Senate GOP Plots Plan B for ObamaCare*, HILL (Jan. 27, 2015, 6:00 AM), <https://thehill.com/home-news/senate/230798-senate-gop-plots-plan-b-for-obamacare> [<https://perma.cc/N3R7-WLE4>] (noting that "centrist Democrats including Sens. Joe Manchin (W.Va.), Mark Warner (Va.) and Heidi Heitkamp (N.D.) . . . [proposed] a new high-deductible health insurance option known as the Copper Plan that would cost less while still meeting the standards of the Affordable Care Act").

³⁴ Jonathan Cohn, *This Is How the New GOP Senate Will Try to Dismantle Obamacare*, NEW REPUBLIC (Nov. 4, 2014), <https://newrepublic.com/article/120125/republican-plans-obamacare-device-tax-mandates-risk-corridors> [<https://perma.cc/DJX8-MCP6>].

³⁵ See *id.*; see also Ezra Klein, *7 Democrats Have a Plan to Make Obamacare Cheaper. Here's How*, VOX (Oct. 28, 2014, 1:30 PM), <https://www.vox.com/2014/10/28/7083343/obamacare->

plans—poorly fit the needs of most working and middle-class households with limited savings.³⁶

Rather than being more affordable, copper plans are better described as more *unpredictable*: Their lower premiums make them cheaper for those who stay healthy, but their higher deductibles and copayments make them costlier for those who get sick. This contravenes a core aim of insurance: to transfer resources from people who do not experience losses to people who do.³⁷ This problem is exacerbated by copper plans' surface appeal. People may be attracted by lower premiums and not think about the future cost of copayments and deductibles if they become ill.³⁸

B. Cost Shifting to the Sick

Another strategy for lowering premiums, which the Trump Administration is currently pursuing, would expand the sale of plans that are not subject to the ACA's rules. These include short-term health plans, which the Administration wants to expand to include 364-day periods with renewability for up to 36 months,³⁹ and association health plans, which were historically limited to small businesses but which the Administration has sought to let a broader range of buyers access.⁴⁰ Association health plans may vary premiums based on factors that are disallowed in the individual marketplace, such as gender and the industry in which someone is employed.⁴¹ Short-term plans are even less regulated than association health plans and are permitted to

copper-plans-explained [<https://perma.cc/Y2FF-5P92>] (“Basically, you’re paying for insurance that doesn’t protect you unless you get really, really sick.”).

³⁶ See Timothy Stoltzfus Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N.Y.U. L. REV. 419, 433 (2001) (“Only the very wealthy, or the very poor, can afford to self-insure for sickness and accident without risking financial disaster.”).

³⁷ See Jay M. Feinman, *The Law of Insurance Claim Practices: Beyond Bad Faith*, 47 TORT TRIAL & INS. PRAC. L.J. 693, 711 (2012).

³⁸ See Oechsner & Schaler-Haynes, *supra* note 23, at 306–07.

³⁹ Dylan Scott, *Trump’s New Plan to Poke Holes in the Obamacare Markets, Explained*, VOX (Feb. 20, 2018, 10:10 AM), <https://www.vox.com/policy-and-politics/2018/2/20/17031640/short-term-insurance-trump-obamacare> [<https://perma.cc/GQ2U-26L6>].

⁴⁰ See Michelle Andrews, *Read the Fine Print Before Picking an Association Plan for Your Small Business*, NPR (June 27, 2018, 10:00 AM), <https://www.npr.org/sections/health-shots/2018/06/27/623626154/read-the-fine-print-before-picking-bout-an-association-plan-for-your-small-busin> [<https://perma.cc/J7WG-EJE9>]. The Association Health Plan expansion was struck down by the U.S. District Court for the District of Columbia, but the decision is currently being appealed. See *New York v. U.S. Dep’t of Labor*, 363 F. Supp. 3d 109, 118 (D.D.C. 2019), *appeal filed*, No. 19-5125 (D.C. Cir. Apr. 30, 2019).

⁴¹ See Andrews, *supra* note 40.

exclude patients with preexisting conditions, charge them higher premiums, or exclude health benefits that the ACA defines as essential.⁴²

As critics of short-term and association health plans argue, the Trump Administration's approach reduces premiums for healthy buyers by shifting costs to patients with preexisting conditions.⁴³ The availability of these plans would probably most harm middle-aged and older patients with high premiums who are more likely to have preexisting conditions than younger patients. Some of the Administration's defenders argue that preexisting conditions typically result from irresponsible conduct and that others should not be required to pay the cost of treating them.⁴⁴ But many preexisting conditions do not reflect irresponsible conduct.⁴⁵ Even when these conditions are attributable in part to irresponsibility, it is disproportionate to expose patients with them to the unlimited risks of uninsurance.

C. Increasing Subsidies

Some legislators have proposed offsetting the impact of rising premiums by extending subsidies to households making over 400% of the federal poverty line. California is using state funds to subsidize

⁴² David McFarlane & Alice Hall-Partyka, *Court Upholds Short-Term, Limited Duration Insurance Policy Rule*, C&M HEALTH LAW (July 23, 2019), <https://www.cmhealthlaw.com/2019/07/court-upholds-short-term-limited-duration-insurance-policy-rule/> [<https://perma.cc/2U8A-9AVG>]; *Seven Health Organizations File Lawsuit Against the Short-Term, Limited-Duration Plan Final Rule*, AM. PSYCHIATRIC ASS'N (Sept. 14, 2018), <https://www.psychiatry.org/newsroom/news-releases/seven-health-organizations-file-lawsuit-against-the-short-term-limited-duration-plan-final-rule> [<https://perma.cc/Q7AQ-AH3V>]. While Affordable Choices plans also permit purchasers to opt out of certain health benefits, their goal is to allow purchasers to select plans based on their values; in contrast, short-term plans are pitched as allowing purchasers to select plans based on expected medical needs. See, e.g., Jayne O'Donnell & Ken Alltucker, *President Donald Trump's Answer to Obamacare: Short-Term Health Insurance*, USA TODAY (Aug. 1, 2018, 5:23 PM), <https://www.usatoday.com/story/news/nation/2018/08/01/president-trumps-answer-obamacare-short-term-health-insurance/879337002/> [<https://perma.cc/B293-KR5B>] (reporting that experts believe short-term plans "may appeal to healthier adults who don't need coverage for a chronic disease but want to spend less on health insurance premiums").

⁴³ See, e.g., Kevin Lucia & Sabrina Corlette, *It's All About the Rating: Touted "Benefits" of Association Health Plans Ignore Key Facts*, CTR. ON HEALTH INS. REFORMS (Feb. 4, 2019), <http://chirblog.org/its-all-about-the-rating/> [<https://perma.cc/JC9U-8DSY>]; Dania Palanker et al., *States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans*, COMMONWEALTH FUND (May 2, 2019), <https://www.commonwealthfund.org/publications/issue-briefs/2019/may/states-step-up-protect-markets-consumers-short-term-plans> [<https://perma.cc/NH6A-NDRJ>].

⁴⁴ See, e.g., Sarah Kliff, *GOP Legislator Says Healthy People Lead "Good Lives," Should Get Cheaper Health Insurance*, VOX (May 2, 2017, 9:30 AM), <https://www.vox.com/policy-and-politics/2017/5/2/15514006/mo-brooks-preexisting-conditions> [<https://perma.cc/D9GD-PRFU>].

⁴⁵ See *id.* (discussing "expensive health care conditions that aren't the result of any choice at all," such as epilepsy and multiple sclerosis).

premiums for households below 600% of the poverty line,⁴⁶ and a bill to provide all households subsidies has been proposed in Congress.⁴⁷

Increasing subsidies would cushion households in the individual market against rising premium costs, but would shift those costs onto the shoulders of the broader public. While preferable to shifting costs onto the shoulders of the sick, insurance subsidies are likely not a high priority for public spending. The United States arguably already overspends on health care in comparison to other social spending, and could achieve greater health improvement by spending on education, environmental improvement, housing, or even direct income assistance to households.⁴⁸ Spending money to subsidize middle- and upper-income households' access to insurance while doing nothing to limit the price of insurance is unlikely to be an efficient way of improving health. While increasing subsidies for the purchase of health insurance remains compatible with this Article's proposal for allowing greater content choice, content choice could obviate the need for increased subsidies.

An alternative to increasing subsidies for private insurance is to replace private insurance with publicly provided insurance, thereby partially or fully replacing premiums with taxes. Like increasing subsidies, a publicly provided insurance system is compatible with content choice.⁴⁹ Furthermore, content choice could help address two of the biggest challenges for expanding publicly provided insurance. First, it could avoid drawing a controversial categorical line between interventions that are provided at public expense to all and those that are

⁴⁶ Samantha Young & Ana B. Ibarra, *California Gov. Newsom Proposes Penalty to Fund Health Insurance Subsidies*, KAISER HEALTH NEWS (June 4, 2019), <https://khn.org/news/newsom-proposes-penalty-to-fund-health-insurance-subsidies/> [https://perma.cc/8NUW-JDZJ].

⁴⁷ Katie Keith, *House Democrats Introduce Bill to Strengthen the ACA*, HEALTH AFF. (Mar. 27, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190327.894190/full/> [https://perma.cc/V547-QJLX].

⁴⁸ See, e.g., Elizabeth H. Bradley et al., *Health and Social Services Expenditures: Associations with Health Outcomes*, 20 BMJ QUALITY & SAFETY 826, 829 (2011) (“[T]he ratio of social expenditures to health expenditures may influence health outcomes beyond that which results from health spending alone.”); M. Gabriela Alcalde, *How to Build Healthy Places Through Cross-Sector Collaboration*, HEALTH AFF. (Oct. 7, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20151007.051063/full/> [https://perma.cc/V547-QJLX] (examining how Kentucky has improved public health by targeting “various sectors that contribute to making a community healthy”).

⁴⁹ See Robert M. Veatch, *Single Payers and Multiple Lists: Must Everyone Get the Same Coverage in a Universal Health Plan?*, 7 KENNEDY INST. ETHICS J. 153, 155 (1997) (explaining how single-payer insurance could include different packages of benefits).

available to none.⁵⁰ Second, by making the plans cheaper, it could reduce the amount of tax revenue needed to fund access to the publicly provided plan.⁵¹

D. Allowing Content Choice

The shortcomings of the aforementioned strategies highlight the appeal of content choice as an alternative route to affordable health insurance. This Section provides an overview and analysis of past scholarly discussions of content choice. At the outset, it is important to differentiate content choice—choice about *which interventions* are covered—from other forms of choice about insurance that have been offered or advocated. The ACA and many prior proposals provide an extensively or completely standardized package of interventions, but permit choice among different insurers who administer the standardized package or among different ways of paying for that standardized package. The main goal of offering this form of choice is to incentivize insurers to lower costs, rather than to enhance individual autonomy. Consider, for instance, Alain Enthoven’s classic proposal for a “consumer-choice health plan.”⁵² Enthoven advocates a marketplace in which insurers must all offer at least a federally standardized benefits package.⁵³ While insurers are permitted to offer benefits over and above the package, the central goal of Enthoven’s consumer choice proposal is not to enable consumers to select insurance coverage that matches their conception of a good life, but rather to subject insurers to market discipline that constrains insurance costs and incentivizes insurers to bargain with providers for lower-cost medical care.⁵⁴ The critique that purchasers are ill equipped to navigate choices about pre-

⁵⁰ See Ezekiel J. Emanuel, *The Problem with Single-Payer Plans*, HASTINGS CTR. REP., Jan.-Feb. 2008, at 38, 41.

⁵¹ See Robert H. Frank, *Why Single-Payer Health Care Saves Money*, N.Y. TIMES (July 7, 2017), <https://www.nytimes.com/2017/07/07/upshot/why-single-payer-health-care-saves-money.html> [https://perma.cc/8ASZ-47BW]; Emmanuel Saez & Gabriel Zucman, *Make No Mistake: Medicare for All Would Cut Taxes for Most Americans*, GUARDIAN (Oct. 25, 2019), <https://www.theguardian.com/commentisfree/2019/oct/25/medicare-for-all-taxes-saez-zucman> [https://perma.cc/AT6E-NJ24].

⁵² See Alain C. Enthoven, *Consumer-Choice Health Plan: A National-Health-Insurance Proposal Based on Regulated Competition in the Private Sector*, 298 NEW ENG. J. MED. 709 (1978).

⁵³ *Id.* at 714; see also Alain C. Enthoven, *Effective Management of Competition in the FEHBP*, 8 HEALTH AFF. 33, 42 (1989) (praising an approach where “all health plans . . . cover exactly the same list of covered services, subject to the same limits, copayments, and deductibles” and stating that “there is a strong presumption in favor of standardization”).

⁵⁴ See Enthoven, *supra* note 53, at 42 (describing the goal of managed competition as “to motivate managed care plans to produce a favorable combination of efficiency and equity”).

miums, deductibles, and copayments⁵⁵ may not apply, or at least not so strongly, to proposals that would allow purchasers to select among plans that genuinely differ in content while potentially being more standardized along these other dimensions.

1. *Critiquing Content Choice*

The most recent critique of content choice is a 2015 Hamilton Project white paper by the legal academic Nicholas Bagley and the health economists Austin Frakt and Amitabh Chandra.⁵⁶ Bagley, Chandra, and Frakt open by identifying problems stemming from the absence of content choice:

A combination of legal rules and institutional pressures . . . forces consumers into . . . plans that cover the same health-care technologies. As a result, consumers have no choice but to insure themselves against the risk of needing expensive care of marginal clinical value—even if they would prefer to purchase cheaper coverage that excluded such care. That, in turn, sends an “if you build it, we will pay for it” signal to technology developers, encouraging them to invest in new technologies that yield incremental benefits without regard to cost.⁵⁷

The authors recognize that even though values and wealth affect demand for health care, “instead of buying health plans that meet their variable demand, the rich and poor alike must buy plans that cover health-care technologies of questionable value.”⁵⁸ They also note that “[t]he welfare consequences of making people buy the same health plan are perhaps even larger than making them purchase the same cars, computers, or colleges, which nobody would consider realistic and few would consider desirable.”⁵⁹

Despite recognizing the potential attractiveness of allowing health plans to differ in content, Bagley, Chandra, and Frakt conclude that adverse selection renders such differentiation impossible. The ACA’s requirement that individual market insurers sell coverage to any willing buyer means that “patients can switch plans when they become sick,” and therefore, “plans with more-comprehensive cover-

⁵⁵ Hoffman, *supra* note 12 (manuscript at 25–29).

⁵⁶ BAGLEY ET AL., *supra* note 10. Bagley and Frakt also authored a 2017 article analyzing content choice. See Austin B. Frakt & Nicholas Bagley, *Why It’s So Hard for Insurers to Compete Over Technology*, 318 JAMA 687 (2017).

⁵⁷ BAGLEY ET AL., *supra* note 10, at 5.

⁵⁸ *Id.* at 7.

⁵⁹ *Id.* at 17.

age would be likely to attract less-healthy patients, which would in turn lead premiums for those generous plans to skyrocket.”⁶⁰ They provide the following illustration:

Consider, for example a young, married couple with no children with a modest demand for technology, both because they’re healthy and because they value exotic vacations more than exotic treatments. They select the low-technology (high cost-effectiveness) option and use the savings to travel abroad. Now suppose that they have a child who needs treatment for cystic fibrosis. Novel therapies for this condition have an incremental cost-effectiveness ratio in the hundreds of thousands of dollars. The family may rationally want to switch from their plan with stingy coverage rules to an expansive plan that covers high-cost therapies with low cost-effectiveness.⁶¹

Bagley, Chandra, and Frakt review and ultimately reject three proposals for stemming adverse selection—allowing the denial of coverage for preexisting conditions, risk adjustment, and permitting the sale of multiyear plans—arguing that allowing plans to consider preexisting conditions is contrary to the core ideals of the ACA, risk adjustment is unworkable, and multiyear plans would stifle competition.⁶² They conclude that “allowing health plans to compete on the scope of what technologies they cover . . . would require regulations that are unlikely ever to be politically and culturally attractive,”⁶³ and that “[d]irect competition between plans that cover technology to different levels of cost-effectiveness appears to be a nonstarter, closer to science fiction than plausible policy.”⁶⁴

Although their concerns have merit, their verdict is overstated. As they concede, plans already differ in actuarial value, choice of provider, and network breadth.⁶⁵ These differences all present opportunities for adverse selection, but do not undermine implementability. While choice about content presents similar dangers, adding regulated choice about content to the existing mix of choices represents a difference of degree rather than kind. Furthermore, choice about content may not raise the overall risk of adverse selection if it substitutes for other forms of choice, such as actuarial value or network breadth,

⁶⁰ *Id.* at 8.

⁶¹ *Id.* at 9 (citation omitted).

⁶² *Id.* at 7–10.

⁶³ *Id.* at 2.

⁶⁴ *Id.* at 17.

⁶⁵ *See id.* at 9.

rather than adding to them. Parts III, IV, and V will emphasize the idea that choice about content can replace other, less valuable, forms of choice, expanding the value of choice to purchasers without creating the downsides of excessive options.

Additionally, Bagley, Chandra, and Frakt's proposals for addressing health care costs and misaligned incentives for innovation—replacing the tax exclusion of employer-based insurance with a credit, strengthening Medicare coverage determinations, and allowing reference pricing for some treatments in Medicare⁶⁶—face their own political headwinds. The tax exclusion of employer-based insurance is politically entrenched,⁶⁷ and their proposed reforms to Medicare would require federal legislative action and make the government the scapegoat when treatments are excluded from Medicare coverage or made unavailable because of reference pricing.⁶⁸ They would also require the government to set cost-effectiveness thresholds, a task fraught with both political and legal problems.⁶⁹ In contrast, this Article's proposal has the political advantage of making insurance purchasers, rather than the government, responsible for the decision to exclude treatments from coverage. Making cheaper treatment a choice rather than a top-down imposition has both political and legal advantages.

The remainder of this Section considers five prior proposals⁷⁰ for content choice, two of which are the focus of Bagley, Chandra, and Frakt's critique.⁷¹ These proposals emphasize different aspects of content choice. Some of these proposals are advanced by scholars—Mark Pauly, Arti Rai, Einer Elhauge, and Zeke Emanuel—who have spent time in government as well as academia. Pauly is described as conservative and advised the George H.W. Bush administration in the

⁶⁶ *Id.* at 11–16.

⁶⁷ Alex Muresianu & Nicole Kaeding, *Another Look at Reforming the Health Insurance Exclusion*, TAX FOUND. (June 27, 2018), <https://taxfoundation.org/another-look-at-reforming-the-health-insurance-exclusion/> [<https://perma.cc/4AM7-WQKH>]; Kate Zernike, *The Hidden Subsidy That Helps Pay for Health Insurance*, N.Y. TIMES (July 7, 2017), <https://www.nytimes.com/2017/07/07/health/health-insurance-tax-deduction.html> [<https://perma.cc/7KR8-8HQQ>].

⁶⁸ See Margot Sanger-Katz, *Another of Obamacare's Unloved Provisions Is Gone*, N.Y. TIMES (Feb. 9, 2018), <https://www.nytimes.com/2018/02/09/upshot/obamacare-ipab-medicare-congress.html> [<https://perma.cc/CU65-ATWJ>].

⁶⁹ See generally Govind Persad, *Priority Setting, Cost-Effectiveness, and the Affordable Care Act*, 41 AM. J.L. & MED. 119 (2015) (discussing legal and political challenges in the implementation of traditional cost-effectiveness analysis).

⁷⁰ See *infra* Table 1 for a summary of each proposal.

⁷¹ See BAGLEY ET AL., *supra* note 10, at 9 (critiquing Korobkin's and Pauly's proposals).

1990s,⁷² while Emanuel, Elhauge, and Rai all worked for the Obama campaign or administration, with Emanuel having a major role in the development of the ACA.⁷³ That academics fluent in policy have expressed openness to the idea of content choice suggests that it is more than a “science fiction” proposal.⁷⁴

2. *Relative-Value Health Insurance*

Russell Korobkin, whose work is a primary target of Bagley, Chandra, and Frakt’s critique, observes that plans without content choice fail to account for “the heterogeneity in preferences for medical care and thus would almost certainly result in significant inefficiencies”⁷⁵ He suggests that patients could be offered a choice between different forms of “*relative value health insurance (RVHI)*, a product that would cover medical interventions that meet or exceed a given level of cost-effectiveness and exclude from coverage relatively less cost-effective treatments.”⁷⁶ According to Korobkin, “RVHI could be offered with different cost-benefit thresholds, enabling consumers with different subjective preferences for allocating their financial resources to medical care versus other goods and services to satisfy those preferences at the time that they purchase insurance,”⁷⁷ minimizing the problem of having to make financial trade-offs at the point of treatment.

As Korobkin observes, the “consequence” of medical necessity is that “all buyers of private health insurance must purchase ‘Cadillac’-

⁷² Ezra Klein, *An Interview with Mark Pauly, Father of the Individual Mandate*, WASH. POST (Feb. 1, 2011, 3:20 PM), http://voices.washingtonpost.com/ezra-klein/2011/02/an_interview_with_mark_pauly_t.html [<https://perma.cc/F25T-XSFE>].

⁷³ Michael Rainey, *Ezekiel Emanuel: Obamacare Has Saved Over \$2 Trillion so Far*, FISCAL TIMES (Mar. 25, 2019) (noting that Emanuel was “one of the architects of the Affordable Care Act in the Obama administration”), <https://www.thefiscaltimes.com/2019/03/25/Emanuel-Obamacare-Has-Saved-Over-2-Trillion-So-Far> [<https://perma.cc/RPV5-M45N>]; Guy Rolnik, *Horizontal Shareholding, Antitrust, Growth and Inequality*, PROMARKET (July 1, 2016), https://promarket.org/horizontal-shareholding-antitrust-growth/?mc_cid=7d82c41321&mc_eid=08df55fd49 [<https://perma.cc/XM5Q-S5MY>] (explaining that Elhauge “was chairman of the Antitrust Advisory Committee to Barack Obama’s 2008 campaign”); Edward Wyatt, *Obama Orders Regulators to Root Out ‘Patent Trolls’*, N.Y. TIMES (June 4, 2013), <https://www.nytimes.com/2013/06/05/business/president-moves-to-curb-patent-suits.html> [<https://perma.cc/6RAN-5GU5>] (“Ms. Rai . . . was the administrator for the Office of External Affairs at the patent office.”).

⁷⁴ *But see* BAGLEY ET AL., *supra* note 10, at 17 (deriding content choice as “science fiction”).

⁷⁵ Russell Korobkin, *Relative Value Health Insurance*, 39 J. HEALTH POL., POL’Y & L. 417, 419 (2014).

⁷⁶ *Id.* at 420.

⁷⁷ *Id.* at 421.

quality health care at a Cadillac price, even if they would prefer to purchase a more modest level of care at a more modest price.”⁷⁸ Korobkin identifies insurance purchasers’ unwaivable right to treatment judged “medically necessary” as the most obvious obstacle to RVHI.⁷⁹ He notes, however, that external medical necessity review could be avoided by explicitly excluding some treatments from the health insurance contract.⁸⁰ Korobkin suggests that cost-effectiveness data could be used to generate multiple “levels” of plans, with Level 10 plans including interventions with all levels of cost-effectiveness while Level 1 plans include only treatments with high cost-effectiveness.⁸¹

Korobkin proposes resolving the adverse selection objection that Bagley, Chandra, and Frakt identify through precommitment, at least for some period of time, suggesting that “if a customer purchased a Level 3 policy and then switched to a more generous Level 8 policy, he would be covered for interventions rated 8 or higher for any new conditions but only for interventions rated 3 or higher for preexisting conditions.”⁸² Anticipating the concerns Bagley, Chandra, and Frakt raise, Korobkin notes that “this rule would not undermine the ACA’s philosophy that all Americans should be able to purchase reasonably priced health insurance regardless of their health status.”⁸³ While Korobkin’s precommitment proposal could address Bagley, Chandra, and Frakt’s concern about sicker patients jumping to more costly plans, especially if patients are required to commit for a substantial time, Part III argues that regulating the content of plans and limiting customers’ ability to switch plan types does much of the same work.

3. *Limiting Coverage of New Technology*

Mark Pauly’s proposal for content choice focuses on why health insurance does not offer plans with lower premiums and less access to high-cost treatments, and argues that offering such plans might motivate research and development investment in less effective but less expensive treatments. Pauly notes that currently, “[p]eople cannot generally choose knowledgeably among a variety of plans characterized by explicitly different policies toward new technology.”⁸⁴ This is

⁷⁸ *Id.* at 424.

⁷⁹ *See id.* at 422.

⁸⁰ *Id.* at 424–25.

⁸¹ *See id.* at 427.

⁸² *Id.* at 434.

⁸³ *Id.*

⁸⁴ Mark V. Pauly, *Competition and New Technology*, 24 HEALTH AFF. 1523, 1528 (2005).

because “plans in most markets do not say much about their technology-rationing policies . . . and, as far as we know, health plans are fairly similar in terms of coverage of new technology.”⁸⁵ Pauly observes that proposals for innovation in health care tend to focus on the desire to produce higher quality at lower cost, rather than recognizing the desirability of offering treatment that is lower in both quality and cost.⁸⁶

Pauly argues that increased affordability will require a “legal system that allow[s] consumers to opt out of the best possible improvements in care (regardless of cost) for a less aggressive alternative.”⁸⁷ Like Korobkin, Pauly suggests that choice-differentiated plans could use cost-effectiveness thresholds, either in the form of fixed thresholds or thresholds that vary from year to year in order to keep spending constant.⁸⁸ He also suggests two other plan designs: a plan that “delay[s] new technology,” and a “‘no new heroic measures’ health plan,” which limits spending specifically on end-of-life care.⁸⁹ Part II examines similar suggestions.

Pauly considers several potential reasons why current plans do not offer content choice. He rejects liability for failing to provide medically necessary care as the explanation, because plans can avoid liability by explicitly specifying what treatments are excluded.⁹⁰ Instead, he focuses on providers’ potential unwillingness to participate in plans with limits and patients’ movement from year to year between insurers.⁹¹ He also discusses adverse selection, noting the worry that “higher risks would be more likely to choose plans that add technology more rapidly, so that any resulting adverse selection would drive out those ‘inflationary’ plans compared with ones with slow premium growth that are reluctant to add expensive but beneficial technology.”⁹² But Pauly—in contrast to Bagley, Chandra, and Frakt and Korobkin—argues that “although adverse selection could be a reason

⁸⁵ *Id.*

⁸⁶ See Mark V. Pauly, *‘We Aren’t Quite as Good, But We Sure Are Cheap’: Prospects for Disruptive Innovation in Medical Care and Insurance Markets*, 27 *HEALTH AFF.* 1349, 1350 (2008). Pauly asks, “Why does not some insurer offer a health plan with premiums that grow less rapidly because of slower take-up of costly but beneficial innovations? Why not push a scan with a little less accuracy but much lower cost? What about a lower-price drug with more uncomfortable side effects?” *Id.*

⁸⁷ *Id.* at 1352.

⁸⁸ See Pauly, *supra* note 84, at 1532.

⁸⁹ *Id.* at 1533.

⁹⁰ *Id.* at 1528–29.

⁹¹ See *id.* at 1529.

⁹² *Id.*

for the existence of a smaller variety of plans than would occur in its absence, it does not seem to be a plausible explanation for what is happening with technology and spending growth.”⁹³ Drawing on his background in economics, Pauly instead emphasizes that sellers often cluster their offerings “too ‘close together’” in an effort to appeal to the median consumer rather than reaching a niche.⁹⁴

4. *Rationing Through Choice*

The analyses of content choice that Korobkin, Pauly, and Bagley, Chandra, and Frakt offer are all prompted by the problems in health insurance affordability immediately before and after the ACA’s passage, as discussed in Part I. But interest in content choice substantially predates the ACA.

In a 1997 article, Arti Rai proposes what she calls “rationing through choice,” an approach that allows patients to opt out of expensive treatments in advance.⁹⁵ She identifies two reasons why rationing through choice is preferable to the development of a universal standard for which interventions should be offered. First, ethical considerations underdetermine the appropriate standard.⁹⁶ Second, setting a universal standard through a democratic process unfairly disadvantages individuals with atypical preferences.⁹⁷ Under Rai’s approach, like Korobkin’s, individuals seeking insurance would have access to a variety of different insurance plans that covered or excluded certain interventions, with the main differentiator being cost-effectiveness.⁹⁸

Rai, like most of the scholars discussed above, is concerned about the prospect of adverse selection.⁹⁹ But rather than embracing a limited preexisting condition exclusion, as Korobkin does,¹⁰⁰ Rai attempts to address adverse selection through risk adjustment that would provide sicker patients a greater quantity of resources to select their preferred plan.¹⁰¹ Rai also proposes limitations on the content of available plans, but her limitations face problems. One such limitation is a prohibition on making “ex ante rationing choices that contem-

⁹³ *Id.*

⁹⁴ *Id.* at 1530.

⁹⁵ Arti Kaur Rai, *Rationing Through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care*, 72 *IND. L.J.* 1015, 1021 (1997).

⁹⁶ *See id.* at 1030–31.

⁹⁷ *See id.*

⁹⁸ *Id.* at 1018–19.

⁹⁹ *See id.* at 1043.

¹⁰⁰ *See* Korobkin, *supra* note 75, at 434.

¹⁰¹ Rai, *supra* note 95, at 1043.

plate[] very serious and irreversible deprivations of liberty,”¹⁰² which would seem to rule out decisions to ever deny oneself lifesaving treatment in the future, given that death is an irreversible deprivation of all goods, including liberty. She also proposes prohibiting buyers from binding themselves to a plan more than three to five years in the future.¹⁰³ This is hard to accept, as Part IV will discuss, given that we allow individuals to substantially constrain their own futures by electing or refusing major medical procedures, and also allow people to make other major decisions that constrain their futures, such as decisions to become a parent, join the military, marry, or assume debts.

5. *Precommitment to Content Choice*

In a 1994 article, Einer Elhauge offers qualified praise for content choice. He argues that decisions to deny access to certain treatments that “rely[] on the prior consent of those denied care . . . send[] the message that society considers each individual’s choices important.”¹⁰⁴ His main concerns are whether individuals should be held to their past commitments,¹⁰⁵ and under what conditions commitments should be made.¹⁰⁶

Like Rai, Elhauge worries about individuals’ capacity to bind themselves in the future. But, as discussed above, no special justification is needed for a young adult to be able to bind herself to a marriage or a mortgage, nor is any particular solicitude for the plight of a “future self” warranted in these cases. It is doubtful that decisions about health care should be treated differently. Elhauge asks the question, “when *should* we respect the exercise of past autonomy over the present?”¹⁰⁷ One potential answer is, “Whenever the exercise of past autonomy created a genuine commitment.” Respect for commitments does not require rendering them irrevocable—the law includes mechanisms for people to leave marriages or stop paying mortgages, although exercising these mechanisms typically comes with major costs—but the ability to bind oneself to long-term plans is part of the autonomy that Elhauge recognizes as valuable.¹⁰⁸ Elhauge also dis-

¹⁰² *Id.* at 1038.

¹⁰³ *Id.* at 1038–39.

¹⁰⁴ Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449, 1526 (1994).

¹⁰⁵ *See id.* at 1527–29; *see also* Rai, *supra* note 95, at 1038 (echoing this concern).

¹⁰⁶ Elhauge, *supra* note 104, at 1530–35.

¹⁰⁷ *Id.* at 1528.

¹⁰⁸ *See id.* at 1526 (“[T]he most powerful reason for designing a health care system that permits a diversity of moral choice [is] the moral significance of respecting individual autonomy.”); *see also* Seana Valentine Shiffrin, *Promising, Intimate Relationships, and Conventional-*

cusses the risk of adverse selection, and notes that ill people might self-select into plans that allocate more resources to expensive life-saving treatment.¹⁰⁹ Like Rai, he suggests risk adjustment as a solution,¹¹⁰ but his analysis is also compatible with the Affordable Choices approach's regulation of plan content. And Elhauge recognizes the difference between choosing a plan based on one's health status and choosing a plan based on the value one assigns to health care,¹¹¹ a topic that Part III discusses.

6. *Community Health Programs*

In a 1991 book, Ezekiel Emanuel suggests allowing individuals to choose from an expansive menu of different "community health programs" ("CHPs").¹¹² Unlike Korobkin and Pauly, who favor content choice primarily because it improves affordability for buyers and incentivizes socially valuable innovation, Emanuel's justification for content choice emphasizes the ability to shape one's life. Members of each CHP would together "articulate the broad outlines of their shared conception of the good life,"¹¹³ and would include coverage for interventions that fit that conception. CHP members would also determine what proportion of the CHP's resources should be devoted to various treatments, such as "nursing home care, drugs, bone marrow transplants, dialysis for patients over age 65, or clinical research."¹¹⁴ CHP participants would also determine the criteria for provision of the offered treatments.¹¹⁵ This structure makes CHP participants "citizen-members" who "are responsible for deciding various aspects of the CHP's policies, ranging from what services will be provided to what informed consent procedures will exist."¹¹⁶ Emanuel emphasizes that participation in a CHP enables members to collectively shape their lives: they are "not just recipients of services conceived and administered by others, but participating citizens determining the health

ism, 117 PHIL. REV. 481, 502 (2008) ("An autonomous life requires . . . meaningful, moral relations with others. Meaningful, moral relations depend on agents having the ability to make binding promises."). *But see* Aditi Bagchi, *Contract and the Problem of Fickle People*, 53 WAKE FOREST L. REV. 1, 3 (2018) ("The same ideal of moral agency that makes promise valuable makes the power to revise and reject commitments that we have made valuable too.").

¹⁰⁹ Elhauge, *supra* note 104, at 1533.

¹¹⁰ *Id.* at 1534.

¹¹¹ *See id.* at 1535.

¹¹² EZEKIEL J. EMANUEL, *THE ENDS OF HUMAN LIFE* 178 (1991).

¹¹³ *Id.* at 179.

¹¹⁴ *Id.* at 181.

¹¹⁵ *See id.* at 180–81.

¹¹⁶ *Id.* at 183.

care policies they will receive.”¹¹⁷ Although all citizens receive a voucher that funds the CHP of their choice, CHPs can choose to re-fund some of the voucher funds to their members or to impose additional assessments on their members to fund more costly treatments.¹¹⁸ The sets of services offered in CHPs could vary substantially, just as conceptions of the good life do.¹¹⁹

Although Emanuel does not provide a detailed analysis of adverse selection, he does propose strategies for combating it. First, the only criteria CHPs are permitted to use in determining who may enroll are those that reflect the CHP’s conception of the good life,¹²⁰ and CHPs are prohibited from selecting or excluding participants on the basis of health status.¹²¹ Second, CHP vouchers include risk adjustment by age, with older enrollees receiving larger vouchers, in order to deter CHPs from excluding older enrollees who are likely to need more treatment.¹²² Third, movement between CHPs would be restricted, with efforts made to prevent patients from selecting CHPs on the basis of their anticipated health care needs rather than on the basis of their conception of the good life.¹²³ Part III builds on the first and third of these strategies in particular by discussing how the Affordable Choices framework would resist adverse selection.

117 *Id.*

118 *Id.* at 185, 190.

119 *See id.* at 212–18.

120 *Id.* at 184.

121 *Id.*

122 *Id.* at 187.

123 *Id.* at 190–91.

TABLE 1. PROPOSALS FOR CONTENT CHOICE

Proposal	Author	Description of Plan(s)	Distinctive Features of Proposal
<i>Relative Value Health Insurance</i> ¹²⁴	Russell Korobkin	10 plan “levels” varying by cost-effectiveness	Combats adverse selection through precommitment
<i>Various</i> ¹²⁵	Mark Pauly	Cost-effectiveness threshold Delayed access to new technology Limits certain costly end-of-life treatments	Dismisses adverse selection as an unlikely major problem
<i>Rationing Through Choice</i> ¹²⁶	Arti Rai	Multiple cost-effectiveness thresholds	Combats adverse selection through risk adjustment Emphasizes individual autonomy Limits precommitment
<i>Allocating Health Care Morally</i> ¹²⁷	Einer Elhauge	Cost-effectiveness threshold Excludes costly end-of-life treatments	Combats adverse selection through risk adjustment Emphasizes individual autonomy
<i>Community Health Programs</i> ¹²⁸	Ezekiel Emanuel	Collectively chosen packages of treatments	Combats adverse selection through risk adjustment Emphasizes community choice Limits movement between plans

II. AFFORDABLE CHOICES FOR HEALTH INSURANCE

This Part presents a positive proposal for content differentiation: the Affordable Choices approach. Section II.A begins by explaining the normative underpinnings of the Affordable Choices approach, and how it can improve affordability and autonomy while resisting adverse selection. Section II.B outlines some categories of plans that might be offered within an Affordable Choices framework. Section II.C pro-

¹²⁴ See Korobkin, *supra* note 75; see also *infra* Section I.D.2 (discussing Korobkin’s proposal).

¹²⁵ See Pauly, *supra* note 86; Pauly, *supra* note 84; see also *infra* Section I.D.3 (discussing Pauly’s proposal).

¹²⁶ See Rai, *supra* note 95; see also *infra* Section I.D.4 (discussing Rai’s proposal).

¹²⁷ See Elhauge, *supra* note 104; see also *infra* Section I.D.5 (discussing Elhauge’s proposal).

¹²⁸ See EMANUEL, *supra* note 112; see also *infra* Section I.D.6 (discussing Emanuel’s proposal).

vides a thumbnail sketch of how Affordable Choices plans could be offered on an existing ACA exchange, and also discusses how they could be offered as employer-based, Medicare, or Medicaid plans. Section II.D discusses the legal provisions that enable Affordable Choices plans to be offered as part of individual market and employer-based insurance, and the legal changes that would be necessary in order to offer them as part of Medicare and Medicaid.

A. Principles for Plan Construction

The Affordable Choices approach retains the core values that animate the ACA—guaranteed access for people with preexisting conditions, subsidies for poorer households, provision of preventive care at no out-of-pocket cost, and restrictions on differential pricing.¹²⁹ But it abandons the one-size-fits-all vision of insurance content often associated with the ACA’s essential health benefits¹³⁰ in favor of giving purchasers a broader range of choices.

As noted earlier, the Affordable Choices framework would offer regulated, not unbounded, choice. This Section explains four ways that it would regulate choice: *reasonable disagreement*, *health-neutral appeal*, *preventing harm to others*, and *achieving monetary savings*.

1. Reasonable Disagreement

The interventions excluded from Affordable Choices plans should be ones about which reasonable disagreement exists. Indicia of reasonable disagreement might include physicians deciding not to provide a given intervention, patients electing not to receive it, recommendations against it by expert bodies such as Choosing Wisely or the U.S. Preventive Services Task Force,¹³¹ its exclusion from reimbursement or approval by private or public insurers within the United States, or its exclusion by health systems in other developed countries. The reasonable disagreement principle helps forestall two dangers discussed in Parts III and IV: that a plan will be unfair to the sick or an unreasonable choice for purchasers.

As Section II.B explains, the reasonable disagreement principle supports the availability of “international reference coverage” plans,

¹²⁹ See Maher, *supra* note 20, at 144–46.

¹³⁰ See Amy B. Monahan, *The Regulatory Failure to Define Essential Health Benefits*, 44 AM. J.L. & MED. 529, 531 (2018) (explaining that all ACA marketplace plans “must cover the same bundle of treatments and services, known as the Essential Health Benefits”).

¹³¹ See David Liebovitz, *Meaningful EHR Attributes for an Era of Accountability, Transparency, Shared Decision Making, and Value Assessment*, 34 J. LEGAL MED. 43, 46 (2013).

which are plans that would provide the set of interventions offered in other developed countries, such as the United Kingdom, Taiwan, Germany, or Canada. The reasonable disagreement principle could also support offering plans that are based on expert recommendations or plans that provide the set of interventions that were available five or ten years ago rather than the newest set of interventions.¹³²

2. *Health-Neutral Appeal*

Affordable Choices plans should appeal to people on the basis of their values, rather than their health status.¹³³ A plan appeals to buyers on the basis of health status when people believe that they are unlikely to develop certain medical needs and so select a plan that excludes treatments for those needs. For instance, individual plans that exclude pregnancy-related care might appeal to some men.¹³⁴ Permitting men to select such plans is potentially objectionable both because their choice is motivated by expected health status and because it tracks a legally protected social identity.¹³⁵ But a plan could also appeal on the basis of health status without tracking a legally protected identity—for instance, Alaskans (who live outside the range for Lyme disease) wanting to purchase a plan that excludes Lyme disease care. In contrast, someone who values other goals more highly than maximal medical benefit might select a plan that excludes expensive drugs that are marginally more effective than cheaper alternatives. This is an example of a choice grounded in values, because the chooser selects her plan based on her life goals rather than her expected medical needs. Someone who believes that costly treatment after the onset of advanced dementia would not further her life plans, and therefore selects a plan that excludes such treatment, similarly selects her plan based on values rather than health status.

A plan that appeals to health status as opposed to values enables adverse selection: it draws in healthier populations and makes other

¹³² See Pauly, *supra* note 84, at 1533 (discussing the possibility of plans that offer slightly older interventions).

¹³³ See EMANUEL, *supra* note 112, at 191; Elhauge, *supra* note 104, at 1535.

¹³⁴ See Tina Sfondeles, *Amid Furor, Shimkus Doesn't Back Off 'Prenatal Care' Remark*, CHI. SUN-TIMES (Mar. 10, 2017, 8:34 PM), <https://chicago.suntimes.com/2017/3/10/18333949/amid-furor-shimkus-doesn-t-back-off-prenatal-care-remark> [<https://perma.cc/8GKU-D3QS>] (reporting remarks by Rep. John Shimkus (R-Ill.) that questioned why men should have to pay for prenatal care).

¹³⁵ Pregnancy Discrimination Act of 1978, Pub. L. No. 95-555, 92 Stat. 2076 (“An Act to amend title VII of the Civil Rights Act of 1964 to prohibit sex discrimination on the basis of pregnancy.”).

plans more expensive as their enrollees become sicker.¹³⁶ Perfectly distinguishing status-based from values-based choice will be difficult, which means that the adverse selection problems associated with status-based choice must be weighed against the affordability and autonomy gains from allowing values-based choice. For instance, while some people may choose a reference coverage plan based on the United Kingdom's National Health Service ("NHS") package of interventions because of health status (for instance, because they will not need an expensive treatment that the NHS plan excludes), there are also compelling reasons unrelated to health status to select a plan based on the NHS. Part III will return to the trade-off between allowing values-based choice and preventing status-based choice.

3. *Preventing Harm to Others*

Affordable Choices plans should also protect and promote the health of non-participants. This principle will generally prioritize treating communicable diseases. For example, a plan participant's being cured of hepatitis protects third parties by decreasing their risk of contracting hepatitis.¹³⁷ This favors including hepatitis C treatments, even if costly, in Affordable Choices plans. Preventing harm to others would also prioritize treatments that prevent someone from becoming a danger to others—for instance, treatments for drug or alcohol dependence and for serious mental health conditions. Treatments that protect a participant's dependents, such as prenatal care or screening for postpartum depression, would also be prioritized.

4. *Achieving Monetary Savings*

Treatments or treatment categories excluded from Affordable Choices plans should be those whose exclusion will substantially lower costs. Excluding cost-neutral treatments will not improve affordability. This is compatible with excluding categories of costly treatments used by only a few people because this type of broad exclusion can lower costs even if no single instance makes a major difference on its own.¹³⁸

¹³⁶ See Elhauge, *supra* note 104, at 1533.

¹³⁷ See *infra* Section V.B.

¹³⁸ See Elhauge, *supra* note 104, at 1467–68.

B. *Plan Options*

The principles described in Section II.A suggest that several plan types could be offered within an Affordable Choices framework.¹³⁹ These include international reference coverage plans,¹⁴⁰ which provide only the interventions covered by another country or locality; historic reference coverage plans, which provide only the interventions that were offered at some point in the past (except where a newer treatment is cheaper); cost-effectiveness plans, which provide only treatments that meet a specified cost-effectiveness threshold; evidence-based plans, which exclude treatments that are not recommended by expert bodies; and advance directive plans, which exclude specific treatments (often at the end of life) that some purchasers may not value. Table 2 summarizes each of these possible plans and provides real life examples as well as treatments that are excluded from each plan.

¹³⁹ See *infra* Table 2.

¹⁴⁰ My use of the term “reference coverage” to describe a health plan based on the services offered in other developed countries is meant to parallel “reference pricing,” the pricing of treatments based on their price in other developed countries. See William V. Padula, *State and Federal Policy Solutions to Rising Prescription Drug Prices in the U.S.*, 22 J. HEALTH CARE L. & POL’Y 15, 22 (2019).

TABLE 2. TYPES OF AFFORDABLE CHOICES PLANS

Type	Examples	Excluded Interventions
<i>International reference coverage plans</i>	United Kingdom plan ¹⁴¹ New Zealand plan ¹⁴²	Some costly and/or ineffective treatments
<i>Historic reference coverage plans</i>	Plans based on interventions available in 2010 or 2000	Newer, costly treatments
<i>Cost-effectiveness plans</i>	“Rationing Through Choice” proposal (Rai) ¹⁴³ “Relative Value Health Insurance” proposal (Korobkin) ¹⁴⁴	All treatments above cost-effectiveness threshold
<i>Evidence-based plans</i>	Plans based on Choosing Wisely or U.S. Preventive Services Task Force recommendations ¹⁴⁵	Treatments that lack an evidence base or are not recommended by expert bodies
<i>Advance directive plans</i>	Plans based on proposals by Ronald Dworkin ¹⁴⁶ or Daniel Callahan ¹⁴⁷	All life-extending treatment for patients with dementia (Dworkin) or beyond a certain age (Callahan).

International reference coverage plans best satisfy the principles in Section II.A. Because they appeal to a broad population, the interventions they exclude can be thought of as automatically subject to reasonable disagreement—because the exclusion list has been democratically vetted by reasonable decisionmakers—and the interventions excluded also contribute to substantial cost savings. The list of developed countries whose marketing authorizations can be used for drug exports could be used to define the list of reference coverage offer-

¹⁴¹ See *infra* text accompanying notes 154–55.

¹⁴² See *infra* text accompanying note 153.

¹⁴³ See Rai, *supra* note 95.

¹⁴⁴ See *supra* text accompanying note 131.

¹⁴⁵ See Korobkin, *supra* note 75.

¹⁴⁶ See Ronald Dworkin, *Will Clinton's Plan Be Fair?*, 41 N.Y. REV. BOOKS 20 (Jan. 13, 1994), <https://www.nybooks.com/articles/1994/01/13/will-clintons-plan-be-fair/> [<https://perma.cc/ECS7-6JYT>] [hereinafter Dworkin, *Will Clinton's Plan Be Fair?*]; Ronald Dworkin, *Justice in the Distribution of Health Care*, 38 MCGILL L.J. 883, 891 (1993) [hereinafter Dworkin, *Justice in the Distribution of Health Care*].

¹⁴⁷ See Dworkin, *Will Clinton's Plan Be Fair?*, *supra* note 146; Dworkin, *Justice in the Distribution of Health Care*, *supra* note 146, at 891.

ings,¹⁴⁸ paralleling a similar proposal to use that list to determine reciprocity in drug approval.¹⁴⁹

International reference coverage could generate large savings. For example, a 2019 *Journal of General Internal Medicine* article documented that Medicare spent \$17.8 billion on medications that Ontario's Drug Benefit Formulary excludes.¹⁵⁰ Medicare's Part D prescription drug program covers approximately 40 million beneficiaries, which equates to spending of more than \$400 per beneficiary.¹⁵¹ Medicare also spent several billion dollars on drugs approved in Canada, but not in Australia or England.¹⁵² Other nations, like New Zealand, similarly use formularies to control drug pricing, resulting in New Zealanders having access to fewer and older medications, but also enjoying per capita spending on pharmaceuticals that is more than three times lower.¹⁵³ Savings are also possible on treatments other than pharmaceuticals. The United Kingdom limits access to treatments that are not cost-effective, including treatments that have potential benefit but that are very costly, such as some cancer treatments,¹⁵⁴ and treatments with low or uncertain benefits, such as knee arthroscopies for arthritis and injections for non-specific back pain.¹⁵⁵

¹⁴⁸ See 21 C.F.R. § 312.110(b)(2) (2019) (permitting export of investigational new drugs that have "valid marketing authorization in Australia, Canada, Israel, Japan, New Zealand, Switzerland, South Africa, or in any country in the European Union or the European Economic Area," and comply with other requirements).

¹⁴⁹ See Reciprocity Ensures Streamlined Use of Lifesaving Treatments Act of 2019, S. 2161, 116th Cong. § 2 (2019); Derek Lowe, *Reciprocal Approval of Drugs, According to Ted Cruz and Mike Lee*, AAAS (Dec. 15, 2015), <https://blogs.sciencemag.org/pipeline/archives/2015/12/15/reciprocal-approval-of-drugs-according-to-ted-cruz-and-bill-lee> [<https://perma.cc/XAC5-N8ZE>] (describing legislation sponsored by Sens. Ted Cruz (R-TX) and Mike Lee (R-UT) that would require the FDA to rapidly approve or refuse treatments that have been approved in other developed countries); cf. Speeding Access to Already Approved Pharmaceuticals Act of 2015, H.R. 1455, 114th Cong. § 2 (2015) (using European Union approval as a trigger for FDA expedited review of new treatments).

¹⁵⁰ Alexander C. Egilman et al., *Medicare Spending on Drugs and Biologics Not Recommended for Coverage by International Health Technology Assessment Agencies*, 34 J. GEN. INTERNAL MED. 2319, 2320 (2019).

¹⁵¹ See *id.* at 2319.

¹⁵² See *id.* at 2320.

¹⁵³ See Rajan Ragupathy et al., *A 3-Dimensional View of Access to Licensed and Subsidized Medicines Under Single-Payer Systems in the US, the UK, Australia and New Zealand*, 30 PHARMACOECONOMICS 1051, 1054, 1059–60, 1061 (2012).

¹⁵⁴ See Suzanne Elvidge, *NHS England Cuts Treatments from Cancer Drugs Fund*, PHARMACEUTICAL J. (Sept. 8, 2015), <https://www.pharmaceutical-journal.com/news-and-analysis/nhs-england-cuts-treatments-from-cancer-drugs-fund/20069298.article> [<https://perma.cc/PS3J-H3ZT>].

¹⁵⁵ *NHS England to Stop 'Ineffective' Treatments*, BBC NEWS (June 30, 2018), <http://www.bbc.com/news/health-44665560> [<https://perma.cc/SXF8-R3NT>].

Historic reference coverage plans, cost-effectiveness plans, and evidence-based plans can also satisfy the principles in Section II.A, but present a greater risk of enabling excessive adverse selection or overwhelming choosers with excessive choices. Advance directive plans that exclude specific interventions, particularly end-of-life treatments, are likely to be the most controversial. Although reasonable people disagree about whether end-of-life treatments fit with their life goals, people may also select plans that exclude certain end-of-life treatments because of differences in predicted health status, rather than differences in values. The legal and political challenges in distinguishing values-based plans from plans that appeal to people on the basis of health status, as Part III will discuss further, make them a lower priority for inclusion.

C. *Affordable Choices on an ACA Exchange*

The Affordable Choices framework is agnostic about the mechanism by which insurance is offered. As Section II.D explains, Affordable Choices plans could be offered in the ACA's individual marketplace as employer-based insurance, or within government-provided insurance like Medicare and Medicaid. This Section discusses how Affordable Choices plans could be added to an individual marketplace, using Colorado's exchange as an example.

As they do currently, prospective purchasers would list various facts that affect ACA premiums, such as date of birth, zip code, county, and income, which determines eligibility for subsidies.¹⁵⁶ Some Exchanges, like Colorado's, then ask about the purchaser's medical needs in order to help them identify the best balance of premiums versus copayments and deductibles, and allow the purchaser to see whether their doctor is in network and whether the plan includes the medications that they use.¹⁵⁷ An Exchange could incorporate Affordable Choices plans by asking whether the purchaser would like to see plans that may be more affordable but that exclude some treatments. Purchasers who agree would be provided with a checkbox to include various types of Affordable Choices plans. For purchasers who view Affordable Choices plans, the list of plan options would include an additional column (next to "Coverage of my doctors and medications") for "Coverage of treatments," explaining that the plan in ques-

¹⁵⁶ See *Quick Cost and Plan Finder*, CONNECT FOR HEALTH COLO., <https://planfinder.connectforhealthco.com/input-your-information> [<https://perma.cc/4DZ6-XWG9>].

¹⁵⁷ See *id.*

tion does not cover all treatments. The summary plan description would explain more fully which treatments are excluded.

Adding Affordable Choices plans could increase the number of available choices and thereby raise cognitive burdens on participants, an objection discussed in Part IV.¹⁵⁸ But current exchanges already include many more plans than is optimal from a cognitive burden perspective; for example, there are 45 plans available to participants in Denver.¹⁵⁹ Affordable Choices plans could even simplify the process of selecting a plan, if they used savings from offering fewer costly treatments to offer low or zero deductibles and out-of-pocket maximums.

D. *The Legality of Affordable Choices*

This Section discusses what legal changes, if any, would be needed to enable Affordable Choices plans to be offered as part of ACA marketplace, employer-based, and government-provided insurance.

1. *ACA Marketplaces*

The Affordable Choices framework is compatible with most ACA regulations on individual and small-group marketplace insurance. Like current ACA marketplace plans—and unlike short-term or association plans—Affordable Choices plans would be required to cover preexisting conditions, could not have lifetime or annual caps, would require an acceptable medical loss ratio, and could only differentiate pricing based on certain allowable factors such as age, location, and tobacco use.¹⁶⁰

The only potential source of tension between the Affordable Choices framework and the ACA regulatory scheme is the ACA's requirement that marketplace plans provide essential health benefits ("EHBs"). But even here, the ACA has been interpreted to give states substantial discretion to decide which benefits are essential by selecting a "benchmark plan"—that is, a plan whose benefits serve as a blueprint for other plans offered on the state exchange.¹⁶¹ While Af-

¹⁵⁸ See Monahan, *supra* note 130, at 531 (explaining that essential health benefits "serve consumer-oriented goals by . . . providing individuals with a simplified shopping experience through plans that each cover the same treatments and services").

¹⁵⁹ See *Quick Cost and Plan Finder*, *supra* note 156.

¹⁶⁰ See Maher, *supra* note 20, at 144–46.

¹⁶¹ Govind Persad & Harald Schmidt, *Sufficiency, Comprehensiveness of Health Care Coverage, and Cost-Sharing Arrangements in the Realpolitik of Health Policy*, in *WHAT IS ENOUGH?* 273, 279–80 (Carina Fourie & Annette Rid eds., 2016); Monahan, *supra* note 130, at 540 (noting

fordable Choices plans could not exclude entire classes of EHBs, the exclusion of some drugs or treatments in a class, or higher deductibles and copayments for specific treatments would all be consistent with the EHB requirement.¹⁶² In 2020, states gained even more discretion to choose the benchmark plan on which essential health benefits are based, so long as the plan is at least equivalent in overall scope to a “typical employer plan.”¹⁶³ Furthermore, insurers are permitted to substitute “actuarially equivalent” packages of benefits both within a given category and across categories, which permits Affordable Choices plans to offer an actuarially equivalent, but not identical, package of treatments.¹⁶⁴ Alternatively, new guidance from the U.S. Department of Health and Human Services permits states to seek permission from the federal government to offer plans that do not cover the essential health benefits package defined by the ACA, and use federal funding to subsidize enrollees in these plans.¹⁶⁵ This represents an alternative, but more controversial, pathway toward offering Affordable Choices plans.

2. *Employer-Based Insurance*

Plans that exclude certain interventions are already being offered as employer-based insurance. For example, Bind Benefits, an “on-demand health insurance” startup, offers plans with zero deductibles and low copayments for “primary care and specialist visits, maternity coverage, hospital care, [and] medications.”¹⁶⁶ Bind does not sell insur-

that the U.S. Department of Health and Human Services’ interpretation of essential health benefits “did not involve a nationally-defined set of EHBs . . . , but instead adopted a state-based approach”).

¹⁶² See Monahan, *supra* note 130, at 538–39, 542. Unlike Medicare Part D formularies, which must cover all pharmaceuticals in certain classes, individual marketplace plans are only required to cover the same number of drugs in each category and class that the state’s “benchmark plan” covers, so long as the plan covers at least one drug per class. Valerie A. Hutchins et al., *Analyzing the Affordable Care Act: Essential Health Benefits and Implications for Oncology*, 9 J. ONCOLOGY PRAC. 73, 76 (2013).

¹⁶³ See Katie Keith, *Unpacking the Final 2019 Payment Notice (Part 1)*, HEALTH AFF. (Apr. 10, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180410.631773/full/> [<https://perma.cc/XTB3-LFWB>].

¹⁶⁴ *Id.* (“[I]nsurers can substitute benefits (other than prescription drug benefits) within the same EHB category and between EHB categories so long as the substituted benefit is actuarially equivalent to the benefit being replaced.”).

¹⁶⁵ See Katie Keith, *Georgia Releases Broad 1332 Waiver Application*, HEALTH AFF. (Nov. 5, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20191105.878300/full/> [<https://perma.cc/RLS3-KKE9>].

¹⁶⁶ Bertha Coombs, *Insurance Start-Up Launches On-Demand Health Coverage*, CNBC (June 28, 2018, 7:15 AM), <https://www.cnbc.com/2018/06/27/insurance-start-up-launches-on-demand-health-coverage.html> [<https://perma.cc/9GTL-W5WC>].

ance itself, but instead works as a benefit administrator for self-insured employers.¹⁶⁷ Bind is able to offer low out-of-pocket costs by excluding specific procedures: to receive knee arthroscopy, for instance, a consumer would pay a fee that depends on the cost of the procedure, with fees as high as \$6,000 for more expensive providers.¹⁶⁸ As an example, one Bind plan requires separate payment for 31 procedures, mostly elective surgeries, if these procedures are not needed as part of an emergency.¹⁶⁹ These fees are categorized as “add-in premiums” to purchase coverage for the excluded procedures, rather than as standard copayments, in order to sidestep the ACA’s out-of-pocket caps.¹⁷⁰ Bind’s product has been selected by several firms, including Fortune 500 firms, and was named Minneapolis’ most promising startup in 2018.¹⁷¹

Although Bind’s success indicates the appeal of insurance design that reduces deductibles and copayments through content choice, Bind has been criticized for discriminating against older or sicker patients who are more likely to need costly, excluded procedures like hip replacements or arthroscopies.¹⁷² In fact, Bind pitches itself as appealing primarily on the basis of health status, rather than values. In contrast, Affordable Choices plans that systematically limit content, rather than focusing specifically on excluding a few treatments as Bind

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ See 2019 MEDTRONIC BIND ON-DEMAND HEALTH INSURANCE PLAN SUMMARY (2019) (on file with The George Washington Law Review). This Bind plan was offered to employees at Medtronic, a prominent medical device firm. See *id.*

¹⁷⁰ See Julie Appleby, *New Health Plans Expose the Insured to More Risk*, KAISER HEALTH NEWS (Mar. 13, 2019), <https://khn.org/news/new-health-plans-expose-the-insured-to-more-risk/> [<https://perma.cc/UF38-KHA7>].

¹⁷¹ Katharine Grayson, *Bind Benefits Wins Minnesota’s Most Promising Startup Poll*, MINNEAPOLIS/ST. PAUL BUS. J. (Dec. 18, 2018, 6:52 AM CDT), <https://www.bizjournals.com/twincities/news/2018/12/18/bind-benefits-wins-minnesotas-most-promising.html> [<https://perma.cc/W9QJ-83P5>]; Katharine Grayson, *Health Care Startup Bind Boosts Funding Haul to \$70M, Teams with UnitedHealthcare*, MINNEAPOLIS/ST. PAUL BUS. J. (June 28, 2018, 2:50 PM CDT), <https://www.bizjournals.com/twincities/news/2018/06/28/health-care-startup-bind-raises-10m-more-teams.html> [<https://perma.cc/XXW3-DDUT>].

¹⁷² Tom Murphy, *Startup’s On-Demand Health Insurance Draws Attention*, NBC CHICAGO (Dec. 17, 2018, 2:12 PM), <https://www.nbcchicago.com/news/health/Bind-Startup-On-Demand-Health-Insurance-502954911.html> [<https://perma.cc/QQ3Z-KA88>] (reporting statement by “Sabrina Corlette, a research professor at Georgetown’s Center on Health Insurance Reforms,” that Bind’s model “gets close to the line if not a little bit over the line of being discriminatory because it would only be people who have certain health conditions that would face higher premiums”).

does, might allow health insurance costs to track patients' values rather than their health status.¹⁷³

3. Medicare

Offering Affordable Choices plans through government-provided insurance programs like Medicare and Medicaid is also possible, but would require explicit statutory changes. The Medicare Advantage program, in which private firms contract with Medicare to provide coverage to eligible beneficiaries,¹⁷⁴ would be the most natural avenue for offering Affordable Choices plans. However, Medicare Advantage plans cannot exclude services that Medicare covers, and Medicare covers all reasonable and necessary services without regard to cost.¹⁷⁵

Although Medicare claims the authority to consider costs in determining reasonableness, it does not exercise this authority.¹⁷⁶ Additionally, its authority is at the program rather than the plan level—Medicare does not claim the authority to permit some plans to exclude a given treatment as unreasonable while allowing other plans to include it.¹⁷⁷ An Affordable Choices Medicare Advantage plan based on the United Kingdom's list of treatments, for instance, could only exclude injections for non-specific back pain if these injections were not reasonable and necessary—and if they were not reasonable and necessary, they would not be covered under any Medicare plan.

Nicholas Bagley has criticized Medicare's cost-indifference, arguing that it not only costs taxpayers money for no clear benefit, but also “encourages the development and adoption of expensive treatments that offer only trivial health benefits over cheaper alternatives.”¹⁷⁸ Rather than Medicare exercising its claimed authority to consider costs, Bagley advocates for relaxing “Medicare's statutory commitment to covering a median provider's reasonable costs” in favor of

¹⁷³ See *infra* Part III.

¹⁷⁴ *How Do Medicare Advantage Plans Work?*, MEDICARE.GOV, <https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans/how-do-medicare-advantage-plans-work> [<https://perma.cc/U5M7-DGWW>].

¹⁷⁵ Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L.J. 519, 554 (2013) (observing that Medicare “is unable to consider costs in deciding what to cover”).

¹⁷⁶ *Id.* at 551–52.

¹⁷⁷ See *id.* at 550–51 (explaining that though “the Medicare program issues thousands of coverage determinations . . . each year,” it has no way of enforcing compliance with its determinations).

¹⁷⁸ *Id.* at 553.

paying providers “the costs that low-cost benchmark organizations spend to cover the costs of medically necessary care.”¹⁷⁹

As an alternative to Bagley’s proposal, Congress could permit Medicare Advantage plans to cover packages of benefits that are actuarially equivalent to traditional Medicare and that meet the four regulatory principles discussed in Section II.A. This would allow Affordable Choices plans to provide a more restricted menu of treatments, such as the United Kingdom’s list, in exchange for lower premiums, additional insurance (such as dental or long-term care), or non-health benefits to recipients.

Providing non-health benefits could be a popular change. For example, when cancer patients and their caregivers were asked “which benefits Medicare should cover for people with cancer in the last 6 months of life,” half of respondents were prepared to accept less than the most expensive level of cancer treatments in exchange for receiving home-based long-term care coverage, more extensive palliative care than Medicare provides, or cash benefits.¹⁸⁰ And only a small minority of participants “chose the maximum level of cancer treatment . . . , even though this level of treatment is commonly provided by the current Medicare benefit package definition of reasonable and necessary—at great expense to Medicare and society.”¹⁸¹ This finding is particularly striking given that respondents were much more likely to benefit from costly cancer treatment than the general public would be. African-American caregivers and patients were particularly enthusiastic about receiving long-term care, palliative care, or cash benefits, and lower-income caregivers and patients were enthusiastic about cash benefits.¹⁸² Part IV returns to this finding and argues that a one-size-fits-all health insurance regime is likely to unfairly mandate that society as a whole select what the majority values. This research suggests that an Affordable Choices plan modeled on the United Kingdom’s or New Zealand’s plan, if it used the savings from providing less costly cancer treatment to provide monetary rebates or access to long-term care, would appeal to many cancer patients and caregivers, and might be even more appealing to the general public.

¹⁷⁹ *Id.* at 564.

¹⁸⁰ Donald H. Taylor Jr. et al., *There Is a Mismatch Between the Medicare Benefit Package and the Preferences of Patients with Cancer and Their Caregivers*, 32 J. CLINICAL ONCOLOGY 3163, 3164–66 (2014).

¹⁸¹ *Id.* at 3167.

¹⁸² *Id.* at 3166.

4. Medicaid

Like Medicare, Medicaid must cover certain services whenever medically necessary. These include inpatient and outpatient hospital services, physician services, laboratory services, and X-rays.¹⁸³ Many states also offer certain benefits, such as prescription drugs, physical therapy, and hospice, that are not federally required.¹⁸⁴ Some also allow Medicaid recipients to choose between several different Medicaid plans.¹⁸⁵

Whether a state could include an Affordable Choices plan as a Medicaid option depends on how much leeway states have in defining medical necessity. The reasonable disagreement principle could strengthen the case for claiming that excluded treatments are not genuinely medically necessary because they are not provided in other developed countries. But the fact that medical necessity is typically determined by looking to medical practice in the United States may present an obstacle. Colorado's definition of medical necessity, for instance, incorporates "generally accepted professional standards for health care in the United States."¹⁸⁶

Interestingly, Colorado recently revised its medical necessity standard to retain the United States standard of care, but changed the cost-effectiveness language to require that the good or service "[i]s not more costly than other equally effective treatment options" at issue.¹⁸⁷ This language might provide an entry point to offer Affordable Choices plans. But, like Bagley's advocacy for using cost-effectiveness in Medicare, the language would better support the exclusion of medications that are more costly and no more effective from *all* Medicaid plans, rather than from only Affordable Choices plans.

If Medicaid did include Affordable Choices plans—which would require language that permits, but does not require, states to consider costs when providing Medicaid—these plans could compensate for offering fewer interventions by lowering or eliminating already-low copayments. But a better alternative would be to offer health benefits

¹⁸³ *Mandatory & Optional Medicaid Benefits*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html> [https://perma.cc/W9RS-67CR].

¹⁸⁴ Robin Rudowitz et al., *10 Things to Know About Medicaid: Setting the Facts Straight*, KAISER FAM. FOUND. (Mar. 6, 2019), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/> [https://perma.cc/T5JN-FC9U].

¹⁸⁵ See *Tips for Choosing a Health Plan*, N.Y. MEDICAID CHOICE, <https://www.nymedicaid.com/choose/more-tips-choosing-health-plan> [https://perma.cc/MNE3-KQ9X].

¹⁸⁶ COLO. CODE REGS. § 2505-10 8.076.1(8) (2019).

¹⁸⁷ *Id.*

not currently covered, in-kind benefits other than health care, or cash benefits. One recent study of Medicaid participants found that although they placed the highest value on health coverage, they were also very interested in neighborhood improvements, job training and placement programs, education, and assistance with housing.¹⁸⁸ In another study, beneficiaries of California's Medicaid program preferred more extensive dental and vision coverage than the program offered, and were willing to reduce access to brand-name pharmaceuticals in order to obtain this coverage.¹⁸⁹

III. FAIRNESS TO THE SICK: ADDRESSING ADVERSE SELECTION

While Part II argued that content choice, as provided by Affordable Choices plans, can improve both the affordability of health insurance and the autonomy of buyers, the next few Parts examine whether content choice is fair by considering both normative arguments and consequent legal concerns. This Part discusses whether content choice is fair to the sick, focusing on strategies for forestalling adverse selection.

As Bagley, Chandra, and Frakt emphasize, insurance offerings that differ in content are vulnerable to adverse selection, where healthier people select narrower coverage packages, while sicker people select broader coverage packages that end up being very expensive because of high utilization by a sicker population.¹⁹⁰ One major purpose of health insurance is to enable people to obtain otherwise cost-prohibitive medical treatments by pooling their risk of incurring these costly health expenditures. If people who expect to develop a costly illness are able to selectively choose plans that offer generous coverage for that illness, the cost of those plans will rise due to high utilization, which in turn will drive away people who do not expect to

¹⁸⁸ See Marion Danis et al., *Priorities of Low-Income Urban Residents for Interventions to Address the Socio-Economic Determinants of Health*, 21 J. HEALTH CARE FOR POOR & UNDERSERVED 1318, 1328 (2010). This study did not give them the option to scale back health insurance in order to obtain more non-health benefits—insurance was an all-or-nothing decision. See *id.* at 1323.

¹⁸⁹ See Marion Danis et al., *The Coverage Priorities of Disabled Adult Medi-Cal Beneficiaries*, 17 J. HEALTH CARE FOR POOR & UNDERSERVED 592, 595–96 (2006). This suggests that poorer patients do not always “buy as much as they can get” by way of health care coverage. *Contra* Hoffman, *supra* note 12 (manuscript at 33).

¹⁹⁰ BAGLEY ET AL., *supra* note 10, at 8. The concept of adverse selection is often traced to George A. Akerlof, *The Market for “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970); see also Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. ECON. 629 (1976) (discussing a similar concept).

develop the illness in question and do not wish to pay for coverage they will not use.¹⁹¹ This, in turn, can produce a “death spiral” for patients with costly diseases, where plans that cover expensive treatments become wholly unaffordable.¹⁹²

At the outset, a traditional economic definition of adverse selection does not distinguish between purchasers who select higher- or lower-cost plans because of their values and purchasers who select such plans because of their predicted health needs. But values-based and status-based purchasers arguably have different normative entitlements to be protected against the effects of adverse selection.¹⁹³ Norman Daniels has argued that insurance design should prevent individuals from monetizing their health status.¹⁹⁴ For example, Daniels’s approach would classify individuals’ genetic predispositions to dementia as a factor that should not increase their health care costs. The simplest way of protecting this individual is to place them in a common risk pool with individuals without that predisposition, thus spreading the costs of the predisposition between the lucky and the unlucky. In contrast, Daniels’s approach would not require that individuals who value costly procedures be placed in a common risk pool with others. It could be fair for such individuals to bear the higher costs attributable to their values. As discussed in Part II, packages of benefits can and should be differentially attractive to enrollees whose *values* differ, both with respect to the relative importance of different

¹⁹¹ See Daniel J. Hemel, *Pooling and Unpooling in the Uber Economy*, 2017 U. CHI. LEGAL F. 265, 271 (noting that choice can produce an “adverse selection problem” because “employees who know they are sick opt into the more generous plans[, while] employees who know they are healthy opt into the less expensive, high deductible plans”).

¹⁹² See *Scottsdale Indem. Co. v. Vill. of Crestwood*, 673 F.3d 715, 718 (7th Cir. 2012).

¹⁹³ This is a point of agreement between friends and skeptics of content choice. Compare Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 399 n.10 (2001) (discussing the “adverse selection that can occur when a patient with a specific health need seeks the plan that provides the most generous coverage for that need” and arguing that “[r]ather than arming consumers with the ability to shop to meet a specific need, the goal should be to offer clear choices between more and less generous plans”), with Christine Cassel, *The Right to Health Care, the Social Contract, and Health Reform in the United States*, 39 ST. LOUIS U. L.J. 53, 59 (1994) (“We simply cannot have each individual buying insurance based only on his or her own health care risks. That is no longer an insurance mechanism—that person may as well pay out of pocket for health care and avoid the extra charges of the insurance company.”).

¹⁹⁴ See Norman Daniels, *Insurability and the HIV Epidemic: Ethical Issues in Underwriting*, 68 MILBANK Q. 497, 507 (1990) (“The design of health-care systems throughout most of the world rests on a rejection of the view that individuals should have the opportunity to gain economic advantage from differences in their health risks.”); see also JESSICA L. ROBERTS & ELIZABETH WEEKS, *HEALTHISM* (2018) (arguing that health differences should not translate into economic differences).

health outcomes and the relative importance of health versus other goods. But they should minimize their differential attractiveness to enrollees whose current or expected *health status* differs.

The simplest way of obviating adverse selection is to eliminate selection altogether, by offering only one insurance plan.¹⁹⁵ But offering only a single plan sacrifices the autonomy and affordability advantages choice seeks to achieve. Navigating the trade-off between preventing adverse selection and providing choice involves weighing different values against one another.¹⁹⁶ Both preventing adverse selection and providing choice can improve plan affordability. Preventing adverse selection also ensures that participants with costly illnesses are subsidized by others. Providing choice, meanwhile, enables participants to tailor their health spending to track what they value, improving participants' well-being while respecting their autonomy. Determining how much and what sort of choice to provide depends both on the empirical likelihood that choice will produce adverse selection, and the relative normative importance of these values.

Despite its desire to prevent adverse selection, the ACA permits substantial choice. Most notably, ACA plans vary in how they balance premiums against out-of-pocket costs, with "platinum" plans having the highest premiums but the lowest deductibles and copayments, "bronze" plans the reverse, and "silver" and "gold" plans in the middle.¹⁹⁷ ACA plans also vary in network breadth. These differences open room for cherry-picking (where plans try to attract healthy enrollees and avoid ill ones) and adverse selection (where ill enrollees gravitate toward specific plans).¹⁹⁸ Because the ACA already countenances some risk of adverse selection in exchange for greater choice, an Affordable Choices approach could improve on the ACA by re-

¹⁹⁵ See William M. Sage & Peter J. Hammer, *A Copernican View of Health Care Antitrust*, LAW & CONTEMP. PROBS., Autumn 2002, at 241, 274 ("[T]he tendency among private and public payers to offer enrollees a choice of health plans can subject more expensive, higher-quality options to adverse selection.").

¹⁹⁶ Cf. David M. Cutler & Richard J. Zeckhauser, *The Anatomy of Health Insurance* 57 (Nat'l Bureau of Econ. Research, Working Paper No. 7176, 1999), <https://www.nber.org/papers/w7176.pdf> [<https://perma.cc/BB4W-2XH7>] (discussing the trade-off between increased adverse selection due to competition between plans and improved affordability due to competition).

¹⁹⁷ Sallie Thieme Sanford, *Mind the Gap: Basic Health Along the ACA's Coverage Continuum*, 17 J. HEALTH CARE L. & POL'Y 101, 108 (2014) ("Plans will be offered at four 'metal levels'—bronze, silver, gold and platinum—with progressively higher actuarial values such that bronze plans would have the lowest premiums but correspondingly higher expected out-of-pocket costs . . .").

¹⁹⁸ See Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1610–11 (2011) (discussing "risk classification by design," where ill and healthy patients are attracted to different plan designs).

placing some choices the ACA offers—such as those relating to deductibles and copayments—with choices that are more valuable for autonomy and affordability, but that are not substantially more likely to permit adverse selection. Put another way, the Affordable Choices framework would not merely add to the choices available under the ACA, but would hold the amount of choice constant while making the available choices more valuable to choosers.

As discussed in Section I.D, prior analyses of content choice have either downplayed the problem of adverse selection,¹⁹⁹ or tried to address it via risk adjustment or preexisting condition exclusions.²⁰⁰ In contrast, the Affordable Choices approach limits adverse selection by regulating the content of and access to Affordable Choices plans.²⁰¹ These regulations include limits on *which treatments* can be excluded, limits on *when* people can choose plans that exclude certain interventions, and limits on *who* can choose these plans.

A. *Limits on Excluded Benefits*

Affordable Choices plans limit adverse selection by requiring that plans be designed to appeal to purchasers on the basis of values, rather than on the basis of prior or expected health status.²⁰² As discussed in Part II, one category of Affordable Choices plans is international reference coverage plans, which offer a package of interventions based on a different country's health care system.²⁰³ Such plans would not achieve all of the cost savings of the national plans on which they are based, mostly because other systems not only offer fewer interventions but typically pay lower prices for the inter-

¹⁹⁹ See Pauly, *supra* note 84, at 1529–30; see also Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1225 (2004) (“[W]hile adverse selection in insurance markets is clearly a possibility, it is often not the serious problem that it is taken to be.”).

²⁰⁰ See Elhauge, *supra* note 104, at 1534; Korobkin, *supra* note 75, at 424; Rai, *supra* note 95, at 1038; see also Havighurst, *supra* note 193, at 399 n.10 (“The adverse selection problem can be ameliorated by, among other things, allowing plans to limit their coverage of ‘pre-existing conditions’ . . .”).

²⁰¹ The types of risk adjustment defended by Rai and Emanuel are compatible with an Affordable Choices framework, though they are not necessary to such a framework.

²⁰² Selecting an appropriate list of benefits is a recognized strategy for limiting adverse selection. See Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1803 n.118 (1992) (arguing that “careful cuts made all along the margin of health care rather than gross categorical exclusions” can reduce the risk that offering choices will generate adverse selection, and that “creativity in designing options” might be superior to a standardized package of benefits in achieving affordability, while avoiding excessive adverse selection).

²⁰³ See *supra* note 140 and accompanying text.

ventions that they do offer.²⁰⁴ But an international reference coverage plan could still offer substantial savings, particularly because its ability to say no would strengthen its negotiating position.²⁰⁵ Because these plans serve entire national populations in democratic regimes, they are not likely to be a pretext for cherry-picking healthy patients or driving away ill ones, and they are designed by looking to what the citizens of those nations value.

Cost-effectiveness plans, meanwhile, are less resistant to adverse selection than reference coverage plans, but are still less likely to appeal to buyers on the basis of health status, because they exclude a basket of treatments rather than excluding one specific treatment.²⁰⁶ The Affordable Choices plans most vulnerable to adverse selection are those that allow purchasers to opt out of specific expensive treatments. Consider, for example, prominent legal academic Ronald Dworkin's suggestion that patients whose dementia has become sufficiently advanced should not receive costly life-prolonging treatments, but only comfort care.²⁰⁷ While Dworkin envisioned implementing this as national policy,²⁰⁸ it could also be offered as an Affordable Choices option that excluded life-prolonging treatments for patients with dementia, or charged higher co-insurance or copayments for such treatments. The availability of such plans could enable people who would not value life-extending treatment after the onset of advanced dementia to better shape their lives according to their values.²⁰⁹ But the availability of these plans would raise costs for people who assign higher value to costly, life-prolonging treatments after the onset of dementia, because others who either do not value these treatments or do not think they will need them could now opt out of joining the same risk pool.

²⁰⁴ See John B. Kirkwood, *Buyer Power and Healthcare Prices*, 91 WASH. L. REV. 253, 254 (2016).

²⁰⁵ See Leah Rand & Govind Persad, *Are Medicaid Closed Formularies Unethical?*, 21 AM. MED. ASS'N J. ETHICS 654, 655 (2019) (noting that the ability to say no to certain treatments "can enable payers to negotiate more effectively with pharmaceutical firms by allowing payers to credibly threaten to refuse to pay high prices"); Benjamin Sommers & Aaron S. Kesselheim, *Massachusetts' Proposed Medicaid Reforms—Cheaper Drugs and Better Coverage?*, 378 NEW ENG. J. MED. 109, 110 (2018).

²⁰⁶ See generally Rai, *supra* note 95, at 1043 (discussing adverse selection in the context of cost-effectiveness plans).

²⁰⁷ See Dworkin, *Justice in the Distribution of Health Care*, *supra* note 146, at 891.

²⁰⁸ See *id.* at 888 (noting that society "should aim to make collective, social decisions about the quantity and distribution of health care").

²⁰⁹ Cf. *id.* at 891 (arguing that "the money spent on premiums" for insurance providing expensive interventions after the onset of dementia "would have been better spent, no matter what happens, making life before dementia . . . more worth while").

Offering a plan based on Dworkin's approach as an Affordable Choices option would defuse the concern that public opinion about whether to provide life-prolonging treatment after the onset of dementia is sufficiently fractured that reaching societal agreement on a national list of interventions will be difficult.²¹⁰ The challenge for offering such a plan is distinguishing between the person who is making a values-based choice—who is committed to forgoing post-dementia interventions, regardless of whether she will develop dementia—and the person who opportunistically selects a plan that will exclude costly interventions if she develops dementia only because she believes she will never develop dementia in the first place. Whether a Dworkin-inspired plan should be offered depends both on the prospects for differentiating these two bases for choice and on the relative importance assigned to autonomy versus the mitigation of bad luck. That is, given the difficulty of differentiating between value-based and status-based choices, should we prioritize allowing people to select the plans they value (at the risk of permitting some status-based choice), or ensuring that people will be fully compensated for their disadvantageous health status (at the risk of proscribing some values-based choice)?²¹¹

B. *Limits on Movement Between Plans*

As well as limiting the types of plans offered, an Affordable Choices framework would also limit when participants can enter and leave plans. Limiting movement aims to prevent what Emanuel calls a medical "conversion": for instance, when a longtime participant in a plan that excludes life-extending care after the onset of dementia switches to a plan that includes life-extending care after she learns that she is highly likely to develop dementia.²¹²

The simplest way of limiting movement is to require individuals who purchase Affordable Choices plans that exclude certain treatments to precommit to these plans: while they may move between insurers who offer the same plan, they may not move into a plan that offers more treatments.²¹³ This precommitment approach not only helps avoid adverse selection, but also can be an important way of

²¹⁰ See Rai, *supra* note 95, at 1025 (arguing that individuals' diverse values generate "a plethora of substantive allocation standards").

²¹¹ Cf. Leslie Pickering Francis, *Moral Principles and Legal Practice*, 35 IND. L. REV. 989, 992 (2002) (reviewing DAVID ORENTLICHER, *MATTERS OF LIFE AND DEATH* (2001)) (discussing the question of whether to prioritize the avoidance of "false positives" or that of "false negatives" when determining how much deference to give to patients' choices).

²¹² See EMANUEL, *supra* note 112, at 191.

²¹³ See *id.*

realizing the financial benefit of some Affordable Choices plans. The savings from not covering expensive post-dementia treatments for a 25-year-old over the next year will be negligible, just as a one-year mortgage is of limited utility; the real value to the purchaser, for both mortgage and insurance precommitment, comes from the ability to bind oneself in the much further future. This means that Affordable Choices plans might be offered as part of longer-term insurance contracts in order to obtain greater premium savings.²¹⁴

An alternative way of limiting exit from less comprehensive plans is an “escrow” model that borrows features from individual retirement accounts. Participants in Affordable Choices plans would pay the same premiums as participants in plans that do not limit benefits, but the difference between that premium and the “true” lower premium of the Affordable Choices plan would be held in reserve in an interest-bearing account, accessible at retirement or some date to be determined. Participants who want to exit the Affordable Choices plan and return to a plan without defined limits would forfeit the reserved premiums and accumulated interest.

To minimize adverse selection, choices about entering and leaving plans should be made at a time when people have little information about their expected medical needs. Requiring people to make choices long before they can reliably predict their odds of developing certain diseases leads to choices that are more likely to reflect value judgments about what sort of life they want to lead, rather than predictions of their future health. For instance, requiring people to make decisions about their Alzheimer’s disease treatment preferences before old age will decrease the relevance of health status to those decisions. This presents a trade-off between minimizing adverse selection and reducing misprediction, a value discussed in Part IV.

Christopher Robertson’s proposal allows insured patients to opt out of treatments for which they are eligible in return for cash payments.²¹⁵ Allowing insured patients to opt out of treatments *after* they know they are eligible to receive them has some advantages over this Article’s strategy of having insured patients opt out *prior* to knowing their eligibility: for instance, it could avoid some of the concerns about

²¹⁴ See Wendy Netter Epstein, *Private Law Alternatives to the Individual Mandate*, 104 MINN. L. REV. 1429, 1476–83 (2020) (discussing “low introductory rates, long-term contracts, and limited exit rights”). Longer-term plans also have downsides, such as limits on competition and challenges in establishing proper prices. See EMANUEL, *supra* note 112, at 185.

²¹⁵ See Christopher Robertson, *The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game*, 98 CORNELL L. REV. 921, 945 (2013).

misprediction that Part IV will discuss. But opting out before eligibility is known allows insurance purchasers to benefit upfront from lower premiums. It also aligns with other practices, like mortgages, that allow purchasers to commit in advance to limit their options. And opting out before eligibility is known is likely to be more effective at sending a market signal of demand for cheaper interventions.

One objection to combating adverse selection via precommitment is that improved diagnostic technologies will enable early prediction of future health status, making it difficult to differentiate between values-based choices and choices based on health status predictions.²¹⁶ This concern, while real, does not abrogate the potential for timing-based restrictions to help mitigate adverse selection because many health problems are difficult for even the best technology to predict in advance.²¹⁷ Even if diagnostics could predict one's risk of heart disease or stroke, it would be difficult to predict eligibility for artificial nutrition and hydration or long-term ventilation because these interventions can respond to many different conditions.²¹⁸ For example, diagnostics will have a more difficult time predicting the risk of a gunshot wound or an antibiotic-resistant infection than predicting the risk of a disease with a major genetic component.²¹⁹ So long as health status predictions remain imprecise, they will likely not motivate insurance decisions on their own. An individual purchaser who values expensive, life-sustaining treatment after the onset of dementia but learns that she lacks genetic risk factors for Alzheimer's disease may still prefer policies that include life-sustaining treatment after the onset of dementia, given the stakes of the outcome and the degree of uncertainty that remains.

C. *Limits on Who Is Eligible*

Affordable Choices plans that exclude specific, predictable conditions (such as advance directive plans) might still be tenably offered to certain subsections of the population. For instance, even if

²¹⁶ Cf. Roberta M. Berry, *The Human Genome Project and the End of Insurance*, 7 U. FLA. J.L. & PUB. POL'Y 205, 231 (1996) (“[T]he increased knowledge obtained through genetic testing will pose a threat to the functioning of the insurance mechanism.”).

²¹⁷ See Cassel, *supra* note 193, at 59 (“None of us can predict our health care needs. Even if we fully mapped the genetic structure of everyone in the United States, we will still be unable to fully predict health care risks. Who could have predicted the Hanta virus? Who could have predicted AIDS?”).

²¹⁸ See Douglas R. Gracey, *Options for Long-Term Ventilatory Support*, 18 CLINICS CHEST MED. 563, 563 (1997) (discussing the “number of acute and chronic conditions” that can produce a need for mechanical ventilation).

²¹⁹ See *supra* note 217 and accompanying text.

Alzheimer's disease risk prediction becomes extremely accurate, people who test *positive* for Alzheimer's disease risk factors could still be offered the option of choosing Affordable Choices plans that exclude life-extending treatment after the onset of dementia. If Dworkin and others are right, many people who expect to develop dementia would still select such plans because they see no value in further extending their life after the onset of dementia. Limits on eligibility could also be used for conditions that track identity categories: for instance, plans that exclude expensive chemotherapies for breast and ovarian cancer could be made available only to women (in order to prevent the problem of men selecting these plans on the basis of health status), and the reverse for prostate cancer treatment.²²⁰

In addition to *ex ante* limits on eligibility, *ex post* assessment of plan entry and exit could help determine whether a plan is appealing to participants based on health status or based on values. For example, a specific plan with many individual subscribers who do not have a common but costly condition provides some evidence that the plan's appeal is based on expected health status rather than values.²²¹ This and the other strategies examined in this Part are unlikely to completely counter insurers' myriad strategies for avoiding purchasers with costly conditions,²²² but taken together they could reduce risk-related cost differentials substantially, providing roughly, if not exactly, equitable access.

IV. FAIRNESS TO PURCHASERS: AUTONOMY AND CHOICE

The previous Part addressed the concern that Affordable Choices plans would permit adverse selection that undermines access to health insurance for ill people and discussed strategies for reducing adverse

²²⁰ This use of sex or race is likely constitutional when genuinely predictive of certain medical needs. See *Mitchell v. Washington*, 818 F.3d 436, 446 (9th Cir. 2016) ("It is not difficult to imagine the existence of a compelling justification [for considering race] in the context of medical treatment."). Recognizing that breast and ovarian cancer are vastly more common among women, and prostate cancer vastly less so, is compatible with recognizing that breasts, ovaries, and prostates are not unique to one gender identity. Cf. Elizabeth Villarreal, *Pregnancy and Living Wills: A Behavioral Economic Analysis*, 128 *YALE L.J.F.* 1052, 1053 n.6 (2019) (noting that "people of various gender identities can become pregnant").

²²¹ Cf. Enthoven, *supra* note 53, at 43 (suggesting the use of exit questionnaires to identify selection on the basis of health status by insurers). This strategy is complicated by correlations between values and health status expectations (for example, people who value cost-effectiveness may tend to be better off economically or engage in healthier behaviors).

²²² See, e.g., Randall R. Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 *VAND. L. REV.* 965, 986 (1981) (discussing risk sorting); Jost, *supra* note 36, at 480 (reviewing insurers' strategies for risk sorting).

selection. This Part considers the fear that Affordable Choices plans will produce bad outcomes for plan purchasers. Section IV.A provides an overview of the availability and value of choice in the context of other essential goods. Section IV.B discusses the concern that choosers will inaccurately predict their future preferences regarding health care access. Section IV.C considers the risk of “decision fatigue” that choices about health care present. Lastly, Section IV.D discusses whether choosers will suffer harm from being held responsible for the health or economic outcomes that flow from their choices.

A. *Choice for Essential Non-Health Goods*

American society typically gives households substantial control over purchasing decisions, not only for discretionary purchases, but also for essential non-health goods like housing, food, clothing, transportation, and education. The standard regulatory arrangement for these purchases involves (1) quality and safety standards and (2) subsidized provision to households who lack sufficient buying power. Beyond these two types of regulation, households are free to spend more or less in exchange for more or less generous packages of goods.²²³

1. *Food*

Federal and state governments set basic standards of food safety and quality, and prohibit the sale of foods that are tainted or hazardous, even if some consumers would prefer to save money by purchasing these foods.²²⁴ Beyond these limits, purchasers have broad power to choose, even though some choices are not just prettier or tastier, but also more healthful or nutritious. For instance, some experts recommend buying organic produce grown without pesticides or herbicides,²²⁵ but price-sensitive consumers are still permitted to choose conventionally grown produce.

²²³ This policy choice may reflect the insight that enabling individuals to purchase what they value can be more cost-effective than providing everyone the same good. See Melissa Hidrobo et al., *Cash, Food, or Vouchers? Evidence from a Randomized Experiment in Northern Ecuador*, 107 J. DEV. ECON. 144, 154 (2014) (observing that “vouchers” that can be used to purchase different foods “lead to significantly larger improvements in dietary diversity” and that direct food provision “is the least cost-effective means of improving food consumption and dietary diversity outcomes”).

²²⁴ See J.D. Trout, *A Restriction Maybe, but Is It Paternalism? Cognitive Bias and Choosing Governmental Decision Aids*, 2 N.Y.U. J.L. & LIBERTY 455, 461 (2007).

²²⁵ Margot J. Pollans, *Bundling Public and Private Goods: The Market for Sustainable Organics*, 85 N.Y.U. L. REV. 621, 650–51 (2010) (discussing “evidence that organic foods have health benefits”).

The government also subsidizes access to a basic level of food for households in need. Programs like the Supplemental Nutrition Assistance Program (“SNAP”) and the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (“WIC”) provide households with, in effect, a voucher to buy food.²²⁶ These programs do not require that participants buy the same quality or quantity of food that wealthier households do. Instead, SNAP permits participating households broad choice about what they buy,²²⁷ and has been praised for providing this choice²²⁸ and for integrating SNAP recipients into the same food marketplace as non-SNAP recipients.²²⁹ WIC offers less choice than SNAP and excludes certain more costly products—such as organic foods—thereby enforcing, rather than permitting, different standards of quality.²³⁰

2. *Housing*

Housing regulations, like food regulations, include both subsidies for access and minimum quality standards. States and localities typically require that housing not be infested by vermin, be adequately heated, and meet certain minimum size and amenity requirements.²³¹ Beyond these basic requirements, however, households have substantial choice. They may choose homes that are old or new, attached or detached, small or large, or near or far from work. And choice is per-

²²⁶ Mary E. Kennelly et al., *Strengthening Vendor Standards in the Supplemental Nutrition Assistance Program: Are Healthier Foods Within Reach?*, 16 J. HEALTH CARE L. & POL’Y 141, 153 (2013).

²²⁷ See VICTOR OLIVEIRA ET AL., U.S. DEP’T OF AGRIC., DESIGN ISSUES IN USDA’S SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM 41 (2018), <https://www.ers.usda.gov/webdocs/publications/86924/err-243.pdf?v=0> [<https://perma.cc/UQV6-CKRB>] (“SNAP allows participants to make their own food choices based on their own diverse tastes, circumstances, information, and spending habits.”).

²²⁸ See Aaron Saiger, *What We Disagree About When We Disagree About School Choice*, 99 IOWA L. REV. BULL. 49, 56–57 (2014) (“[E]veryone can see why it is better to let SNAP recipients exercise personal choices among groceries on store shelves than to issue each of them an identical food basket.”); Donna Yellen et al., *Hunger in Maine*, ME. POL’Y REV., Winter/Spring 2011, at 140, 141 (describing SNAP as “offering independence, food choice, and flexibility”).

²²⁹ See Samuel Estreicher & Clinton G. Wallace, *Equitable Health Savings Accounts: Bridging the Left-Right Divide*, 56 HARV. J. ON LEGIS. 395, 415–16 (2019).

²³⁰ See Miranda Perry Fleischer & Daniel Hemel, *Atlas Nods: The Libertarian Case for a Basic Income*, 2017 WIS. L. REV. 1189, 1244 n.188 (2017) (explaining the numerous rules applied to WIC benefits).

²³¹ Donald E. Campbell, *Forty (Plus) Years After the Revolution: Observations on the Implied Warranty of Habitability*, 35 U. ARK. LITTLE ROCK L. REV. 793, 814–16 (2013); John Infranca, *Housing Changing Households: Regulatory Challenges for Micro-Units and Accessory Dwelling Units*, 25 STAN. L. & POL’Y REV. 53, 71 (2014).

mitted even when it involves tradeoffs with health or other values, as when a family chooses a higher-crime, more polluted, or less walkable neighborhood in order to save money or obtain other desired amenities like a larger home or a shorter commute.

In fact, paralleling the concern discussed in Section II.D that requiring all households to purchase the same full-service insurance package enshrines majority preference as law, mandated minimum housing sizes have been criticized for imposing arbitrary cultural values on homeowners and renters who would reasonably prefer smaller dwellings. Frank Alexander points out that minimum size requirements lack a rigorous empirical basis and may reflect the “social preferences of politically influential groups,” and that requiring “one person per room, or even two persons per room, represent[s] a conscious choice to allocate personal spending on something other than housing.”²³²

Housing access is subsidized federally via the Section 8 housing voucher program, and also at the state and local levels.²³³ Just as SNAP benefits can be used to purchase a wide variety of foods, Section 8 vouchers can be used to rent a wide range of housing types and locations.²³⁴ Although the program is underfunded with a long waiting list and landlords are free to refuse Section 8 tenants, the Section 8 program has nonetheless been praised for giving lower-income Americans a broader range of housing options,²³⁵ particularly in comparison to the one-size-fits-all public housing that Section 8 was designed to replace. Section 8 vouchers need not be used to rent the same quality or type of housing typically purchased or rented by better-off consum-

²³² Frank S. Alexander, *The Housing of America's Families: Control, Exclusion, and Privilege*, 54 EMORY L.J. 1231, 1255–56 (2005) (arguing that housing “standards may well reflect the values, customs, or prejudices of a dominant subclass of American culture,” and observing that the “criterion of minimum square footage was derived in part from upper class usage”).

²³³ See *Housing Choice Vouchers Fact Sheet*, U.S. DEP'T HOUSING & URB. DEV., https://www.hud.gov/topics/housing_choice_voucher_program_section_8 [https://perma.cc/W98H-S5VM].

²³⁴ See *id.*

²³⁵ See Jaime Alison Lee, *Poverty, Dignity, and Public Housing*, COLUM. HUM. RTS. L. REV., Winter 2015, at 97, 143 (“Mobility programs[, such as Section 8,] support the dignity and autonomy of residents in the sense that [t]he ability to choose where to live and with whom to associate is linked to the idea of freedom in the American popular imagination.” (quoting Michelle Adams, *Separate and [Un]equal: Housing Choice, Mobility, and Equalization in the Federally Subsidized Housing Program*, 71 TUL. L. REV. 413, 424 (1996))); Rigel C. Oliveri, *Vouchers and Affordable Housing: The Limits of Choice in the Political Economy of Place*, 54 HARV. C.R.-C.L. L. REV. 795, 797 (2019) (“[B]ecause each voucher is used by an individual in the private housing market, the program has the ability to . . . provide a maximum amount of choice for home-seekers.”).

ers. Some state and local housing programs, meanwhile, are more similar to WIC in that they are more directive about what types of housing they provide, and potentially include less luxurious options such as micro-housing.²³⁶

3. *Education*

State and federal law requires that education meet a basic level of quality.²³⁷ But beyond these requirements, families and learners are free to choose cheaper or costlier educational facilities, as well as schools, colleges, and universities with different academic foci and strengths. Education is available free of charge for children at the primary and secondary levels, and is subsidized for learners at the tertiary level via scholarships, grants, and public funding. Importantly, this funding can be used to purchase tertiary education that is cheaper than might be the norm for middle-class or wealthy learners: students can use Pell Grants, for instance, for tuition at community colleges as well as at four-year universities.²³⁸

4. *Insurance*

The goods discussed above differ from health care in that they are not provided using an insurance mechanism which has the potential to suffer from adverse selection. But home ownership requires the purchase of insurance, and homeowners are offered a wide range of choices about insurance—choices not only about premiums and deductibles, but also about whether or not to purchase coverage for certain specific types of loss.²³⁹ The same is true for optional renters insurance.²⁴⁰ Similarly, while assessing health care quality requires expertise, the same is true for mortgage terms or higher education quality.

²³⁶ See Lisa T. Alexander, *Evicted: The Socio-Legal Case for the Right to Housing*, 126 *YALE L.J.F.* 431, 443 (2017).

²³⁷ See Every Student Succeeds Act, Pub. L. No. 114-95, § 1001, 129 Stat. 1802, 1814 (2015) (codified at 20 U.S.C. § 6301 (2018)); *College Accreditation in the United States*, U.S. DEP'T EDUC., <https://www2.ed.gov/admins/finaid/accred/accreditation.html#Overview> [<https://perma.cc/X9ZL-KNP2>].

²³⁸ Emma Kerr, *Everything You Need to Know About the Pell Grant*, U.S. NEWS & WORLD REP. (Mar. 28, 2019), <https://www.usnews.com/education/best-colleges/paying-for-college/articles/everything-you-need-to-know-about-the-pell-grant> [<https://perma.cc/PM56-4L8Z>].

²³⁹ See *Property Insurance*, USA.GOV, <https://www.usa.gov/property-insurance#item-36587> [<https://perma.cc/FP3S-3A7F>].

²⁴⁰ See *id.*

B. Misprediction

The preceding examples support allowing choice in purchasing essential goods. This Section responds to the objection that allowing choice regarding health insurance, particularly in combination with the long-term contracts discussed in Part III,²⁴¹ exposes people to the risk of mispredicting their future needs and values.

Some critics cite concerns about misprediction to justify limiting patients' choices. Criticisms of "consumer-directed health care" stress that health care needs are difficult to predict,²⁴² and that consumers will make poor choices when given the opportunity to choose.²⁴³ Concerns about misprediction have also been used to support objections to advance medical directives,²⁴⁴ and to patients' ability to consent to medical procedures that are irreversible or burdensome to reverse, such as organ donation,²⁴⁵ physician-assisted dying,²⁴⁶ sterilization,²⁴⁷ and surgery to affirm gender or address gender dysphoria.²⁴⁸

²⁴¹ See Cassel, *supra* note 193, at 59 (arguing that health care needs cannot be predicted).

²⁴² See *supra* note 217 and accompanying text.

²⁴³ See Hoffman, *supra* note 12 (manuscript at 74–76); Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 518 (2004) ("What a consumer wants, or can currently afford, may not suffice when that consumer becomes a patient.").

²⁴⁴ E.g., Justine A. Dunlap, *Mental Health Advance Directives: Having One's Say?*, 89 KY. L.J. 327, 347 (2001) ("[P]eople cannot accurately predict advances in health care or what course they will actually want followed in certain circumstances. When the time comes to act . . . circumstances and consequences may be wildly divergent from those existing or imagined at the time of the creation of the directive."); Holly Fernandez Lynch et al., *Compliance with Advance Directives: Wrongful Living and Tort Law Incentives*, 29 J. LEGAL MED. 133, 164 n.137 (2008) (discussing, but rejecting, the view that "we ought to abolish advance directives written by the healthy, accepting only those written once a patient is ill and able to properly assess his or her treatment preferences").

²⁴⁵ E.g., Barbara L. Atwell, *The Modern Age of Informed Consent*, 40 U. RICH. L. REV. 591, 608–10 (2006) (arguing that "emerging adults" should have to meet a higher "deliberative consent" standard in order to receive various non-emergent interventions such as "sperm donation, surrogacy, breast implants, genetic tests, sterilization, many forms of cosmetic surgery, and perhaps even tattoos," as well as "live kidney and liver donations" and "bone marrow donations").

²⁴⁶ E.g., Kathleen McGowan, *Physician Assisted Suicide a Constitutional Right?*, 37 CATH. LAW. 225, 253 (1997) ("[D]eath by assisted suicide is final and does not allow a change of heart. As such, it creates a definite risk of 'irreversible error.'").

²⁴⁷ E.g., Atwell, *supra* note 245, at 610; Piers Benn & Martin Lupton, *Sterilisation of Young, Competent, and Childless Adults*, 330 BRIT. MED. J. 1323, 1324 (2005) (discussing "whether the possibility that the patient will later regret the decision to be sterilised should be taken into account when deciding whether to offer the procedure").

²⁴⁸ E.g., *Adams ex rel. Kasper v. Sch. Bd. of St. Johns Cty.*, 318 F. Supp. 3d 1293, 1300 (M.D. Fla. 2018) (explaining that surgical interventions for patients "with gender dysphoria or who seek gender affirmance . . . may be delayed until the age of legal majority because, unlike the other treatments, they are largely irreversible"); see also Lindsee A. Acton, *Overturing In*

These concerns about misprediction and regret, however, have not precluded the availability of consumer-directed health plans or irreversible procedures. This willingness to permit self-binding medical decisions is consistent with our attitude toward other major commitments, such as marriage, parenthood, career preparation, and the assumption of mortgage or educational debt. In none of these cases do we regard misprediction or regret—despite its frequency—as sufficient to prevent competent adults from limiting and shaping their future options.²⁴⁹

The movement away from medical paternalism and toward patient autonomy and informed consent was predicated on the importance of allowing patients to select the treatments they value. Marshall Kapp identifies the connection between choice and autonomy in a defense of consumer-directed health care, stating,

[T]he 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). 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.²⁵⁰

From Kapp's perspective, opponents of consumer-directed health care "seek to infantilize" individual health care purchasers "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 [purchasing] decisions . . . are too inscrutable and emotionally charged for mere consumers themselves to possibly figure out."²⁵¹ Kapp concludes: "In reality, though, it is highly debatable whether health care purchases are that much more

re Gardiner: *Ending Transgender Discrimination in Kansas*, 48 FAM. L.Q. 563, 569 (2014) (explaining that guidelines for access to surgical treatment for gender dysphoria require patients to "undergo typically twelve months of hormone therapy" and to "live successfully for twelve months in a full-time real-life experience as the desired sex/gender").

²⁴⁹ See, e.g., *Pifer v. Pifer*, 12 Va. Cir. 448, 452 (Va. Cir. Ct. 1975) (refusing to grant an annulment based on a mistake of fact on the basis that "no contract involving the risk of facts and events not foreseen—which is particularly inherent in the marital state—would be safe from attack or being set at naught").

²⁵⁰ Marshall B. Kapp, *The Ethical Foundations of Consumer-Driven Health Care*, 12 J. HEALTH CARE L. & POL'Y 1, 6 (2009) (footnote omitted).

²⁵¹ *Id.*

fundamentally incomprehensible than other important decisions that consumers make every day about buying, for example, real property, life and casualty insurance, financial investments, or automobiles.”²⁵² The Affordable Choices approach agrees with Kapp’s recognition of the link between autonomy and patient choice, but improves on the model of consumer-directed health care that Kapp advocates in two ways. First, it provides a basis for regulating the menu of health insurance options to protect purchasers, third parties, and society—just as purchasers are protected from dangerous financial investments.²⁵³ Second, moving spending decisions earlier, to the point when insurance is *purchased* as opposed to the later point when care is actually *received*, avoids exposing patients to the unpredictable risk of out-of-pocket spending.

Turning briefly from ethics to doctrine, purchasers who have mispredicted their insurance needs could conceivably attempt to rescind their insurance contracts on mistake-of-fact grounds. But this is implausible for two reasons. First, buyers’ lack of knowledge of their own health needs is what makes insurance rational to buy and sell.²⁵⁴ Second, purchasers would gain little from successfully rescinding the contract.²⁵⁵

Even though misprediction is unlikely to lead to the legal invalidation of insurance contracts, it is still normatively worth combating. Providing a framework for evaluating options could help combat misprediction. Decision aids and counseling processes have been developed to help people choose medical tests and procedures,²⁵⁶

²⁵² *Id.* (footnote omitted).

²⁵³ See Wallis K. Finger, Note, *Unsophisticated Wealth: Reconsidering the SEC’s “Accredited Investor” Definition Under the 1933 Act*, 86 WASH. U. L. REV. 733, 754 (2009).

²⁵⁴ *Cf.* Grenall v. United of Omaha Life Ins. Co., 165 Cal. App. 4th 188, 194 (Cal. Ct. App. 2008) (rejecting argument that an annuity contract entered into by a purchaser with an undiagnosed terminal illness was void for mistake of fact, because “such risks are an inherent part of life annuity contracts, which reflect, at their essence, a longevity wager measured by average life expectancy”).

²⁵⁵ *Cf.* Mariner, *supra* note 243, at 538 (noting that a successful rescission “would only excuse the patient’s performance, which consists of paying insurance premiums and copayments; it would not require performance of a different sort from the insurer”).

²⁵⁶ Carl H. Coleman, *Regulating Physician Speech*, 97 N.C. L. REV. 843, 895 (2019) (discussing “interactive ‘patient decision aids,’ which are tools designed not only to provide information but to help patients sort through the available options in light of their personal values and goals”); Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 464 (2006) (discussing “decision aids” that “collect and analyze the latest clinical evidence regarding the risks and benefits of different treatment options and then present the information in a manner patients can understand”).

mortgages,²⁵⁷ colleges,²⁵⁸ and even whether and whom to marry.²⁵⁹ Federal funding has even been appropriated for the development of medical decision aids.²⁶⁰ Just as decision aids help patients choose among specific medical treatments, they could likewise assist purchasers in selecting health insurance packages that match their values.²⁶¹ Default rules and other types of choice architecture that present purchasers with choices that are likely to align with their values could also help combat misprediction, especially when tailored to specific groups or demographics.²⁶² Choice architecture could also be designed to specifically identify and promote plans that prior purchasers least regret buying.²⁶³ The Affordable Choices framework does this by offering a regulated set of options that have been embraced in similar places. Unlike pre-ACA “junk” or “mini-med” plans that were advertised as insurance, but which covered almost none of the cost of major medical procedures,²⁶⁴ international reference coverage plans, for example, would cover a set of treatments that have been judged acceptable in major developed countries like Canada or the United Kingdom.

Allison Hoffman has recently questioned the potential of choice architecture to reduce misprediction in health insurance.²⁶⁵ The litera-

²⁵⁷ Debra Pogrud Stark & Jessica M. Choplin, *A Cognitive and Social Psychological Analysis of Disclosure Laws and Call for Mortgage Counseling to Prevent Predatory Lending*, 16 PSYCHOL. PUB. POL'Y & L. 85, 113 (2010).

²⁵⁸ Maurice R. Dyson, *Are We Really Racing to the Top or Leaving Behind the Bottom? Challenging Conventional Wisdom and Dismantling Institutional Repression*, 40 WASH. U. J.L. & POL'Y 181, 198 (2012).

²⁵⁹ Nicole Licata, Note, *Should Premarital Counseling Be Mandatory as a Requisite to Obtaining a Marriage License?*, 40 FAM. CT. REV. 518, 518 (2002).

²⁶⁰ See 42 U.S.C. § 299b-36(d) (2018) (discussing a “[p]rogram to develop, update and produce patient decision aids to assist health care providers and patients”).

²⁶¹ See Lauren E. Willis, *Performance-Based Consumer Law*, 82 U. CHI. L. REV. 1309, 1358 (2015) (discussing “choice engines used to help consumers make complex decisions (like choosing an optimal health insurance plan)” (footnote omitted)).

²⁶² See Ariel Porat & Lior Jacob Strahilevitz, *Personalizing Default Rules and Disclosure with Big Data*, 112 MICH. L. REV. 1417, 1444 (2014) (discussing the personalization of default rules depending on patients’ values); Charles F. Sabel & William H. Simon, *Minimalism and Experimentalism in the Administrative State*, 100 GEO. L.J. 53, 76 (2011) (examining the proposal that defaults be chosen by “intelligent assignment”); Annette Rid & David Wendler, *Use of a Patient Preference Predictor to Help Make Medical Decisions for Incapacitated Patients*, 39 J. MED. & PHIL. 104, 104 (2014) (proposing the use of a “Patient Preference Predictor” that uses surveys and demographics to predict the care that an incapacitated patient would choose).

²⁶³ Cf. Kristin Madison, *Patients as “Regulators”? Patients’ Evolving Influence over Health Care Delivery*, 31 J. LEGAL MED. 9, 23 (2010) (noting the concern that “consumers may make decisions based on short-term financial consequences, without a full understanding of their decisions’ long-term financial and health consequences”).

²⁶⁴ See Oechsner & Schaler-Haynes, *supra* note 23, at 306.

²⁶⁵ See Hoffman, *supra* note 12 (manuscript at 29–33).

ture on which Hoffman bases her critique, however, focuses on the inability of choice architecture to rectify poor *financial* decisions that individuals make when choosing between plans with similar or identical content, such as ACA exchange or Medicare Advantage plans.²⁶⁶ Although she asserts that individuals will also fail to effectively choose between plans with different content, this argument is speculative because content choice has not been empirically examined in depth. And there is some—though not decisive—reason to think that choice architecture may be more effective at reducing misprediction and decisional regret when individuals are making choices about what treatments they value, rather than making choices about how to pay for treatments.²⁶⁷

The risk of misprediction must also be weighed against the benefits of choice. Eliminating choice avoids the possibility of misprediction, just as it eliminates adverse selection. But eliminating choice also sacrifices the gains in well-being and autonomy that are realized when patients can select a plan that better matches their values.

C. *Undesirable Options and Bargaining Power*

Offering insurance purchasers more options could harm them by weakening their bargaining power. Consider Thomas Schelling's famous example: one way to win a game of "chicken"—where two cars drive straight at each other, and the first to swerve loses—is to throw your steering wheel out the window, thereby signaling that you have no option but to continue straight ahead.²⁶⁸ The driver with fewer options is more likely to prevail.

A Schelling-esque situation could arise for insurance purchasers if having more options exposes them to pressure from family members or society to select cheaper plans or reduces sympathy for purchasers whose choices turn out badly.²⁶⁹ For instance, even though poor buyers might be better off if public spending was used to purchase *both* the cheaper package of interventions offered by the United King-

²⁶⁶ See *id.*

²⁶⁷ See Nicholas L. Berlin et al., *Feasibility and Efficacy of Decision Aids to Improve Decision Making for Postmastectomy Breast Reconstruction: A Systematic Review and Meta-Analysis*, 39 MED. DECISION MAKING 5, 6–8, 13 (2019) (finding that decision aids for patients making choices about mastectomy or breast reconstruction reduced decision regret and improved patient knowledge).

²⁶⁸ See THOMAS SCHELLING, *ARMS AND INFLUENCE* 116–18 (1966).

²⁶⁹ See Hoffman, *supra* note 12 (manuscript at 33) (criticizing Korobkin's proposal on the basis that "an insurer, hospital, or policymaker can claim that someone chose her own fate if she selected a Level 5 plan, when later denied Level 6 medical care").

dom's National Health Service *and* the difference between the NHS package and a full-service package in the form of a cash grant or assistance with other goods like food or housing,²⁷⁰ the availability of the NHS package could instead simply lead to its being provided instead of the full package. Concerns about pressure to choose undesirable options have been raised as justifications for regulating or limiting choice in other contexts.

That an option could expose some purchasers to unwanted pressure to choose a cheaper option, or could make it possible to reduce public spending, does not settle whether the options should be available—just as it does not settle similar debates elsewhere. Concerns about options and bargaining power are best seen as an invitation for more empirical research. Just as adverse selection and misprediction present trade-offs between the advantages and downsides of choice, the same is true for concerns about undesirable options. While purchasers have an interest in avoiding undesirable options, they also have an interest in obtaining affordable health insurance that aligns with their values.

D. *Decision Fatigue*

Choosing between health insurance plans may be psychologically burdensome. Empirical evidence shows that people find it burdensome to navigate trade-offs between cost and medical need.²⁷¹ The trade-offs examined, however, involve “the way[s] in which cost sharing causes subjective disutility.”²⁷² Affordable Choices plans, where decisions about financing come long before care is needed, may be more akin to the choice to “outsource the rationing function to someone else—whether it is the physician, the insurer, a government regulator, or some third party.”²⁷³ In an Affordable Choices framework, patients “insource” the decision of what care to receive to an earlier time where medical needs are less pressing.

Beyond shifting the time at which decisions are made, there may be other ways to reduce the psychological burden of insurance decisions. Psychological research suggests that people have a finite stock of willpower available in a given amount of time, and that making

²⁷⁰ See *supra* note 188 and accompanying text.

²⁷¹ Christopher T. Robertson & David V. Yokum, *The Burden of Deciding for Yourself: The Disutility Caused by Out-of-Pocket Healthcare Spending*, 11 *IND. HEALTH L. REV.* 609, 617 (2014) (considering whether “it may . . . be stressful and otherwise psychologically burdensome for patients to think about . . . costs when making decisions”).

²⁷² *Id.* at 631.

²⁷³ *Id.* at 618.

complex decisions, such as choosing between health plans, depletes this stock.²⁷⁴ Offering purchasers a small default menu of plans, and having them only view a broader range of plans if they opt in, could help to reduce decision fatigue.²⁷⁵ Some research on consumer decisions in a non-health context suggests that a single-digit menu of choices is preferable both to no choice and to an excessive number of choices.²⁷⁶

Going further, Affordable Choices plans could reduce both decision fatigue and misprediction and still preserve meaningful choice by standardizing deductibles and copayments and by offering a more limited range of premiums while allowing the package of interventions to vary, reversing the current norm of standardizing interventions while allowing wide variation in premiums and other costs. Replacing the current regime of choice, which mostly involves weighing upfront premiums against point-of-service deductibles and copayments, with a regime of content choice might both improve decision-making and make it less stressful.²⁷⁷ That patients struggle to make good decisions between plans with identical content yet complex differences in financing, as Hoffman and others have documented,²⁷⁸ does not foreclose the potential value of permitting patients to choose between plans with qualitatively meaningful differences in content. Most patients are not experts in economics or in insurance design, but they do have a broad idea of the sort of future life they want.

Legal academic Seana Shiffrin, meanwhile, argues that personal decisions should be based on reasons closely related to an individual's own plans and projects, and that individuals should in some cases be shielded from the financial dimensions of those decisions.²⁷⁹ Shiffrin

²⁷⁴ See Lee Anne Fennell, *Willpower Taxes*, 99 GEO. L.J. 1371, 1390 (2011) (“[S]elf-control seems to share a common, depletable fund with other cognitive tasks, such as decision making. . . . [T]he notion that willpower exertions are taxing seems quite robust.”).

²⁷⁵ See Robertson & Yokum, *supra* note 271, at 623 (“[A] variety of experimental and field studies have revealed a ‘paradox of choice,’ wherein the availability of more choice options actually *decreases* decision quality and satisfaction.”); cf. Monahan, *supra* note 130, at 531 (discussing how more limited plans offer a “simplified shopping experience”).

²⁷⁶ See Natalie Ram, *Tiered Consent and the Tyranny of Choice*, 48 JURIMETRICS J. 253, 283–84 (2008) (describing that, in the context of consumer decision-making, a set size of 6 was preferable to set sizes of 30 or 24, set sizes of 3 and 6 were preferable to a set size of 9, and that set sizes of 6 and 30 were both preferable to a no-choice condition, and concluding that “tiered consent is preferable to blanket consent[and that] some choice is preferable to virtually none”).

²⁷⁷ Cf. Hoffman, *supra* note 12 (manuscript at 24–26) (offering evidence that even informed consumers struggle with premiums).

²⁷⁸ See *id.*

²⁷⁹ Seana Valentine Shiffrin, *Paternalism, Unconscionability Doctrine, and Accommodation*, 29 PHIL. & PUB. AFF. 205 (2000).

argues, for example, that society should not allow smokers to be charged more for medical insurance, because decisions about whether to smoke should be made in light of the impact of smoking on their own personal life goals.²⁸⁰ More generally, she argues that society should assume the costs of decisions that “are highly personal ones involving the body,” or that are “difficult to make and involve hard cases, difficult judgments, or areas in which agents are highly vulnerable or susceptible to overvaluing the opinions or effects on others.”²⁸¹

Shiffrin’s approach would insulate individuals not only from the financial effects of their health *status*, but also from the effects of their health *choices*. As a practical matter, the ACA rejects Shiffrin’s approach: it permits insurers to charge smokers more and wellness program participants less.²⁸² And as a normative matter, Shiffrin’s approach is contestable. While people should not be denied essential treatments, it is acceptable to ask them to bear some of the cost of receiving treatment where reasonable disagreement exists about the worth of that treatment.

V. FAIRNESS TO SOCIETY: SOLIDARITY AND EXTERNALITIES

A. *Solidarity and the Need for a Single Plan*

Some have argued that while a single national insurance plan would promote social solidarity, choice would diminish solidarity between people whose health-related values differ.²⁸³ This concern can be understood empirically or conceptually. The empirical concern is that diminished solidarity will weaken social support for health insurance.²⁸⁴ While this concern is difficult to reject without data, one reason for skepticism is that people in other contexts regard themselves as common beneficiaries of the same institution and serve as a powerful force for maintaining it, even while receiving different individual benefits from the institution. For instance, alumni of a university may share pride in their alma mater despite having pursued different degrees.

²⁸⁰ *Id.* at 247–48.

²⁸¹ *Id.* at 248.

²⁸² Wendy K. Mariner, *The Affordable Care Act and Health Promotion: The Role of Insurance in Defining Responsibility for Health Risks and Costs*, 50 DUQ. L. REV. 271, 288 (2012).

²⁸³ See, e.g., Rashi Fein, *Health Care Reform*, 267 SCI. AM. 46, 50 (1992) (suggesting that “by including everyone” in the same plan, “the fates of diverse income groups are inexorably intertwined”).

²⁸⁴ See *id.*

The conceptual concern, in contrast, sees individual choice between different health insurance options as necessarily socially divisive. This concern is often levied against “consumer-directed” health insurance plans,²⁸⁵ and deploys some of the same language used to criticize “neoliberal” policy initiatives more generally for their alleged overemphasis on choice.²⁸⁶ Lars Thorup Larsen and Deborah Stone, for instance, describe “enabling citizens to choose among multiple insurance plans” as one of three elements that “characterize neoliberal reforms.”²⁸⁷ Larsen and Stone’s other two elements are the placement of health insurance under the control of private firms, and the introduction of “market competition where formerly there had been public-sector dominance or monopoly.”²⁸⁸ As explained in Part II, content choice need not involve privatization or markets, but it does involve providing citizens with choice and, therefore, also involves competition among plans.

The Affordable Choices approach, however, is not *neoliberal* as Stone and Larsen define the term: it does not “hold individual freedom as the highest political value,” nor is it inattentive to “how poverty and powerlessness constrain . . . choice[].”²⁸⁹ Nor does it require the contraction of the state and the expansion of the private sector. But the Affordable Choices framework is *liberal*,²⁹⁰ because it regards

²⁸⁵ See Martha T. McCluskey et al., *Law and Economics: Contemporary Approaches*, 35 *YALE L. & POL’Y REV.* 297, 306–07 (2016) (criticizing the view, attributed to the ACA’s architects, that “health insurance should be like mainstream consumer goods—offered on an internet-driven marketplace, with sufficient choice to enable consumers to expertly weigh their preferences for containing costs”); cf. Marshall B. Kapp, *Home and Community-Based Long-Term Services and Supports: Health Reform’s Most Enduring Legacy?*, 8 *ST. LOUIS U. J. HEALTH L. & POL’Y* 9, 29 (2014) (describing views that “portray consumer choice negatively as a neoliberal conspiracy”).

²⁸⁶ See, e.g., David Singh Grewal & Jedediah Purdy, *Introduction: Law and Neoliberalism*, 77 *LAW & CONTEMP. PROBS.*, no. 4, 2014, at 1, 13 (criticizing “the picture of economic life that neoliberalism celebrates” which glorifies “equal enjoyment of unfettered consumer choice, either as a buyer of traditional commodities or as a consumer of any other activity that can be recast as a form of individual consumption”); Benjamin Justice, *The Originalist Case Against Vouchers: The First Amendment, Religion, and American Public Education*, 26 *STAN. L. & POL’Y REV.* 437, 441 (2015) (describing the core tenet of neoliberalism as “enhancing consumer choice”).

²⁸⁷ Lars Thorup Larsen & Deborah Stone, *Governing Health Care Through Free Choice: Neoliberal Reforms in Denmark and the United States*, 40 *J. HEALTH POL. POL’Y & L.* 941, 941–42 (2015).

²⁸⁸ *Id.* at 942.

²⁸⁹ *Id.* at 945; see also Grewal & Purdy, *supra* note 286, at 6 (describing neoliberalism as committed to economic efficiency, strong property rights, and markets).

²⁹⁰ See Hila Keren, *Women in the Shark Tank: Entrepreneurship and Feminism in a Neoliberal Age*, 34 *COLUM. J. GENDER & L.* 75, 112 (2016) (discussing how “both liberal and neoliberal traditions associate [consumer choice] with liberty and autonomy”).

the ability to make consequential choices about one's life—including one's health—as an important, albeit not the single paramount, value.²⁹¹

Its liberal commitment to choice makes the Affordable Choices approach uncongenial to perspectives that reject individual choice in favor of social agreement on a common plan. Such perspectives are more often expressed in recent debates by adherents of non-liberal left views, but are also compatible with right-wing authoritarian views that stress the importance of shared community values.²⁹² For example, notwithstanding the freedom of choice that SNAP benefits afford recipients, some critics on the left have argued that SNAP should be replaced by publicly provided meals with standardized ingredients,²⁹³ while the Trump Administration has made similar arguments from a right-wing perspective.²⁹⁴

The sort of solidarity compatible with the Affordable Choices framework—so-called *liberal* solidarity—is normatively preferable to so-called *communitarian* solidarity.²⁹⁵ Under liberal solidarity, people collectively commit to support social institutions that enable a diverse

²⁹¹ Cf. Erez Aloni, *Pluralizing the "Sharing" Economy*, 91 WASH. L. REV. 1397, 1456 (2016) (discussing a "pluralistic theory [that] does not advocate unrestrained choice: in cases of market failure, harm to third parties, and opportunistic behavior pluralistic theory endorses a system with some restrictions").

²⁹² Cf. Randall Peerenboom, *Out of the Pan and into the Fire: Well-Intentioned but Misguided Recommendations to Eliminate All Forms of Administrative Detention in China*, 98 NW. U. L. REV. 991, 1070 (2004) (identifying the "higher priority assigned by statist socialists (as well as neo-authoritarians and communitarians) to social stability relative to individual freedoms").

²⁹³ Nathan J. Robinson, *A Public Option for Food*, CURRENT AFF. (Nov. 6, 2017) <https://www.currentaffairs.org/2017/11/a-public-option-for-food> [<https://perma.cc/FP3S-3A7F>].

²⁹⁴ Sasha Abramsky, "America's Harvest Box" Captures the Trumpian Attitude Toward Poverty, NEW YORKER (Feb. 14, 2018), <https://www.newyorker.com/business/currency/americas-harvest-box-captures-the-trumpian-attitude-toward-poverty> [<https://perma.cc/5HCV-6RDP>] ("Currently, SNAP benefits are . . . spendable at almost any store that sells food. The Department of Agriculture wants to dock about half of that money and replace it with an 'America's Harvest box,' consisting of '100 percent U.S.-grown and produced food.'").

²⁹⁵ I draw this distinction from the debate in political theory between liberal and communitarian thinkers. See Daniel Bell, *Communitarianism*, STAN. ENCYCLOPEDIA PHIL. (Mar. 21, 2016), <https://plato.stanford.edu/archives/sum2016/entries/communitarianism/> [<https://perma.cc/LCS8-DZ6X>] (contrasting liberalism, on which "the principal task of government is to secure and distribute fairly the liberties and economic resources individuals need to lead freely chosen lives," with "the Aristotelian ideal of the intimate, reciprocating local community bound by shared ends"). The distinction between liberal and communitarian approaches has influenced legal scholarship. See, e.g., Joshua Kleinfeld, *Reconstructivism: The Place of Criminal Law in Ethical Life*, 129 HARV. L. REV. 1485, 1561 (2016) (observing that "liberals argue that we do not share thick or substantive first-order ethical ideas, so we must find thin or procedural second-order ideas to agree about for purposes of regulating public life; communitarians answer that the second-order agreement is illusory and that we can and do find agreement on the first order").

range of individual choices and lifestyles, rather than pledging allegiance to one specific way of life.²⁹⁶ As an example, recall alums' common pride in and allegiance to their alma mater, despite the wide range of different experiences possible within the same university. Liberal solidarity is compatible with the diverse values and identities that characterize successful, modern-day market democracies.²⁹⁷ In contrast, communitarian solidarity, in which people share an allegiance to a common vision of worthwhile health care, tends to entrench and mandate majority values, and will see diverse ways of life as a weakness rather than a strength.²⁹⁸ Liberal solidarity, for instance, is more likely to allow minority groups to select access to Medicare or Medicaid benefits that diverge from the treatments preferred by the majority.²⁹⁹

Liberal solidarity's emphasis on institutions that facilitate individual choice rather than those that require collective choice has particular appeal in the health care arena. While the collective provision of education means that society or local communities may need to collectively choose a single curriculum for primary and secondary education, health care services are provided individually rather than collectively. Under some circumstances, individual choice better fosters solidarity than collective choice.³⁰⁰ Juxtaposing Emanuel's initial critique of educational vouchers—that “they seem to encourage private, market choices rather than communal deliberation and action”³⁰¹—with his later work illustrates this point. Emanuel initially argues that his proposal for health insurance vouchers does not suffer from the same problems as educational vouchers because

²⁹⁶ See Richard S. Markovits, *Legitimate Legal Argument and Internally-Right Answers to Legal-Rights Questions*, 74 CHI.-KENT L. REV. 415, 455 (1999) (claiming that “liberals . . . are definitionally committed to the second-order good of individuals' choosing for themselves what to value”); cf. Kleinfeld, *supra* note 295, at 1561 (describing liberals as committed to agreement on procedure rather than substance).

²⁹⁷ See Peter H. Schuck, *The Perceived Values of Diversity, Then and Now*, 22 CARDOZO L. REV. 1915, 1939–42 (2001).

²⁹⁸ See Linda C. McClain, *Rights and Irresponsibility*, 43 DUKE L.J. 989, 995–96 (1994) (arguing that “communitarianism, with its emphasis on listening to the ‘moral voice of the community’ and holding individuals to ‘values we all share,’ does not take diversity and pluralism seriously enough”); Schuck, *supra* note 297, at 1946–47 (arguing that although “liberalism is conducive and congenial to diversity, [the] communitarian vision . . . finds diversity at best problematic to its program of communal cohesion,” because “at the heart of the communitarian vision are not individual purposes but common ones”).

²⁹⁹ See, e.g., *Tips for Choosing a Health Plan*, *supra* note 185.

³⁰⁰ See EMANUEL, *supra* note 112, at 187–88.

³⁰¹ *Id.* at 188.

the worst aspects of a voucher system—its undermining of communal association and decision-making—will be limited . . . because individuals and families will not just be purchasing a good, but will be participating in deciding policies under which they will receive their medical care. . . . [T]he way a CHP makes decisions regarding the provision of health care services will require citizen-members to participate in communal deliberations.³⁰²

Emanuel's initial proposal to base content choice on communal deliberation rather than regulated individual choice overlooks a factor that his later critique of single-payer insurance identifies.³⁰³ Communal deliberation can provoke conflict,³⁰⁴ whereas facilitating individual choice is likely to foster greater harmony and solidarity. This possibility is particularly acute for sensitive and personal topics like health care.³⁰⁵ In a diverse society like present day America, the choice between a variety of prepackaged Affordable Choices plans with content deliberation outsourced to other national systems is even more clearly preferable to a collective deliberative effort that attempts to reach consensus on a single, federally-administered national plan.³⁰⁶

Solidarity concerns might translate into mandates that all insurance plans include coverage for certain conditions. Such mandates may, for example, require all plans to provide treatments that have large benefits for society in general, such as vaccinations, lead screening, or treatments for childhood illnesses.³⁰⁷ Requiring coverage for

³⁰² *Id.*

³⁰³ See Emanuel, *supra* note 50, at 41.

³⁰⁴ See Jack Knight & James Johnson, *Aggregation and Deliberation: On the Possibility of Democratic Legitimacy*, 22 POL. THEORY 277, 286 (1994); see also Tali Mendelberg & John Oleske, *Race and Public Deliberation*, 17 POL. COMM. 169, 171–72 (2000) (discussing conflict arising from deliberation).

³⁰⁵ Cf. Joseph Heath, *More Democracy* (unpublished manuscript), <http://homes.chass.utoronto.ca/~jheath/Oldch11.pdf> [<https://perma.cc/AX35-HJ9D>] (criticizing a “participatory economics” proposal in which “households . . . aggregate their plans at the neighborhood level, with an additional process of democratic deliberation and revision,” because “this means that your neighbors get to snoop through your consumption plan, and vote down anything they don’t like”).

³⁰⁶ Cf. Emanuel, *supra* note 50, at 41 (“[W]hen single-payer advocates think about who would run the national health plan, they think of Ted Kennedy. But . . . what if the head were Dick Cheney?”). *But see* Hoffman, *supra* note 12 (manuscript at 80–85) (arguing that collective deliberation about the design of health plans can be successful).

³⁰⁷ See Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1367 (“Mandated health benefits can . . . address problems related to externalities. . . . The positive externalities associated with immunization are a common example of externalities resulting in a suboptimal level of insurance.”); Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation*

treatments with positive social externalities, as discussed in the next Section, is consistent with the values underpinning Affordable Choices plans. But other such mandates might require treatments for which patient and provider interest groups have lobbied, including chiropractic procedures, in vitro fertilization, and off-label treatments for cancer.³⁰⁸ Within a framework of liberal solidarity, some discrete groups' desire for everyone to have access to treatments they provide or personally value is not a persuasive reason to require the public subsidization of such access.

Several factors mitigate potential conflict between state benefit mandates and Affordable Choices plans. First, state benefit mandates do not apply to self-insured plans under the Employment Retirement Income Security Act,³⁰⁹ such as the Bind plans discussed in Section I.D.³¹⁰ Second, some states explicitly allow insurers to offer "limited benefit" plans that need not comply with state benefit mandates;³¹¹ while limited benefit plans have been unpopular because they exclude highly valued treatments (such as all hospital services), Affordable Choices plans that offer a broad range of services could present more popular options. Third, many benefit mandates require only some degree of coverage for a specified condition, which international reference coverage plans, for instance, already provide. Lastly, even if Affordable Choices plans are constrained by state or local benefit mandates, they would still provide cost savings so long as the number of mandates is not excessive.

of Managed Care, LAW & CONTEMP. PROBS., Autumn 2002, at 169, 195 (noting that some mandated benefits "are justified by classic public goods considerations (for example, coverage of clinical trials), some by collective action or adverse selection concerns (for example, pregnancy), and some by predictable forms of consumer irrationality (for example, mental health)").

³⁰⁸ See Sloan & Hall, *supra* note 307, at 195 (observing that some mandated benefits "respond only to private interests of providers or advocacy groups (for example, coverage of chiropractic care)"); see also David A. Hyman, *Health Insurance: Market Failure or Government Failure?*, 14 CONN. INS. L.J. 307, 315 (2008) (asserting that "provider lobbying . . . often aided by a small group of affected patients and/or relatives of patients" typically motivates coverage mandates); cf. Jessica Mantel, *Setting National Coverage Standards for Health Plans Under Health-care Reform*, 58 UCLA L. REV. 221, 262 (2010) (proposing an "actuarial offset requirement [that] would . . . require those advocating legislation or an amendment that would mandate coverage of a particular benefit to identify offsetting exclusions").

³⁰⁹ Monahan, *supra* note 307, at 1371–72.

³¹⁰ See *supra* Section I.D.2.

³¹¹ Isabel Friedenzohn, *Limited-Benefit Policies: Public and Private-Sector Experiences*, STATE COVERAGE INITIATIVES ISSUE BRIEF, July 2004, at 1, 1, http://www.statecoverage.org/files/Limited-Benefit%20Policies%20-%20Public%20and%20Private-Sector%20Experiences_1.pdf [<https://perma.cc/JE6M-N58T>].

Solidarity concerns might also give rise to legal complaints that Affordable Choices plans violate antidiscrimination provisions in the ACA or the Americans with Disabilities Act. Such complaints have been directed at plans that exclude treatments with poor cost-effectiveness. Oregon's Medicaid plan, for instance, has been accused of illegal discrimination for excluding cancer treatment for patients with poor prognoses.³¹² Private insurers have similarly been accused of discriminating against patients with disabilities by imposing step therapy requirements (where cheaper drugs must be tried before costlier ones) only on certain treatments.³¹³ That Affordable Choices plans are selected by patients, rather than externally imposed, and that permission is granted to insurers to use "reasonable medical management technique[s]"³¹⁴ makes the charge of discrimination less compelling.

B. Externalities

As discussed above, treatments that have large benefits for the general public are appropriate for benefit mandates.³¹⁵ For instance, all Affordable Choices plans should include vaccinations and prenatal care. These interventions share a core feature with many public goods, namely that they have benefits—*positive externalities* in economic terms—for the public.³¹⁶

Health care, however, is not typically a public good.³¹⁷ Unlike paradigm public goods like clean air, health care is excludable (people can be kept from receiving it) and rival (two people cannot simultaneously take the same pill or be operated on by the same surgeon).³¹⁸ Subsidized access to medical care—or mandatory purchase of that

³¹² Persad, *supra* note 69, at 145.

³¹³ See Sharona Hoffman, *Step Therapy: Legal, Ethical, and Policy Implications of a Cost-Cutting Measure*, 73 *FOOD & DRUG L.J.* 38, 52 (2018); see also Steven D. Pearson, *Why the Coming Debate over the QALY and Disability Will Be Different*, 47 *J.L. MED. & ETHICS* 304, 306 (2019) (discussing criticism of an employer who launched "a new health insurance plan for its employees in which coverage could be denied if a new drug did not meet a specific [cost-effectiveness] threshold").

³¹⁴ Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 *Fed. Reg.* 12,834, 12,847 (Feb. 25, 2013) (codified at 45 *C.F.R.* pts. 147, 155, 156).

³¹⁵ See Monahan, *supra* note 307, at 1367.

³¹⁶ See Elhauge, *supra* note 104, at 1480–81 ("[I]mmunizations have a health benefit 'external' to the purchaser: they protect other persons against the spread of any contagious diseases that unimmunized persons might otherwise contract.").

³¹⁷ M. Gregg Bloche, *Corporate Takeover of Teaching Hospitals*, 65 *S. CAL. L. REV.* 1035, 1090 (1992) ("[M]edical care is not a public good."). *Contra* Madison & Jacobson, *supra* note 11, at 116 ("[H]ealth care is a public good.").

³¹⁸ See Bloche, *supra* note 317, at 1090 ("For any given level of aggregate medical services

care—is instead typically justified by a societal commitment to at least some medical treatments being “merit goods” that should be universally accessible, just as some, but not all, types of food and housing are.³¹⁹

Even when a treatment lacks obvious positive health externalities, seeing others suffer the bad consequences of going untreated may be unsettling.³²⁰ For instance, a patient who purchases a plan that excludes heart transplants and then dies of preventable heart failure may upset others, even if there are compelling reasons to prioritize other spending over heart transplant coverage. Such outcomes will be infrequent, but possible, in Affordable Choices plans. Ultimately, psychological upset suffered by others—in contrast to physical harm—cannot justify limiting competent decisionmakers’ reasonable choices regarding what health care to obtain. The legal limits of the right to refuse medical treatment illustrate the difference between psychological upset and risk of physical harm. Patients can be quarantined or forced to receive treatment because of risks to others’ health,³²¹ but they cannot be forced to receive treatment merely because their refusal would upset others or contravene community values.³²²

expenditure, caring for one patient reduces the services available to others. Moreover, exclusion of nonpaying patients poses little administrative difficulty.”).

³¹⁹ See Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 7, 51 (“[H]ealth care is a paradigmatic example of a so-called merit good, something that society does not wish to see distributed solely on the basis of individuals’ ability and willingness to pay. But characterizing health care in general as a merit good does not preclude its being treated as a consumer good at the margin.”); Mead Over, *The Public Interest in a Private Disease: An Economic Perspective on the Government Role in STD and HIV Control*, in SEXUALLY TRANSMITTED DISEASES 3, 4 (3d ed. 1999) (“[A]lthough food is a private, not a public, good, many societies guarantee a minimum amount of it to everyone on the grounds that it is a ‘basic need’ or ‘merit good.’”).

³²⁰ See Mark A. Hall, *Public Choice and Private Insurance: The Case of Small Group Market Reforms*, 1998 U. ILL. L. REV. 757, 761 (“Adequate health care is a public good not only due to contagious disease but because of the distress we feel when we see or contemplate others, including our future selves, suffering or dying needlessly from preventable or correctable illness or injury.”).

³²¹ E.g., *In re* Commitment of Almaguer, 117 S.W.3d 500, 503 (Tex. App. 2003); *In re* Washington, 716 N.W.2d 176, 184 (Wis. Ct. App. 2006) (Kessler, J., concurring in part, dissenting in part) (discussing a “scheme that gives public health departments the authority to compel persons with contagious tuberculosis to accept treatment for the disease”), *aff’d in part, disapproved in part*, 735 N.W.2d 111 (Wis. 2007).

³²² See, e.g., *In re* Conroy, 486 A.2d 1209, 1223, 1225 (N.J. 1985) (“In cases that do not involve the protection of the actual or potential life of someone other than the decisionmaker, the state’s indirect and abstract interest in preserving the life of the competent patient generally gives way to the patient’s much stronger personal interest in directing the course of his own life . . . even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.”).

VI. FAIRNESS TO PROVIDERS

Providers of medical treatment might object to Affordable Choices plans either because they believe these plans may expose them to malpractice liability if they honor the plans' exclusion of certain costly but potentially beneficial treatments, or because these plans limit their professional autonomy regarding which treatments to provide and prescribe. This Part considers these objections.

A. *Malpractice Liability*

Medical providers may worry that not providing costly treatments, even at patients' direction, could expose them to malpractice liability for falling below the customary standard of care.³²³ Affordable Choices plans mitigate this concern in two ways. First, the reasonable disagreement principle discussed in Section II.B means that the treatments excluded from Affordable Choices plans will not be ones that physicians would invariably provide, and patients invariably request, in the absence of Affordable Choices plans' restrictions. Rather, they will be treatments whose merits are in dispute, which weakens the case for malpractice liability.³²⁴ While medical practice always involves some risk of malpractice liability, participating in an Affordable Choices plan would not substantially raise the risk of liability. Second, physicians are increasingly recognized as having an ethical obligation to consider the risk of "financial toxicity" and discuss this risk with patients.³²⁵ Isaac Buck has argued that this ethical obligation should give rise to a legal duty.³²⁶ By allowing patients to refuse access to expensive treatments with dubious value, Affordable

³²³ See Mark A. Hall & Carl E. Schneider, *When Patients Say No (To Save Money): An Essay on the Tectonics of Health Law*, 41 CONN. L. REV. 743, 748 (2009) (discussing the scenario of "a patient suing a doctor for substandard care where the patient refused recommended care because it seemed too expensive").

³²⁴ Cf. *Berthelot v. Stallworth*, 2003-1771 (La. App. 4 Cir. 9/14/04); 884 So. 2d 648, 654 (denying medical malpractice claim on the basis that plaintiff's expert admitted that there were "several standards in the medical community for ordering baseline mammograms"), *writ denied*, 2004-2516 (La. 1/28/05); 893 So. 2d 72.

³²⁵ Peter A. Ubel et al., *Full Disclosure—Out-of-Pocket Costs as Side Effects*, 369 NEW ENG. J. MED. 1484, 1484 (2013) ("[P]hysicians need to disclose the financial consequences of treatment alternatives just as they inform patients about treatments' side effects."); see Alicia Hall, *Financial Side Effects: Why Patients Should Be Informed of Costs*, HASTINGS CTR. REP., May-June 2014, at 41, 43.

³²⁶ See Isaac D. Buck, *The Cost of High Prices: Embedding an Ethic of Expense into the Standard of Care*, 58 B.C. L. REV. 101, 144 (2017) (proposing a change in malpractice law such that "when a patient is administered an expensive procedure, or a highly-priced pharmaceutical drug, that patient could face legally compensable harm").

Choices plans may protect physicians from liability for causing financial toxicity.

B. *Conscience and Freedom of Practice*

Even absent concerns about malpractice liability, providers may prefer to have access to the full spectrum of potential treatments for conditions, without financially motivated limitations. Having to abide by restrictions in Affordable Choices plans may be perceived by providers as destructive to trust between physicians and patients,³²⁷ psychologically burdensome,³²⁸ or a cause of “moral distress.”³²⁹

Considering the cost of treatment can, indeed, be cognitively and psychologically burdensome. But so can other duties, like a physician’s duty to respect patients’ values. The shift from paternalistic, physician-driven decision-making to a regime that centers patients’ values was, and is, no doubt burdensome to many physicians who found it easier to simply implement the treatment they believed was best.³³⁰ Yet, we regard the duty to consider and defer to patients’ values to be an acceptable burden for physicians.

The case for asking physicians to consider costs as part of implementing Affordable Choices plans is particularly strong because the costs at issue are ones that patients themselves have recognized as relevant. Rather than asking providers to violate norms of trust or interpersonal loyalty in the physician-patient relationship, as older models of managed care were criticized for doing, Affordable Choices plans ask providers to broaden their loyalty to patients to include a concern for patients’ financial well-being (which in turn affects their health),³³¹ as well as recognize that different patients assign different importance to health care. Asking a provider to consider costs by participating in an Affordable Choices plan no more makes them a “double agent”³³² than asking them to consider quality as well as length of life when choosing a treatment. In both cases, physicians

³²⁷ Cf. M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919, 923 (2002) (criticizing efforts to permit or require physicians to consider costs).

³²⁸ Maxwell J. Mehlman, *Can Law Save Medicine?*, 36 J. LEGAL MED. 121, 135–36 (2015) (asserting that “some physicians will suffer psychologically” from considering costs).

³²⁹ Scott R. Berry et al., *The Effect of Priority Setting Decisions for New Cancer Drugs on Medical Oncologists’ Practice in Ontario: A Qualitative Study*, 7 BMC HEALTH SERVS. RES. 193, 196 (2007).

³³⁰ See Madison, *supra* note 263, at 25 (“The informed consent requirement . . . inherently limits individual physicians’ abilities to dictate the course of treatment they provide.”).

³³¹ See Buck, *supra* note 326, at 138 (discussing the link between financial burden and lower health-related quality of life).

³³² See Marcia Angell, *The Doctor as Double Agent*, 3 KENNEDY INST. ETHICS J. 279, 280,

demonstrate loyalty by considering multiple dimensions of patient well-being.

Gregg Bloche has objected to the claim that abiding by patients' choice of health plans accords with respecting their values and well-being, and argues that the freedom of choice of "later selves" supports ignoring earlier commitments.³³³ But regarding earlier and later selves as normatively distinct would have radical implications stretching across, and far beyond, health care.³³⁴ In particular, once we accept that earlier selves' authority could be limited in order to protect the self-determination of later selves, it becomes difficult to resist limiting earlier selves' authority in order to protect others more generally.³³⁵ We should be suspicious of the selective invocation of multiple selves in the medical context, particularly when its practical effect would be to enlarge the scope of physicians' discretionary authority, increase demand for costly services, and reduce the burden on physicians of weighing patients' financial interests against their medical interests or of saying no to a patient who could benefit from an intervention.³³⁶ Focusing on a technically difficult surgery without having to think about cost may enable physicians to enjoy the satisfaction of heroically exercising specialized skills,³³⁷ but the more fraught and uncertain task of helping a patient weigh medical benefits against financial

282–84 (1993) (characterizing doctors as "double agents" who are asked to consider costs and arguing "that we embrace this new ethic at our peril").

³³³ See Bloche, *supra* note 327, at 927–29.

³³⁴ See, e.g., Govind Persad, *Evaluating the Legality of Age-Based Criteria in Health Care: From Nondiscrimination and Discretion to Distributive Justice*, 60 B.C. L. REV. 889, 935 (2019) (noting that adopting this view would make, for example, determining property rights and navigating familial relationships difficult).

³³⁵ See DEREK PARFIT, REASONS AND PERSONS 341 (1984) (arguing that, if we accept the multiplicity of selves, "[i]t becomes more plausible to claim that . . . we are right to ignore whether experiences come within the same or different lives").

³³⁶ See Bloche, *supra* note 327, at 928, 953 (noting that ill patients are more deferential to physician judgment, arguing that "emotive, fearful, and hopeful thinking at moments of medical crisis" should be prioritized over the "dispassionate, efficiency-oriented reasoning associated with the ex ante perspective," and suggesting that "[n]eeds for care and respect, protection against abandonment, and preservation of hope for rescue in dire circumstances engender health care spending well in excess of levels we would choose ex ante"). Bloche does admirably recognize that his background as a physician influences his reasoning. *Id.* at 938 n.92.

³³⁷ M. Gregg Bloche, *The Invention of Health Law*, 91 CALIF. L. REV. 247, 306 n.201 (2003) (observing that the "risks and costs of the rescue effort . . . weigh . . . in favor of a rescue endeavor's nobility"); see also MIHALY CSIKSZENTMIHALYI, FLOW 155–56 (1990) (noting that "surgical operations have all the characteristics that a flow activity should have. . . . [T]he surgeon's task is crystal-clear: to cut out the tumor, or set the bone, or get some organ pumping away again," and that "[t]he way surgery is practiced helps block out distractions, and concentrates all one's attention on the procedure").

burdens is arguably a truer expression of loyalty. While providers retain the legal right to refuse patients in Affordable Choices plans, just as they retain the right to refuse Medicaid patients or only accept self-pay patients,³³⁸ their refusal should not be lauded as a rejection of commercialism, but recognized as being in tension with patient self-determination.

CONCLUSION

America's health care system is ripe for improvement. Prices are too high. Public health is underfunded. Ineffective interventions abound. This Article's proposal to allow choice about the content of health insurance will not fix every problem. But it is designed to be complementary to other strategies for improving health care. Likewise, content choice would allow purchasers to select plans that address social determinants of health or exclude ineffective interventions.³³⁹ Some who focus on the problem of excessive prices have criticized efforts to rein in health care utilization as misguided.³⁴⁰ But it is no accident that countries that successfully tackle excessive prices do so by controlling utilization.³⁴¹

The problems with choice identified in health law scholarship remain real, and the critiques that have been offered are valuable. But these critiques should neither romanticize the absence of choice nor overestimate the efficacy of collective choice. It would be a mistake, for instance, to abandon individual choice in favor of even the most careful and deliberative effort to identify which college major, housing

³³⁸ See Sidney D. Watson, *Lessons from Ferguson and Beyond: Bias, Health, and Justice*, 18 MINN. J.L. SCI. & TECH. 111, 122 (2017) ("One out of four doctors and most dentists refuse to treat Medicaid patients."); see also *Ass'n of Am. Physicians & Surgeons, Inc. v. Koskinen*, 768 F.3d 640, 641 (7th Cir. 2014) (discussing physicians who "operate cash-only practices and do not accept insurance").

³³⁹ See *supra* notes 180–82 and accompanying text (discussing social determinants); *supra* Section II.B (discussing plans that rely on expert recommendations).

³⁴⁰ See, e.g., Frank Pasquale, *The Hidden Costs of Health Care Cost-Cutting: Toward A Postneoliberal Health-Reform Agenda*, 77 LAW & CONTEMP. PROBS., no. 4, 2014, at 171, 174 (asserting that although "some scolds claim excess utilization of health care in the United States is driving costs . . . , the most significant culprit behind exorbitant health care costs is high prices, not overutilization"); Adam Gaffney, *What the Health Care Debate Still Gets Wrong*, BOS. REV. (Oct. 17, 2019), <http://bostonreview.net/science-nature-politics/adam-gaffney-what-health-care-debate-still-gets-wrong> [<https://perma.cc/3XBC-S5RR>] (similar).

³⁴¹ See Bagley, *supra* note 175, at 563 (describing how the British National Health Service limits costs); Hoffman, *supra* note 12 (manuscript at 77) (discussing cost control in Britain, France, and Germany).

style, or cuisine “the polity genuinely values.”³⁴² These are all personal decisions about which people deeply and reasonably disagree, reflecting differences in culture and identity. Health care is different, certainly, but not different enough to eliminate choice’s value. And the imperfections of real-world collective choice further strengthen the case for individual choice. The justified hostility to the Trump Administration’s attempt to supplant the food choices SNAP offers with a “Harvest Box” of “100 percent U.S.-grown and produced food”³⁴³ justifies equal wariness about its potential control over the content of a single national health plan.³⁴⁴ That carefully organized, small-scale deliberative initiatives can produce plans that appeal to most or all participants does not mean that real world democracy should supplant choice.

Nor should critiques of content choice assume that the inadequacy of current options, or the failure of choosers when faced with those options, vitiates the value of choice. Universities limit choice in many ways: for example, students do not hire faculty and are not allowed to choose courses arbitrarily or repeatedly take the same course. Yet universities do—and should—allow students to choose their majors or degrees, which are understood as packages of courses curated by experts. Likewise, there is a compelling case against offering plans that are inferior in every way to others; innumerable plans that cover the same interventions but have slightly different deductibles, premiums, and copayments; or “a la carte insurance” without content restrictions.³⁴⁵ But the Oregon Medicaid Plan and the United Kingdom’s NHS each offer distinct and well-designed packages of interventions, as even critics of choice concede.³⁴⁶ Given that the United Kingdom and Oregon plans are each choiceworthy on their own, there is a compelling case for permitting them as options alongside the plans

³⁴² Cf. Hoffman, *supra* note 12 (manuscript at 87) (making this suggestion with respect to health insurance).

³⁴³ See Abramsky, *supra* note 294; Alan Bjerga, *Trump Plan to Swap Food Stamps for Food Faces Skeptical Congress*, BLOOMBERG NEWS (Feb. 20, 2018, 4:00 AM), <https://www.bloomberg.com/news/articles/2018-02-20/trump-plan-to-swap-food-stamps-for-food-faces-skeptical-congress> [<https://perma.cc/P639-GQNW>] (noting that Congressional committee leaders and even the conservative Heritage Foundation were skeptical of the Harvest Box proposal).

³⁴⁴ See Emanuel, *supra* note 50, at 41.

³⁴⁵ See Hoffman, *supra* note 12 (manuscript at 16) (describing “dominated” plans); *Quick Cost and Plan Finder*, *supra* note 156 (listing 45 plans); Sfondeles, *supra* note 134 (reporting statement by Rep. Michael Doyle, D-Pa., in response to desire for insurance excluding prenatal care, that “[t]here is no such thing as a-la-carte insurance”).

³⁴⁶ See, e.g., Hoffman, *supra* note 12 (manuscript at 77, 81) (praising the NHS and Oregon plans).

currently offered, just as we permit students to choose whether to major in economics or in political science. Choice between independently desirable health plans would improve affordability, autonomy, and quality in American health care.